Comprehensive ADHD Medication Management Guide

Stimulants, nonstimulants, clinical selection, switching, monitoring, psychotherapy, and patient counseling

Clinical program reference | Children, adolescents, and adults | November 2026

Scope: This is a proposed evidence-based practice guide, not a standing prescription or proof that all services are offered. Verify the current FDA label, formulation-specific age authorization, dosing, contraindications, and state/federal rules before prescribing. Brand availability and generic formulations change.

1 | ADHD diagnosis and treatment framework

DSM-5-TR ADHD requires a persistent pattern of inattention and/or hyperactivity-impulsivity: at least six symptoms in a domain for children through age 16, or five at age 17 and older; at least six months; several symptoms before age 12; several symptoms in two or more settings; clinically meaningful impairment; and no better alternative explanation. Presentations: predominantly inattentive (F90.0), predominantly hyperactive/impulsive (F90.1), and combined (F90.2). Screening scales alone do not establish the diagnosis.

Preschool ages 4–5: evidence-based parent training in behavior management and classroom behavioral interventions first. If persistent moderate-to-severe impairment despite adequate behavioral treatment, carefully considered methylphenidate may be used per pediatric guidance, often off-label depending on product. **Ages 6–12:** FDA-approved medication plus parent training/classroom interventions and educational support. **Adolescents 13–17:** medication with assent, behavioral/organizational support, and school accommodations. **Adults:** stimulants commonly first-line when appropriate; atomoxetine or other nonstimulants when stimulants are contraindicated, poorly tolerated, ineffective, or not preferred.

2 | How stimulant and nonstimulant medicines work

Methylphenidate and dexmethylphenidate: primarily block dopamine and norepinephrine transporters (DAT/NET), increasing synaptic signaling. **Amphetamine and lisdexamfetamine:** increase catecholamine signaling through transporter-mediated release and reuptake effects; lisdexamfetamine is a prodrug converted to dextroamphetamine. Both stimulant families can improve attention, inhibitory control, and task persistence relatively quickly, often on the first effective dose.

Atomoxetine: selective norepinephrine reuptake inhibitor; benefits generally accumulate over several weeks. **Viloxazine extended-release:** norepinephrine-modulating nonstimulant with additional serotonergic effects; benefit builds over time. **Guanfacine ER and clonidine ER:** central alpha-2 adrenergic agonists, reducing sympathetic outflow and modulating prefrontal cortical signaling; may help hyperactivity/impulsivity and sometimes sleep, but can lower blood pressure and cause sedation.

3 | Choosing a first medication

• Assess ADHD severity, duration of needed coverage, prior response, age and formulation labeling, preference, swallowing ability, adherence, sleep, appetite, growth, blood pressure/pulse, cardiac history, tics, anxiety, mood instability, psychosis, substance-use/diversion risk, pregnancy potential, and concurrent medicines.

• For most school-age children, adolescents, and adults, a stimulant is a reasonable first medication if no contraindication. Methylphenidate is often selected first in children because of tolerability; amphetamine products may provide a stronger average symptom effect for some adults but tolerability varies. There is no universally superior product.

• Consider atomoxetine, viloxazine ER, guanfacine ER, or clonidine ER when clinically appropriate; alpha-2 agonists are pediatric FDA-approved options and may be adjuncts. Avoid selecting medications solely by a computerized attention-test result.

4 | Stimulant medication profiles: methylphenidate family

Methylphenidate immediate release (Ritalin, Methylin)

Approved ages: Commonly labeled age 6+; certain products vary. **When:** Usually morning and midday; sometimes early afternoon; avoid late doses that impair sleep.

Role/comparison: Shorter coverage and flexible titration; often useful to establish response. **Common/serious effects:** Reduced appetite, insomnia, headache, stomach upset, irritability, increased HR/BP; rare psychosis/mania and serious cardiac events in susceptible patients.

Interactions/avoid: MAOIs within 14 days; avoid excess caffeine/sympathomimetics; review antihypertensives, anticoagulants, anticonvulsants and other interactions.

