

The Treatment of Attention-Deficit/Hyperactivity Disorder



Presenter:

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Disclosures

The REACH Institute – Faculty honoraria (per diem)

ADHD

Rule of Threes

- 3 Main Symptoms
 - Inattention, Impulsivity, Hyperactivity
- Impacts 3 Basic Functions
 - Focus, Motivation, Planning/Organization
- 3 Mainstays of Treatment
 - Pharmacotherapy, Behavioral therapy, Accommodations

Evidence-Based Pharmacotherapy Treatment

- First Line: Stimulants
- Stimulants have 70-90% response rate
- May require trials with various formulations to get optimal response
- 65-70% respond to one class; up to 90% respond to either
- Side effects profile similar
- Difference in preparations primarily in duration of action
- Evidence provided by MTA Study

Evidence Based Treatment

The M.T.A study:

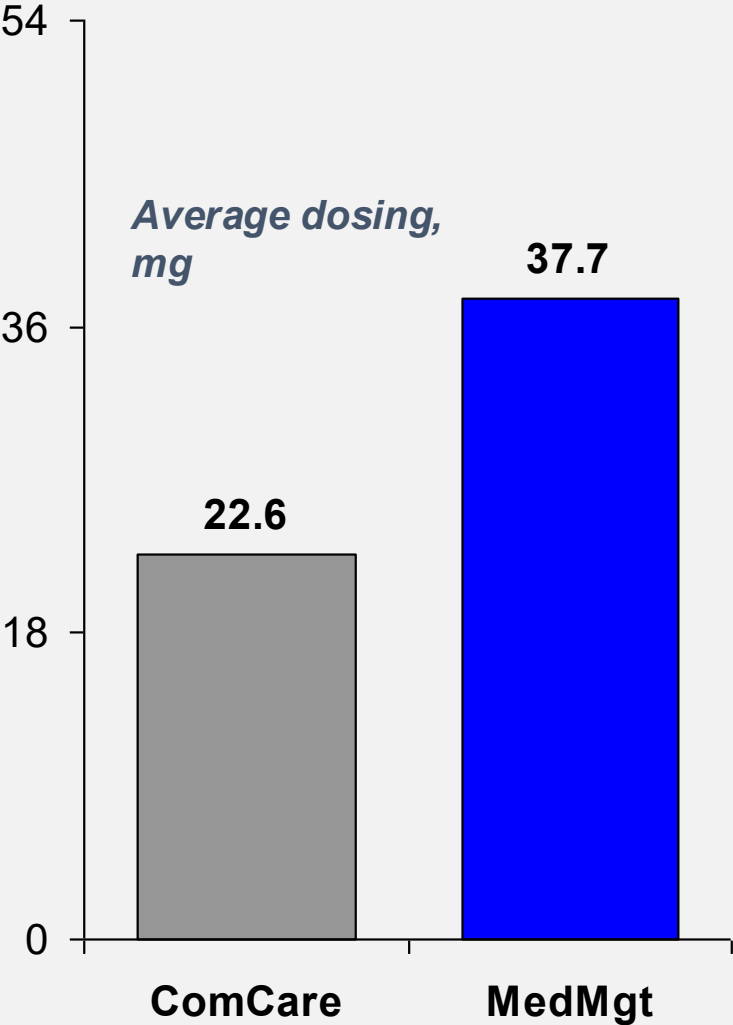
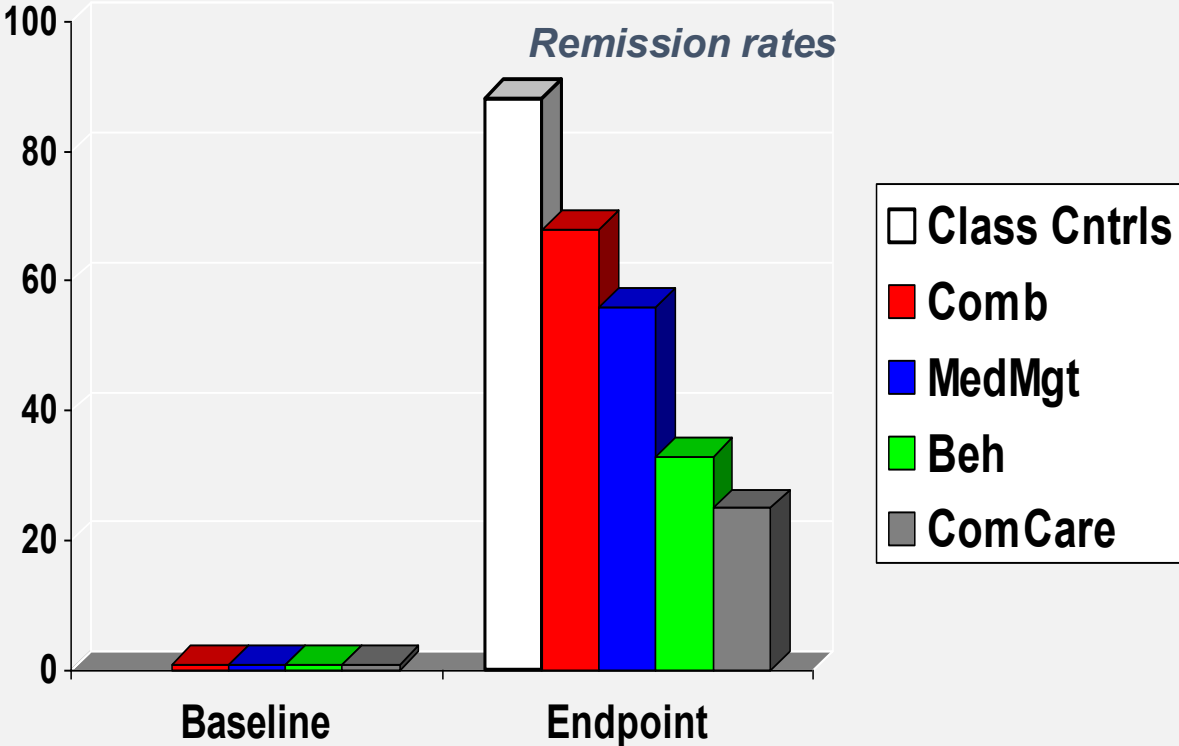
- 1) medication alone – methylphenidate
- 2) medication and behavior therapy
- 3) behavior therapy alone
- 4) treatment as usual

