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While psychotropic use is widely accepted for children and adolescents, there is still insufficient evidence of efficacy between the different agents and in terms of their long-term effects in children.

Remember to always monitor for suicidal ideation/behaviors and activation particularly at initiation of medication, dose changes, and discontinuation of medication.

Notification of and/or consultation with the youth's primary care provider is strongly recommended at the time of initiation of psychotropic medications.

Medical Workup and Baseline Studies are required prior to seeking approval and beginning medication. Conditional approval may be granted with the expectation that the studies will be conducted within 30 days of initiation of the medication or the approval may be rescinded. Medical history and physical exam findings may be from the initial visit or as provided by the pediatrician or primary care provider.

DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
ALL STIMULANTS	Height Weight BMI/BMI Percentile Blood pressure Pulse UCG/HCG if clinically indicated. Assess for tics. Assess personal & family cardiac history, if unable consider EKG if clinically indicated. Take seizure history	Height, Weight, BMI/BMI Percentile, Blood pressure, Pulse every 3 months. AIMS as indicated. EKG as clinically indicated.		Be aware of rebound symptoms & insomnia. Caffeine may increase cardiac side effects. ***Please note: When combining short acting and intermediate or long-acting stimulants, the maximum daily dose of the combination will be determined on a case-by-case basis.***

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Methylphenidate				Male patients should be counseled on their ability to cause priapism; consider appropriate intervention if priapism occurs. Monitor CBC if clinically indicated.
Methylphenidate: Short Acting				
Dexmethylphenidate (Focalin)			20mg/day	High fat meal may delay peak
Methylphenidate (Ritalin, Methylin)			60mg/day	Take 30-45 minutes before meals
Methylphenidate: Intermediate Acting				
Methylphenidate (Metadate ER)			60mg/day	Take 30-45 minutes before meals
Methylphenidate: Long Acting				
Dexmethylphenidate (Focalin XR)			30mg/day	High fat meals may delay peak. 50%I R and 50% DR
Methylphenidate (Ritalin LA)			60mg/day	High fat meals may delay peak. 50% IR and 50% DR
Methylphenidate (Metadate CD)			60mg/day	High fat meals may delay peak. 30% IR and 70% DR
Methylphenidate (QuilliChew ER)			60mg/day	Chew tab
Methylphenidate (Quillivant XR)			60mg/day	Suspension is 20% IR and 80% DR

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Methylphenidate (Concerta)			6-12 years of age: 54mg/day 13 years of age and older: 72mg/day	Nonabsorbable tablet 22% IR and 78% CR
Methylphenidate (Aptensio XR)			60mg/day	Capsule contains multilayered beads. 40% IR and 60% CR
Methylphenidate (Cotempla XR-ODT)			51.8mg/day	25% IR and 75% CR
Methylphenidate (Jornay)			100mg	Jornay PM should only be taken in the evening. Adjust the timing of administration between 6:30 p.m. and 9:30 p.m. to optimize the tolerability and the efficacy the next morning and throughout the day.
Methylphenidate (Daytrana)			30mg/day When converting from one form of methylphenidate to the transdermal patch, initiate at 10 mg regardless of previous dose and titrate as needed.	Transdermal patch Can cause permanent skin discoloration where patch is applied.
Serdexmethylphenidate and Dexmethylphenidate (Azstarys)			52.3 mg/10.4 mg	To avoid substitution errors and overdosage, do not substitute for other methylphenidate products on a milligram-per-milligram basis.

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Amphetamines				Consuming with acidic foods may decrease levels.
Amphetamine: Short Acting				
Dextroamphetamine (Dexedrine, Zenzedi, ProCentra)			40mg/day	
Mixed amphetamine salts (Adderall)			40mg/day	d-amphetamine and l-amphetamine salts in a 3:1 ratio
Amphetamine sulfate (Evekeo)			40mg/day	d-amphetamine and l-amphetamine in 1:1 ratio
Amphetamine: Intermediate Acting				
Dextroamphetamine (Dexedrine Spansule)			40mg/day	50% IR and 50% DR
Amphetamine: Long Acting				
Mixed amphetamine salts (Adderall XR)			3 years of age to 6 years if age 0.5mg/kg/day Over 6 years of age 30mg/day	d-amphetamine and l-amphetamine in 3:1 ratio 50% IR and 50% DR
Amphetamine sulfate (Adzenys XR-ODT)			18.8mg/day	
Amphetamine sulfate (Dyanavel XR)			20mg/day	d-amphetamine and l-amphetamine in 1:1 ratio
Mixed amphetamine salt of single-entity amphetamine (Mydayis)			25mg/day	High fat meals can delay peak. Patients under 13 years of age can experience higher plasma concentrations and adverse effects. Contains an IR bead and 2 types of DR