Methylphenidate extended release (Concerta, Ritalin LA, Metadate CD, Aptensio XR, Quillivant XR, Quillichew ER)

Approved ages: Most products age 6+; verify each label. **When:** Typically once each morning; food and capsule-opening instructions vary by brand.

Role/comparison: Longer school/work coverage, fewer in-day doses; different release curves are NOT milligram-interchangeable. **Common/serious effects:** Appetite suppression, sleep problems, headache, GI effects, BP/HR rise; monitor growth in children.

Interactions/avoid: Do not crush modified-release systems; follow specific product instructions; MAOIs contraindicated.

Jornay PM (delayed/extended-release methylphenidate)

Approved ages: Age 6+ per labeling. **When:** Evening only, at the consistent label-directed time; designed for next-morning coverage.

Role/comparison: May address early-morning symptoms before usual morning stimulants take effect. **Common/serious effects:** Insomnia, appetite loss, mood changes, headache, cardiovascular effects.

Interactions/avoid: Not interchangeable mg-for-mg with other methylphenidate products; monitor timing and sleep.

Daytrana (methylphenidate patch)

Approved ages: Age 6–17 per labeling. **When:** Apply to hip approximately 2 hours before effect needed; remove after up to 9 hours or as prescribed.

Role/comparison: Useful when oral administration is difficult; wear duration affects exposure. **Common/serious effects:** Skin irritation, appetite loss, insomnia, increased HR/BP; rare chemical leukoderma and sensitization.

Interactions/avoid: Avoid heat over patch; rotate sites; dispose securely; MAOIs contraindicated.

Dexmethylphenidate (Focalin IR, Focalin XR)

Approved ages: Age 6+ per labeling. **When:** IR generally twice daily; XR usually each morning.

Role/comparison: Active d-enantiomer of methylphenidate; dose is not equal to racemic methylphenidate. **Common/serious effects:** Appetite loss, insomnia, abdominal pain, anxiety/irritability, HR/BP changes.

Interactions/avoid: MAOIs contraindicated; follow brand-specific food and capsule instructions.

5 | Stimulant medication profiles: amphetamine family

Mixed amphetamine salts IR (Adderall)

Approved ages: Labeling includes age 3+ for some IR products; ADHD treatment in preschoolers requires exceptional caution. **When:** Usually on awakening, then additional early-day doses if prescribed.

Role/comparison: Flexible short-duration dosing; may require multiple daily doses. **Common/serious effects:** Appetite loss, insomnia, dry mouth, anxiety, BP/HR elevation; rare mania, psychosis, serious cardiac reactions.

Interactions/avoid: MAOIs contraindicated; avoid excess caffeine, other stimulants and unreviewed decongestants; acidifying/alkalinizing agents may alter exposure.

Mixed amphetamine salts XR (Adderall XR)

Approved ages: Age 6+ per labeling. **When:** Once each morning.

Role/comparison: Longer coverage than IR; formulation-specific release characteristics. **Common/serious effects:** Appetite suppression, insomnia, irritability, headache, elevated HR/BP.

Interactions/avoid: MAOIs contraindicated; avoid late dosing; do not crush extended-release beads.

Mydayis (mixed amphetamine salts extended release)

Approved ages: Age 13+ per labeling. **When:** Once immediately upon awakening.

Role/comparison: Very long duration; may worsen insomnia if taken later. **Common/serious effects:** Insomnia, appetite loss, weight loss, anxiety, tachycardia.

Interactions/avoid: MAOIs contraindicated; not mg-for-mg interchangeable with Adderall XR.

Lisdexamfetamine (Vyvanse; generics)

Approved ages: Age 6+ for ADHD. **When:** Once each morning; with or without food.

Role/comparison: Prodrug converted to dextroamphetamine; relatively smooth onset for some, but misuse potential remains. **Common/serious effects:** Decreased appetite, insomnia, dry mouth, anxiety, increased HR/BP, weight loss.

Interactions/avoid: MAOIs contraindicated; review serotonergic agents for serotonin syndrome risk and urinary pH-altering drugs.

Dextroamphetamine (Dexedrine, Zenzedi, extended-release formulations)

Approved ages: Some IR labeling includes age 3+; ER products commonly age 6+; verify exact label. **When:** IR morning and early afternoon; ER generally morning.