Results:

- 1) MTA style medication management alone – very good outcome
- 2) Combined with behavioral therapy – even better, 10% advantage , especially for anxious kids
- 3) Behavior therapy alone - little benefit
- 4) Community care: Treatment as usual – poor outcome

MTA Study:

Remission Rate Increased with Increasing Dose



ADHD Medication

- How did the MTA trial achieve high-rates of remission?
 - Higher stimulant doses
 - Better coverage in the evenings
 - Follow-up visits monthly for 30 minutes
 - Active contact with school and support network
 - Follow-up Vanderbilts from home and school at each visit
- Use rating scale data to determine place of optimum response and duration of action of AM dose

Dose Effect Time of Stimulant Preparations (hours)

- Methylphenidate
 - Ritalin/Focalin 4
 - Ritalin LA/Metadate CD/ 6-8
 - Focalin XR 8
 - Concerta MPH 10-12
- Amphetamine
 - Dextro/Levo amphetamine (Adderall) 6
 - Adderall XR 8-12
 - Vyvanse 10-12

**Different charts say different things and people are variable!

Side Effects

- **Common**
 - Appetite suppression
 - Sleep disturbance
 - Headache
 - GI upset
- **Less common**
 - Tic exacerbation
 - Rebound
 - Irritability/Emotional lability/Social withdrawal
 - Reduction in growth velocity
 - Hypertension/Tachycardia/Arrhythmia
- **Rare**
 - Psychosis
 - Abuse potential/Diversion

Titration and Follow-Up

- Benefits and side effects occur right away
- Seeking maximum effect with minimum side effects.
- Treat for remission — Improvement is not enough!
- Follow up in one week by phone or in-person
- Follow rating scales and side effects
 - Physical exam: height, weight, bp, pulse.
- Follow-up a few days after dose change.
- When initially stable see monthly as multimodal plan is put in place then every three months.
- Reassess every new school year

Alternative to Stimulants

Norepinephrine Reuptake Inhibitor

Atomoxetine (Strattera)

Viloxazine (Qelbree)

Alpha 2-Agonists

Clonidine (Catapres, Kapvay)

Guanfacine (Tenex, Intuniv)

- Although there is evidence to support their relative effectiveness compared to placebo, the gold standard is the stimulants due to a much larger **effect size**