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Dextroamphetamine Transdermal System (Xelstrym)			18 mg/9 hours	Local skin reactions may occur. Do not substitute for other amphetamine products on a milligram-per milligram basis because of different amphetamine base compositions and differing pharmacokinetic profiles.
Lisdexamfetamine (Vyvanse)			70mg/day	Continuous release capsule High fat meals may delay peak.

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NON-STIMULANT ADHD MEDICATION				
Atomoxetine (Strattera)	Height Weight BMI/BMI Percentile Blood pressure Pulse UCG/HCG if clinically indicated.	Height, Weight, BMI/BMI Percentile, Blood pressure, Pulse every 3 months.	1.4mg/kg up to 70kg, 100mg if over 70kg	Be aware that atomoxetine may be associated with hepatic injury.
Viloxazine (Qelbree)	Height Weight BMI/BMI Percentile Blood pressure Pulse UCG/HCG if clinically indicated.	Height, Weight, BMI/BMI Percentile, Blood pressure, Pulse every 3 months.	400 mg/day	Dosing adjustments are necessary for severe renal impairment, and use is not recommended in mild-severe hepatic impairment.
Guanfacine *(B)* (Tenex, Intuniv)	Height Weight BMI/BMI Percentile Blood pressure Pulse UCG/HCG if clinically indicated. EKG if clinically indicated.	Height, Weight, BMI/BMI Percentile, Blood pressure, Pulse every 3 months. EKG as clinically indicated or if symptoms (dizzy, lightheaded) occur.	IR: 4mg for children and adolescents ER: Target dose range is 0.05-0.12 mg/kg/day not to exceed: 4mg/day for children and 7mg/day for adolescents ER dose is intended to be given once daily.	Not 1st line therapy for ADHD unless there is a contraindication to 1st line agents or a co-morbidity. Be aware of rebound hypertension with abrupt discontinuation. Adverse reactions increase significantly at doses >3mg.

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Clonidine (Catapres, Kapvay)	Height Weight BMI/BMI Percentile Blood pressure Pulse UCG/HCG if clinically indicated. EKG if clinically indicated.	Height, Weight, BMI/BMI Percentile, Blood pressure, Pulse every 3 months. EKG as clinically indicated or if symptoms (dizzy, lightheaded) occur.	0.4mg for children and adolescents	Not 1st line therapy for ADHD unless there is a contraindication to 1st line agents or a co-morbidity. Be aware of rebound hypertension with abrupt discontinuation.
ALL LITHIUM PRODUCTS				
Lithium Carbonate *(D)* Lithium Citrate *(D)* (Eskalith, Eskalith CR Lithobid)	UCG/HCG and/or assess pregnancy risks, CBC, electrolyte, BUN/Cr, TSH U/A EKG Ht, Wt, BMI/BMI PERCENTILE, BP/P	Serum drug levels per MD, at dose change, then every 3 months for 1 year, then every 6 months, and as clinically indicated. CBC, electrolytes, BUN/Cr, TSH every 4 to 6 months U/A every 4 to 6 months EKG annually or if clinically indicated. Ht, Wt, BMI/BMI PERCENTILE, BP/P every 3 months for 1 year, then annually	<12 yo: safety and efficacy not established. Under 25kg: 600mg. 25-39kg: 900mg. 40-50kg: 1200mg. >50kg: 1500mg Max dose should be guided by serum levels and clinical response. Therapeutic Range = 0.6-1.2 mEq/L	Be aware of dehydration in hot weather and GI illness; acne; tremors; drug-drug interactions with NSAIDS (e.g., ibuprofen); and need for sun block.

