

Health Plan of Michigan Clinical Practice Guideline Management of ADHD

The following guidelines apply to the management and pharmacologic treatment of Attention Deficit and Hyperactivity Disorder.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Children up to age 18, diagnosed with ADHD and receiving a psychostimulant. Diagnosis is based on criteria from DSM-IV-TR™.	Initial and Follow up Assessment (Initiation phase and continuation and maintenance phase)	<p>Patients assessment should include:</p> <ul style="list-style-type: none"> • Patient's and family's ability to cooperate with treatment [D] • Reasonableness of dosing regimen [D] • Medication side effects [D] • Coexisting medical or psychiatric disorders [D] • Risk of drug diversion [D] • School evaluations [D] 	<ul style="list-style-type: none"> • At onset of treatment patient should be seen within 30 days after initiation of medication prescription. • During continuation and maintenance phase, patient should be seen for at least two additional follow up visits within 9months of initiation phase ending.
	Medication selection: Psychostimulants (see addendum)	<ul style="list-style-type: none"> • Start standard immediate release of psychostimulant; give at dosages recommended by the manufacturer. [A] [B] [C] • Titrate immediate release of medication up to the minimally effective dose before converting to a long-acting formulation such as Concerta, Metadate CD, or Adderrall XR. [B] [D] • Augmentation therapy with clonidine may be indicated when a patient does not respond to stimulant drug, alone. [A] [B] 	Evaluate at each visit until treatment goals are reached.
	Referral to psychiatrist	Psychiatric referral is indicated for patients with serious psychiatric symptoms, serious concurrent medical illnesses, failure to respond to standard dose of psycho-stimulant. [D]	Referrals ordered as needed.
	Education and/or professional counseling	Physician counseling may be beneficial to family and patient in helping them understand ADHD causes, treatment options, medication compliance, treatment side effects.	Recommended <i>at least</i> biannually as indicated.
	Emergency plan	The physician should be available to address serious side effects or increasing behavioral problems.	The physician must be readily available if contacted by the patient or family to address emergency follow-up care.

Sources:

1. Diagnosis and Treatment of ADHD. National Institute of Health. Consensus Statement 16(2): 1998, Nov 16-18
2. American Academy of Pediatrics, Clinical Practice Guideline: Treatment of the school-aged child with ADHD. Pediatrics 2001; 108:1033-44
3. Institute for Clinical Systems Improvement. Diagnosis and Management of ADHD in Primary Care for School Age Children and Adolescents, March 2003
4. National Institute of Neurological Disorders and Stroke 4/02. Methylphenidate and Clonidine Help Children with ADHD and Tics.

Levels of Evidence for the most significant recommendations: A=randomized controlled trials; B=controlled trials, no randomization; C=observational studies; D=opinion of expert panel

This guideline represents core management steps. Individual patient considerations and advances in medical science may supercede or modify these recommendations.

Reviewed by HPM PAC November 2007