Atomoxetine

- Dosing based on weight
- Common AEs: irritability, sedation or insomnia, decreased appetite, GI
- Rare accounts of liver damage, suicidal ideation: boxed warning
- Advantages:
 - Once Daily dosing (max 10 Hours)
 - Little abuse potential (adolescents)
 - No apparent effects on growth
 - Does not seem to exacerbate tics
- Disadvantages:
 - Delayed onset (takes 3-6 weeks)
 - Generally not as effective

Atomoxetine Dosing

- 1. Starting dose 0.5mg/kg for first 4 days
- 2. Advance to TARGET dose as close to 1.2 to 1.4mg/kg as you can get. (typical max is 100mg)
- 3. Can be given ONCE or TWICE a day
- 4. Stay at target dose for a month

How supplied: 10, 18, 25, 40, 60, 80, 100mg

Viloxazine (Qelbree)

Dosing for children 6 to 11

- 100mg week 1
- 200mg week 2
- 300mg week 3
- 400mg week 4

*Supplied as 100, 150, 300 & 400 capsules
Can be sprinkled on soft food.*

Dosing for Adolescents 12 to 17

- 200mg week 1
- 400 mg week 2
- Can go to 600mg week 3

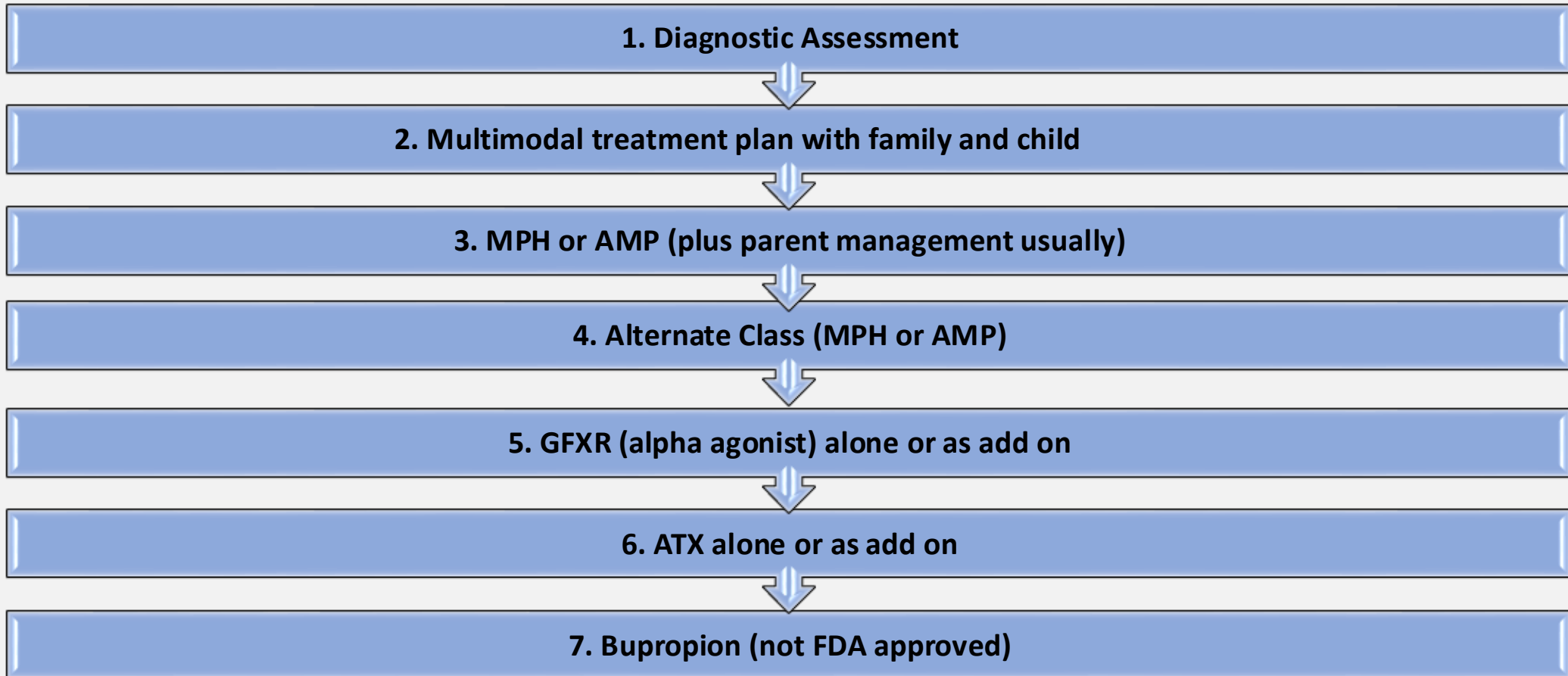
Alpha-2-Adrenergic Agonists

- Guanfacine - start at 0.5mg once or twice a day, 6mg max
- Intuniv (Guanfacine ER) start at 1mg daily- advance weekly, max of 6mg
- Clonidine- start at 0.05mg once at bedtime, advance weekly, 0.4mg max
- Side effects: sedation, lower BP therefore MUST taper when stopping and daily compliance is a safety issue
- Advantages
 - Sedating (sleep difficulties)
 - LA forms given once daily (Kapvay may need BID)
 - Better for hyperactivity and impulsivity than inattention
 - Adjuncts for children with partial response to stimulant