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ANTICONVULSANTS	Anticonvulsant Hypersensitivity Syndrome (AHS) is a rare adverse reaction associated with anticonvulsants. This reaction can range from mild cutaneous rash to drug reaction with eosinophilia and systemic symptoms (DRESS) that can include fever, rash, eosinophilia, and involvement with multiple internal organs. AHS is a diagnosis of exclusion and is underreported; therefore, requiring a high index of suspicion. Monitor for suicidal ideation/behaviors and activation particularly at initiation of medication, dose changes, and discontinuation of medication. Continue ongoing assessments for pregnancy risk.			
Valproic Acid *(D)* (Depakote, Depakote ER, Depakote Sprinkles, Depakene)	UCG/HCG and/or assess pregnancy risk, CBC with platelets, LFT's. Ht, Wt, BMI/BMI PERCENTILE, BP/P	Serum drug levels at dose change, then every 3 months for 1 year, then every 6 months, and as clinically indicated. CBC with platelets, LFT'S at 3 months and 6 months, then every 6 months if WNL. Ammonia if symptoms of encephalopathy. Amylase & Lipase if GI symptoms. Ht, Wt, BMI/BMI PERCENTILE, BP/P at 1 month then every 3 months.	<10 yo: safety and efficacy not established. 10 yo: 60mg/kg/day • children's range is up to 1200mg. • adolescent's range is up to 2500mg. Final dose should be guided by serum levels. Therapeutic Range = 50-125 mcg/ml	For Valproic Acid: Due to the risk of polycystic ovarian syndrome (PCOS) consider alternative in girls.
Carbamazepine *(D)* (Tegretol, Carbatrol, Equetro)	UCG/HCG and/or assess pregnancy risk, CBC with platelets, LFT's, electrolytes. Ht, Wt, BMI/BMI	Serum drug levels at 1 month then every three months and as clinically indicated. CBC with platelets, LFTs, electrolytes at 3 months and	< 6 yo: 35mg/kg/day 6-15 yo: 1000mg/day 16-18 yo: 1200mg/day Final dose should be guided	Oral contraceptives pills (OCPs) may decrease the effectiveness of carbamazepine. Carbamazepine may decrease the effectiveness

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	PERCENTILE, BP/P HLA-B 1502 antigen for Asian population	6 months, then every 6 months if WNL. Ht, Wt, BMI/BMI PERCENTILE, BP/P at 1 month then every three months.	by serum levels. Therapeutic Range = 4-12 mcg/ml	of OCPs. Be aware of any rash-notify MD. The risk of rash increases when used in combination with VPA.
Lamotrigine (Lamictal, Lamictal XR)			2-12 Years of age Taking VPA **200mg** Taking other AEDs * but NOT VPA: **400mg** NOT taking AEDs: **300mg** Older than 12 Years Taking VPA: **200mg.** Taking other AEDs but NOT VPA: **500mg** NOT taking AEDs: **375mg** Please consult the full prescribing information for titration and tapering regimens.	In some individuals, lamotrigine has been known to cause a hypersensitivity reaction marked by severe rash and inflammation. Lamictal XR is not considered first line therapy. Safety and efficacy in children <13yrs old have not been established. Be aware of the risk of aseptic meningitis.
ANTIHYPERTENSIVES				
Beta-Blockers: Propranolol (Inderal, Inderal LA)	UCG/HCG EKG if clinically indicated. Ht, Wt, BMI/BMI PERCENTILE, BP/P	Ht, Wt, BMI/BMI PERCENTILE, BP/P every 3 months, EKG as clinically indicated or if symptoms (dizzy, lightheaded) occur.	60mg if <35kg, 120mg if >35kg based on TBW for children and adolescents up to 17 years of age.	Use only in consultation with primary care provider in patients with asthma or diabetes. Be aware of rebound hypertension with abrupt discontinuation.