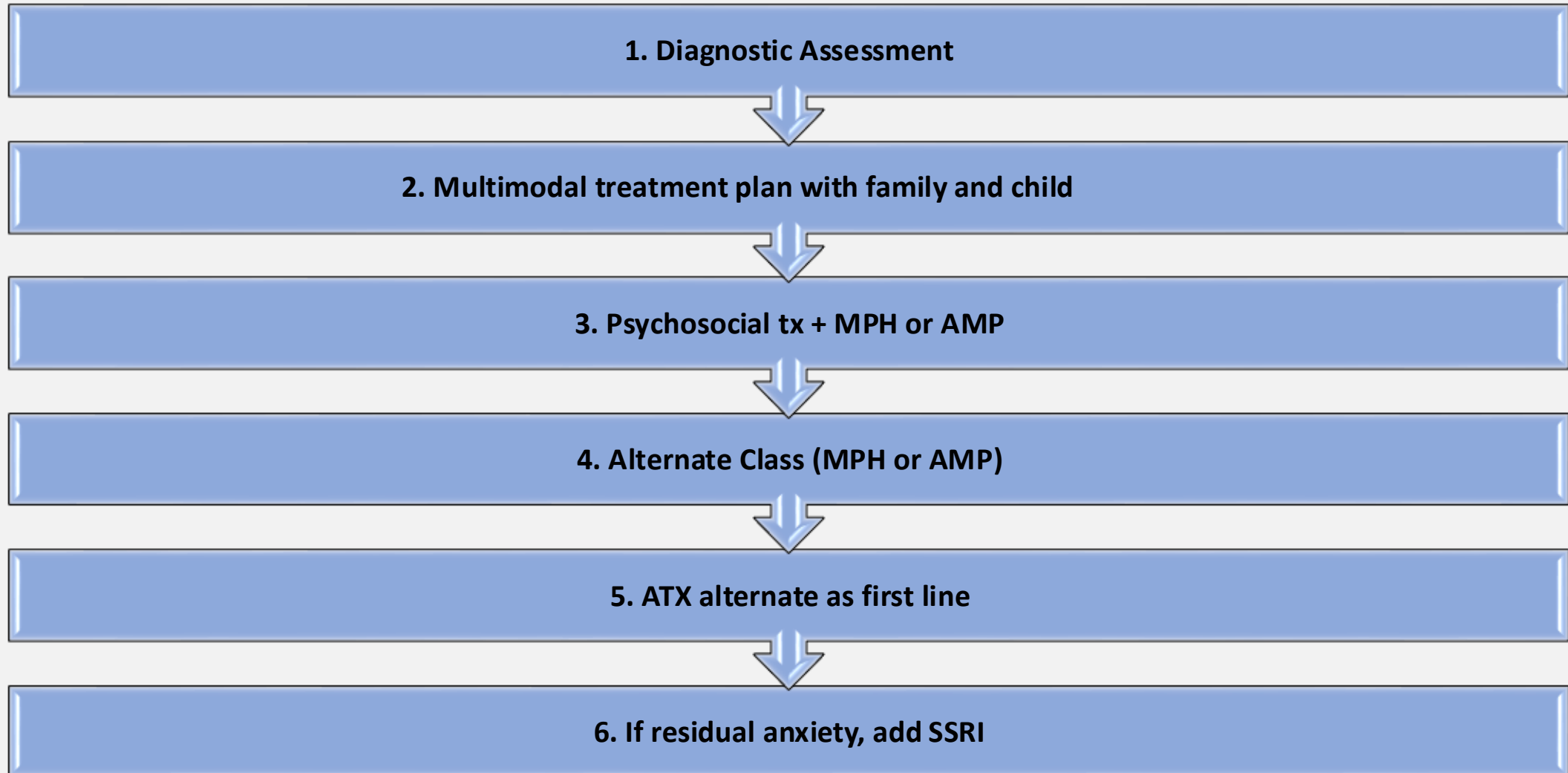
Medication Treatment Responsive Groups

- Children
- Teenagers
- Adults
- Preschoolers (Short et al . 2004, Greenhill et al., 2007)
- Individuals with Intellectual Handicaps (Pearson et al.2004)
- ADHD co-morbid with Other Diagnoses
 - Tourette's Disorder
 - Autism Spectrum Disorder
 - Anxiety/Mood Disorder
 - Conduct Disorder
 - Oppositional Defiant Disorder
 - Substance Abuse Disorder

Garden Variety ADHD



ADHD + Anxiety/Depression





Principles of Behavior Therapy

- Positive reinforcement is much better than negative reinforcement
- Motivation can be improved with pairing preferred and non-preferred activities- work before play!
- Most of us thrive with structure and routine ADHD child needs lots of this!
- Tight collaboration with school- behavior plan, daily report card
- Avoid shaming and excessive punishment

Non-pharmacological Interventions

- Organizational skills training, Peer tutoring
 - Computer assisted instruction – targets attention and working memory- popular in research sector and commercially. Evidence not clear- reviewed by Rutledge 2012
 - EndeavorRx FDA authorized video game. Cost \$100- 25 minutes, 5 days a week for at least 4 consecutive weeks
- Homework focused interventions
- School accommodations
 - Eligibility for a 504 plan
 - Additional time for exams, quiet setting for exams, training interventions at school
 - IDEA (Other Health Impairment) creating an Individual Education Plan (IEP)
 - for appropriate class placement, instructional and behavioral support
- Dealing with co-morbid conditions
- Social skills training if needed

Social Supports

- Support groups (e.g. CHADD)
- Online
 - www.teachingkidstolisten.com
 - www.Help4ADHD.org
- Books
 - 1-2-3 Magic (Tom Phelan)
 - Making the System Work for Your ADHD Child (Peter Jensen)
 - Taking Charge of ADHD: The Complete Authoritative Guide for Parents (Russell Barkley)
 - ADHD: What Every Parent Needs to Know (M Reiff)

Why Should I Treat My Patient's ADHD

Risk of Not Treating

- Academic struggles
- Difficult family and peer relationships