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Alpha-1 Blockers: Prazosin	UCG/HCG EKG if clinically indicated. Ht, Wt, BMI/BMI PERCENTILE, BP/P	Ht, Wt, BMI/BMI PERCENTILE, BP/P every 3 months, EKG as clinically indicated or if symptoms (dizzy, lightheaded) occur.	1mg/day: Starting dose all patients then: 2mg <=6years of age 4mg >6yearrs of age	Be aware of rebound hypertension with abrupt discontinuation.
ANTIDEPRESSANTS				Monitor for suicidal ideation/behaviors and activation particularly at initiation, dose changes, and discontinuation of medication. Use caution upon discontinuation. Withdrawal symptoms have been observed.
<u>SSRIs</u> Citalopram (Celexa) Fluoxetine (Prozac, Sarafem, Salfemra) Fluvoxamine (Luvox) Sertraline (Zoloft) Escitalopram (Lexapro)	UCG/HCG Ht, Wt, BMI/BMI PERCENTILE, BP/P Citalopram: electrolytes	Ht, Wt, BMI/BMI PERCENTILE, BP/P every 3 months Monitor for signs of abnormal bleeding (e.g., ecchymosis, purpura, upper GI bleeding)	**Citalopram** 40mg for children and adolescents **Escitalopram** 20mg for children and adolescents **Fluoxetine** 60mg for children, 80mg for adolescents **Fluvoxamine** 200mg for children, 300mg for adolescents **Sertraline** 200mg for children and adolescents	Be aware of cognitive dulling, agitation, sexual dysfunction, rapid cycling, akathisia, and serotonin syndrome. Be aware of the risk of induction of mania. Be aware of concomitant use of medications metabolized by the CYP450 2D6 isoenzyme as SSRIs have inhibitory effects on this enzyme.

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SNRIs Venlafaxine (Effexor, Effexor XR) Duloxetine (Cymbalta)	UCG/HCG Ht, Wt, BMI/BMI PERCENTILE, BP/P Duloxetine: LFTs	Ht, Wt, BMI/BMI PERCENTILE, BP/P every 3 months.	**Venlafaxine** Not approved for use in children. 225mg for adolescents **Duloxetine** 120mg for children and adolescents 7-17 years of age	Withdrawal symptoms have been observed upon discontinuation of duloxetine and venlafaxine. A gradual dose reduction is recommended whenever possible.
Atypical Antidepressants Bupropion (Wellbutrin, Wellbutrin XL or SR, Zyban) Mirtazapine (Remeron, Remeron SolTab) Trazodone (Desyrel)	UCG/HCG Ht, Wt, BMI/BMI PERCENTILE, BP/P Bupropion: May need EEG if Seizure history. Mirtazapine: CBC & LFTs	Ht, Wt, BMI/BMI PERCENTILE, BP/P every 3 months.	**Bupropion** 150mg for 20-30kg 200mg for 31-40kg 250mg for >40kg **Mirtazapine -** 45mg **Trazodone** 6mg/kg for 6-18 years of age, not to exceed 200mg per day	Be aware of tics and rash with bupropion. Do not use Wellbutrin with Zyban. Zyban contains the same medication as Wellbutrin. Be aware of priapism with trazodone.
Tricyclics Amitriptyline *(D)* (Elavil) Clomipramine (Anafranil) Desipramine *(UD)* (Norpramin) Imipramine (Tofranil) Nortriptyline *(D)* (Aventyl, Pamelor)	UCG/HCG, LFTs EKG Ht, Wt, BMI/BMI PERCENTILE, BP/P	LFTs at 6 weeks and when target dose reached. EKG when maintenance dose is reached, or during dosing titration if indicated, and when medications that affect cardiac rhythm are added. Ht, Wt, BMI/BMI PERCENTILE, BP/P q 3 months. Blood level needed for nortriptyline.	**Amitryptyline** 3mg/kg for children, 200mg for adolescents. **Clomipramine** 3mg/kg up to 100mg for children & 150mg for adolescents. **Desipramine** 5mg/kg for children, 150mg for adolescents. **Imipramine** 5mg/kg up to 100mg for children & 150mg for	**CAUTION:** These medications are generally NOT considered first line. There is marginal evidence to support the use of tricyclic medications in the treatment of depression in children and adolescents. Be aware of drug/drug interactions, especially for medications that prolong QTc interval.