- Risk of injury
- Teen risk-taking and impulsive behavior
- Poor vocational performance
- Dangerous driving

Risk of Treating

- Possible adverse side effects
- Medication misuse/abuse

Bottom Line

- Titrate closely and relatively quickly
- Use your algorithms
- Higher stimulant dose is usually the first step
- Follow up every 3 months only after stable
- Remember psychosocial treatments and school interventions

What would you do for this patient?

- Medication
 - Which one?
 - Dose?
 - How soon to follow up
 - What about sleep?
- Behavior Therapy
 - Suggestions for parents
- Accommodations
 - School-based suggestions?

**My thanks to Dr. J. Wallace at University of Rochester
for the following accommodations menu**

Accommodation Menu

Pro

Focus and Attention

- Seat in the front of the classroom
- Seat away from distractions (fish tank)
- Seat near quiet peers and away from disruptive peers
- Increase space between seats
- Private cue to stay on/return to task
- Involve student in discussions/activities
- Make instructions clear and brief
- Select teachers with energetic, engaging style
- Pair written and oral instructions
- Check to be sure assignments are copied correctly
- Break large assignments into parts with deadlines
- Make extra eye contact with student
- Teach in close proximity to student
- Consider need for smaller environment with more adult support

Accommodation Menu

- **Impulsivity and Hyperactivity**

- ___ Ignore minor impulsive behavior
- ___ Keep student occupied and active
- ___ Supervise closely during transitions
- ___ Reprimand(s) should be brief and private if possible
- ___ Seat near good role model
- ___ Notice and reinforce positive behaviors
- ___ Set up behavior contract with clear short-term goals
- ___ Encourage hand-raising and waiting
- ___ Rewards and consequences should be immediate
- ___ Implement home/school reward token system
- ___ Allow student to stand and move at times
- ___ Provide movement breaks between seated activities
- ___ Consider need for smaller environment with more adult support

Accommodation Menu

Organization and Planning

- ___ Use adults to support organization – teachers, parents, resource teachers
- ___ Create “Homework Loop” to complete daily assignments
- ___ Check to see that assignments are written down correctly
- ___ Be sure correct books go home or consider extra copies
- ___ Encourage parents to set up homework time and place and assistant
- ___ Have teachers ask for completed assignments
- ___ Empty and reorganize book bag and locker at least weekly
- ___ Use colored dividers and folders
- ___ Consider peer assistant for organization
- ___ Use multi-sensory approaches for giving assignments and teaching
- ___ Consider allowing tape recording of assignments and lessons
- ___ Use consistent repetitive approach to getting organized
- ___ Ask student to repeat instructions

Accommodation Menu

Academic Struggles

- ___ Consider referral for testing for any learning concerns/disabilities
- ___ Explore other possible impairing conditions (speech, hearing, learning disabilities)
- ___ Use multi-sensory techniques in all phases of teaching
- ___ Use games, songs and chants/raps for rote learning and memorization
- ___ Accommodate weaknesses in learning – math, reading, foreign language
- ___ Be aware that learning weaknesses worsen attentional problems and vice versa
- ___ Schedule regular meetings/communication with parents about learning concerns
- ___ Direct parents to practice skills with student
- ___ Parents can consider private tutoring or after-school homework support
- ___ Consider need for formal 504 accommodations or Special Education support
- ___ Consider different levels of support (resource room, consult teacher, self-contained setting)
- ___ Emphasize any areas of interest in academics content

ADHD Medication Guide (www.ADHDMedicationGuide.com)

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ADHD Medication Guide*

Revised: July 1, 2025

Methylphenidate Formulations – Long Acting, Oral** (Capsules and tablets in this section are shown at actual size)																			
Releco®†	6-12 Yrs: 18-54mg SR; 18mg SR; 12-17 Yrs: 18-27mg SR; 18mg SR; 18-24mg SR; 18mg SR; 18mg SR	G	18mg	G	27mg	G	36mg	48mg	G	54mg	G	72mg							
Concerta®†	6-12 Yrs: 18-54mg SR; 18mg SR; 12-17 Yrs: 18-27mg SR; 18mg SR; 18-24mg SR; 18mg SR; 18mg SR	G	18mg	G	27mg	G	36mg	48mg	G	54mg	G	72mg							
Ipoclar® 2XR (Methylphenidate)	6-17 Yrs: 18-54mg SR; 18mg SR; 12-17 Yrs: 18-27mg SR; 18mg SR; 18-24mg SR; 18mg SR; 18mg SR	G	18mg	G	27mg	G	36mg	48mg	G	54mg	G	72mg							
Cotempla XR-ODT® (Methylphenidate)	6-17 Yrs: 18-54mg SR; 18mg SR; 12-17 Yrs: 18-27mg SR; 18mg SR; 18-24mg SR; 18mg SR; 18mg SR	G	18mg	G	27mg	G	36mg	48mg	G	54mg	G	72mg							
Aptivio® XR†	6 Yrs-Adult: 10-50mg SR; 10mg SR; 15mg SR; 20mg SR; 25mg SR; 30mg SR; 35mg SR; 40mg SR; 45mg SR; 50mg SR	G	10mg	G	15mg	G	20mg	G	25mg	G	30mg	G	35mg	G	40mg	G	45mg	G	50mg
Quilivant XR (Methylphenidate)	6 Yrs-Adult: 20-50mg SR; 20mg SR; 25mg SR; 30mg SR; 35mg SR; 40mg SR; 45mg SR; 50mg SR	G	20mg	G	25mg	G	30mg	G	35mg	G	40mg	G	45mg	G	50mg				
Quilivant XR (Methylphenidate)	6 Yrs-Adult: 20-50mg SR; 20mg SR; 25mg SR; 30mg SR; 35mg SR; 40mg SR; 45mg SR; 50mg SR	G	20mg	G	25mg	G	30mg	G	35mg	G	40mg	G	45mg	G	50mg				
Ritalin® LA†	6-12 Yrs: 10-60mg SR; 20mg SR; 30mg SR; 40mg SR; 50mg SR; 60mg SR	G	20mg	G	30mg	G	40mg	G	50mg	G	60mg								
Metadate® CD†	6-17 Yrs: 10-50mg SR; 20mg SR; 30mg SR; 40mg SR; 50mg SR	G	20mg	G	30mg	G	40mg	G	50mg										