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		(Therapeutic window = 50-150ng/ml)	adolescents. **Nortriptyline** 150mg for adolescents.	
ANTIPSYCHOTIC	If persistent elevations of prolactin occur (>1year), consider switching antipsychotic to avoid decreased bone density.			
<u>"Typicals"</u> Chlorpromazine *(UD)* (Thorazine) Fluphenazine *(UD)* (Prolixin) Haloperidol (Haldol) Perphenazine (Trilafon) Trifluoperazine (Stelazine) Thiothixene *(UD)* (Navane)	Assess personal and family history of obesity, diabetes, hypertension, and cardiovascular disease. Height Weight BMI/BMI Percentile Blood pressure Pulse AIMS FBS, HgA1c, lipid profile, AST, ALT, if clinically indicated. EKG if clinically indicated.	FBS, HgA1c, lipid profile, AST, ALT, if clinically indicated. EKG if clinically indicated. AIMS every 6 months. Prolactin level if hyperprolactinemia symptoms observed or suspected (no menses, galactorrhea, breast pain or tenderness, bone fracture) TSH if clinically indicated. EEG if clinically indicated.	**Chlorpromazine** 200mg for children 400mg for adolescents **Fluphenazine** 5mg for children 10mg for adolescents **Fluphenazine decanoate** >13yrs old 100mg every 2-4 weeks. **Haloperidol** Children 3-12yrs old or 15-40kg Schizophrenia: 6mg in 2-3 divided doses All other indications 3mg in 2-3 divided doses. Adolescents: 15mg in 2-3 divided doses.	Controversy surrounds the need to monitor those treated with typical antipsychotics for weight gain and metabolic complications. Haloperidol has been shown to induce weight gain and has a weak association with metabolic complications. Chlorpromazine has been shown to have a stronger association with weight gain and metabolic complications, FBS, HgA1c, lipid profile, AST, and ALT should be monitored if clinically

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	Clinical Assessments (as indicated to screen for potential adverse reactions). -Hyperprolactinemia -Diabetes -Sexual Dysfunction -Thyroid Disorder -Anticholinergic Effects -Seizure or Myoclonus		**Haloperidol Decanoate** >13yrs old: 200mg every 4 weeks. **Perphenazine** 12mg for children 32mg for adolescents **Triflouperazine** 10mg for children 15mg for adolescents **Thiothixene** 7mg for children 20mg for adolescents	indicated.
<u>Second Generation Antipsychotics</u> Asenapine (Saphris) Aripiprazole (Abilify, Abilify Discmelt) Clozapine *(B)* (Clozaril, FazaClo) Lurasidone (Latuda) Olanzapine (Zyprexa, Zydis) Paliperidone (Invega) Quetiapine (Seroquel, Seroquel XR) Risperidone (Risperdal, Risperdal M Tab, Consta) Ziprasidone (Geodon)	Assess personal and family history of obesity, diabetes, hypertension, and cardiovascular disease. Height Weight BMI/BMI Percentile Blood pressure Pulse FBS, HgA1c, lipid profile, AST, ALT EKG if clinically indicated. AIMS Clinical Assessments (as indicated to screen	**Year One:** FBS & HgA1c in 3 to 6 months and repeat at 12 months. Repeat fasting lipids at 3 and 12 months. AST, ALT at 6 months **Post Year One:** If HgA1c is <6% repeat annually. If HgA1c is >6% repeat every 6 months. Repeat fasting lipids every 6-12 months in conjunction with lifestyle treatment if lipids were abnormal in the first 12 months. Repeat AST and ALT, at 12-24 months, if baseline and	**Asenapine** 20mg for children and adolescents 10-17yrs old (Not approved for children <10yoa) **Aripiprazole** 30mg for children and adolescents **Clozapine** 300mg for children 600mg for adolescents **Lurasidone** 80mg for children and adolescents **Olanzapine** 12.5mg for children 20mg for adolescents **Paliperidone**	**Asenapine:** This is a sublingual tablet. Patients should place tablet under the tongue and allow it to dissolve. It should not be chewed, crushed, or swallowed. The patients should not eat or drink for 10 minutes after dose. **Clozapine:** Be aware of signs and symptoms of myocarditis and cardiomyopathy. Be aware of changes in menstruation, libido, development of galactorrhea, and erectile and ejaculatory function. **Lurasidone**: Take with food.

	for potential adverse reactions). -Hyperprolactinemia -Diabetes -Sexual Dysfunction -Thyroid Disorder -Anticholinergic Effects -Seizure or Myoclonus	6-month results are normal. If AST and ALT are abnormal or there is concern of NAFLD, obtain AST and ALT every 3 to 6 months. EKG if clinically indicated. AIMS every 6 months. Prolactin level if hyperprolactinemia symptoms observed or suspected (no menses, galactorrhea, breast pain or tenderness, bone fracture) TSH if clinically indicated. EEG if clinically indicated. Clozapine: ANC per FDA REMS requirements.	6mg for adolescents <51kg 12mg for adolescents >51kg **Quetiapine** 600mg for children 800mg for adolescents **Risperidone** 4mg for children 6mg adolescents **Risperidone Consta** >13yrs old 50mg every 2 weeks (consider MDD of 25mg for those patients being treated with fluoxetine or paroxetine). **Ziprasidone** 160mg for children 180mg for adolescents Divided doses are preferred.	**Quetiapine:** Monitor for abuse. **Ziprasidone:** Take with food.
OTHER ANTIANXIETY MEDICATIONS OR SLEEP AIDS				
Diphenhydramine *(B)* (Benadryl) Hydroxyzine HCl (Atarax) Hydroxyzine pamoate (Vistaril) Buspirone *(B)* (Buspar)		**Diphenhydramine:** Monitor for diminished mental alertness. **Hydroxyzine:** Monitor bowel movements & urination.	**Diphenhydramine** <6yrs old: not approved for use. 6yrs old - <12yrs old 150mg. >=12yrs old: 300mg Usual dose for insomnia: 25mg–50mg.	Recommend short-term use if possible. Potential for paradoxical excitation. Nervousness, excitability, and difficulty sleeping can

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		Buspirone: Monitor for sedation, lightheadedness, headache, fatigue, nervousness, and stomachache.	**Hydroxyzine** <5yrs old: Not approved for use. 5yrs-<12yrs old: 50mg. >=12yrs old: 100mg **Buspirone** 40mg for children 60mg for adolescents	occur in some patients. Delirium, hallucinations, seizures, and tremors can occur with high doses. **Hydroxyzine:** Be aware of drug/drug interactions that prolong QTc interval. Buspirone: This is a maintenance medication only; it is not effective for PRN use. Medication may be given with food or on an empty stomach, however; administration must be consistent.
BENZODIAZEPINES *(D)* Clonazepam (Klonopin, Klonopin Wafer) Diazepam (Valium) Lorazepam **(**Ativan) *The FDA has found that benzodiazepines combined with other CNS depressants (including opiates) results in slowed breathing and potentially death. The FDA now requires boxed warnings be added to the labeling of prescription benzodiazepines, along with medication guides.*	UCG/HCG	Monitor for behavioral disinhibition. Monitor for drowsiness, dizziness, sedation, and cognitive blunting.	**Clonazepam** – 2mg **Diazepam** – 10mg **Lorazepam** – 4mg	Not recommended for children and adolescents. Use with caution. Consider the potential for dependence and addiction. Requests should include indication for use and/or target symptom(s). Short-term use is recommended. All requests should include the expected length of therapy. Requests will not be approved for more than

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				30 days at a time. Discontinuation requires gradual tapering to avoid risk of seizures or withdrawal symptoms. All requests should include the plan for discontinuation.
MISCELLANEOUS				
Anticholinergic Medications Benztropine **(**Cogentin) Amantadine (Symmetrel) Trihexyphenidyl (Artane)		For both benztropine and trihexyphenidyl monitor for common side effects: dry mouth, constipation, urinary retention, sedation, tachycardia Monitor for anticholinergic syndrome (hot, dry flushed skin; rash; hyperthermia; unreactive dilated pupils; blurred vision; shock; delirium; delusions; ataxia; dry mucous membranes; decreased bowel sounds; urinary retention)	**Benztropine** - 4mg **Amantadine** - 150mg for children 1-9 yrs old, 200mg for >=10 yrs old. **Trihexyphenidy**l - 0.75mg/kg based on TBW for children and adolescents up to a maximum of 30mg/day.	Use only if needed. Trihexyphenidyl: Monitor for abuse.
Opioid Antagonist Medication for Self-Injurious Behavior Naltrexone	Baseline LFTs	Annually and as clinically indicated.	3mg/kg/day	

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