Methylphenidate Pro-Drug Formulations - Long Acting, Oral** (Medications in this section are shown at actual size)																			
Daytrana® (Methylphenidate transdermal system)	6-17 Yrs: 10-30mg SR; 10mg SR; 15mg SR; 20mg SR; 25mg SR; 30mg SR; 35mg SR; 40mg SR; 45mg SR; 50mg SR	G	10mg	G	15mg	G	20mg	G	25mg	G	30mg	G	35mg	G	40mg	G	45mg	G	50mg

Methylphenidate Formulations – Long Acting/Delayed Onset, Oral** (Medications in this section are shown at actual size)											
Jornay PM®†	6 Yrs-Adult: 20-60mg SR; 20mg SR; 30mg SR; 40mg SR; 50mg SR; 60mg SR	G	20mg	G	30mg	G	40mg	G	50mg	G	60mg

Methylphenidate Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)							
Ipoclar® (Methylphenidate)	6-17 Yrs: Daily: 5-20mg, divided BID or TID; 2.5mg SR	G	2.5mg	G	5mg	G	10mg
Ritalin®	6-12 Yrs: Daily: 10-60mg, divided BID or TID; 5mg SR; 10mg SR	G	5mg	G	10mg	G	20mg
Methylphen Chewable†	6-12 Yrs: Daily: 10-60mg, divided BID or TID; 5mg SR; 10mg SR	G	5mg	G	10mg		
Methylphen Solution (Methylphenidate)	6-12 Yrs: Daily: 10-60mg, divided BID or TID; 5mg SR; 10mg SR	G	5mg	G	10mg		

Daytrana® 6-17 Yrs: 10-30mg SR; 10mg

Daytrana® 15mg / 9 hrs

Daytrana® 20mg / 9 hrs

Daytrana® 10mg / 8 hrs

Daytrana® 15mg / 8 hrs

Daytrana® 20mg / 8 hrs

Daytrana® 30mg / 9 hrs

Administration Keys:

- 1 Daily disintegrating tablets
- 2 Must be swallowed whole
- 3 Chewable
- 4 Can be taken with yogurt, orange juice, or water
- 5 Can open capsule and sprinkle medication on apple sauce
- 6 Can open capsule and mix with apple sauce or yogurt
- 7 Can open capsule and sprinkle medication into water or onto apple sauce

Generic Key:

- 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

* **Important Information:** The ADHD Medication Guide only includes medications indicated by the FDA for the treatment of ADHD. The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SR" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the FDA-approved product information to learn more about each medication.

† **Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhena XR; Ademsy ER (liquid); Cylert (pemoline); Dextroline Spansules (5mg, 15mg); Dextroline tablets; DextroStat tablets; Evebio ODT tablets; LiguADD solution; Metadate CD capsules; Metadate ER tablet (10mg); Methylphen Chewable tablets; Ritalin LA capsule (50mg); Ritalin SR tablets (20mg).

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ADHD Medication Guide

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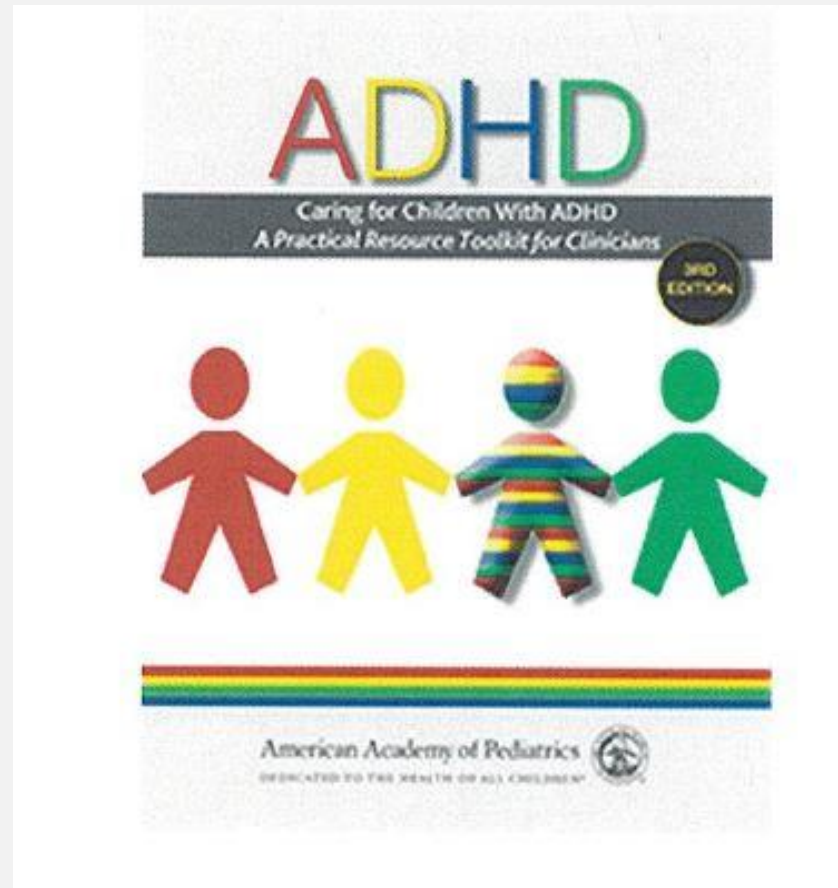
Revised: July 1, 2025

Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)																
Dyanavel® XR ⁵ (d- & l-amphetamine sulfate) (bubblegum flavor)	6 Yrs-Adults: 2.5–20mg; SD: 2.5 or 5mg (biphasic – 20/80)		5mg			10mg			15mg		20mg					
Dyanavel® XR (d- & l-amphetamine sulfate) (7.5mg/mL, bubblegum flavor)	6 Yrs-Adults: 2.5–20mg; SD: 2.5 or 5mg (biphasic – 20/80)	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 (triphasic – 33.3/33.3/33.3)		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 (biphasic – 50/50)		3.1mg		6.3mg		9.4mg		12.5mg		15.7mg	18.8mg				
Adderall XR® [†] (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg Adults: 5–30mg; SD: 20mg (biphasic – 50/50)		5mg		10mg		15mg		20mg		25mg	30mg				
Dexedrine Spansule® (d-amphetamine sulfate)	6–17 Yrs: 10–60mg; SD: 5mg 1-2x/day		5mg		10mg		15mg									
Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)																
Vyvanse® [†] (capsules) (lisdexamfetamine)	6 Yrs-Adults: 10–70mg; SD: 30mg		10mg		20mg		30mg		40mg		50mg	60mg		60mg		70mg
Vyvanse® [†] (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs-Adults: 10–70mg; SD: 30mg		10mg		20mg		30mg		40mg		50mg	60mg		60mg		
Amphetamine Formulations – Long Acting, Transdermal																
Xelstrym™ (d-amphetamine)	6–17 Yrs: 4.5–18mg; SD: 4.5mg Adults: 9–18mg; SD: 9mg		4.5mg / 9hrs ~1.2" x 1.2"		9mg / 9hrs ~1.2" x 1.2"		13.5mg / 9hrs ~1.5" x 1.5"		18mg / 9hrs ~1.7" x 1.7"							
(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										
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		5mg		7.5mg		10mg		15mg		20mg		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		5mg		7.5mg		10mg		12.5mg		15mg		20mg		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		5mg/5mL													
Non-Stimulants** (Medications in this section are shown at actual size)																
Strattera® [†] (atomoxetine)	<70kg: 0.5mg/kg x 3days, then 1.2mg/kg Initial: 40mg/kg, not to exceed 100mg >70 kg: 40mg x 3days, then 80mg (max:100mg)		10mg		18mg		25mg		40mg		60mg		80mg		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							
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 Weight may increase to 0.12 mg/kg/day		1mg		2mg		3mg		4mg							
Onyda™ XR (clonidine, extended release) (orange flavor)	<70kg: 0.5mg/kg x 3days, then 1.2mg/kg Initial: 4mg/kg, not to exceed 100mg >70 kg: 40mg x 3days, then 80mg (max:100mg)	0.1mg 1mL		0.2mg 2mL		0.3mg 3mL		0.4mg 4mL								
Kapvay® [†] (clonidine, extended release)	6–17 Yrs: 0.1–0.2mg BID; SD: 0.1mg qHS		0.1mg													

- 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

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Cohen Children's Medical Center

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AAPP Pharmacist Toolkit: Addressing Stimulant Shortages

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This toolkit is intended to highlight both the evidence base available as well as strategies of clinical decision making used by expert clinicians. The content reflects the views and practice of the authors as substantiated with evidence-based facts as well as opinion and experience. The opinions and recommendations in this document reflect those of the authors and do not necessarily reflect those of their employers or AAPP.

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ADHD

Parents Medication Guide

Revised July 2013



Attention-Deficit/Hyperactivity Disorder

Prepared by:

American Academy of Child
& Adolescent Psychiatry and
American Psychiatric Association
Supported by the Elaine Schlosser Lewis Fund

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