Role/comparison: Dextroamphetamine-only alternative when mixed salts or methylphenidate not optimal. **Common/serious effects:** Appetite loss, insomnia, mood changes, BP/HR rise; rare psychosis/mania.

Interactions/avoid: MAOIs contraindicated; avoid unreviewed sympathomimetics and late-day dosing.

Amphetamine sulfate (Evekeo) and amphetamine ER products (e.g., Dyanavel XR, Adzenys XR-ODT)

Approved ages: Age varies by formulation; some amphetamine sulfate IR products age 3+, many ER products age 6+. **When:** IR divided early-day dosing; ER usually each morning.

Role/comparison: Options for different duration and administration needs (liquid, ODT, tablet). **Common/serious effects:** Class stimulant effects: appetite suppression, insomnia, irritability, cardiovascular effects.

Interactions/avoid: MAOIs contraindicated; products are not dose-equivalent; verify administration instructions.

6 | Nonstimulant medication profiles

Atomoxetine (Strattera; generic)

Age: Age 6+ and adults. **Timing:** Once daily morning or divided morning/late afternoon; may take with or without food.

Mechanism/role: Selective NET inhibition; no Schedule II control, full effect often takes 4–8 weeks or longer; useful if stimulant not desired.

Adverse effects: Nausea, reduced appetite, fatigue, dry mouth, constipation, sexual adverse effects in adults, BP/HR increase; boxed warning for suicidal ideation in children/adolescents; rare severe liver injury.

Contraindications/interactions: Contraindicated with MAOIs, narrow-angle glaucoma, pheochromocytoma, severe cardiovascular disorders; strong CYP2D6 inhibitors (fluoxetine, paroxetine, bupropion) increase exposure; dose adjustment may be needed.

Monitoring: Monitor mood/suicidality, HR/BP, weight/growth, hepatic symptoms; CYP2D6 status or interacting drugs may influence dosing.

Viloxazine ER (Qelbree)

Age: Age 6+ and adults. **Timing:** Once daily at a consistent time; follow capsule/sprinkle instructions.

Mechanism/role: Norepinephrine-modulating nonstimulant; response typically emerges over weeks.

Adverse effects: Somnolence, fatigue, reduced appetite, nausea, insomnia, irritability; boxed warning for suicidal thoughts/behaviors; potential mania/hypomania.

Contraindications/interactions: Contraindicated with MAOIs and sensitive CYP1A2 substrates or narrow-therapeutic-index CYP1A2 drugs; review tizanidine and theophylline carefully; CYP1A2 inhibition may elevate caffeine exposure.

Monitoring: Monitor suicidality, sleep, appetite, HR/BP, mood activation and drug interactions.

Guanfacine ER (Intuniv; generic)

Age: Age 6–17 FDA-approved; adult use off-label in US. **Timing:** Once daily morning or evening, consistently; swallow ER tablet whole.

Mechanism/role: Alpha-2A agonist; helps hyperactivity/impulsivity, can be combined with stimulant in selected youth.

Adverse effects: Sleepiness, fatigue, dizziness, hypotension, bradycardia, constipation; rebound hypertension if abruptly stopped.

Contraindications/interactions: Strong CYP3A4 inhibitors/inducers alter exposure; alcohol, sedatives and antihypertensives increase hypotension/sedation; avoid abrupt withdrawal.

Monitoring: Monitor sitting/standing BP, pulse, sedation, falls, adherence; taper gradually.

Clonidine ER (Kapvay; generic)

Age: Age 6–17 FDA-approved; adult ADHD use off-label. **Timing:** Typically initiated at bedtime and may be divided twice daily per label.

Mechanism/role: Alpha-2 agonist; may reduce hyperactivity/impulsivity, especially as adjunct in selected youth.

Adverse effects: Somnolence, dizziness, dry mouth, constipation, bradycardia, hypotension; rebound hypertension if stopped suddenly.

Contraindications/interactions: Alcohol, sedatives, antihypertensives, and other rate-slowing drugs may intensify effects; avoid abrupt withdrawal.

Monitoring: Monitor BP/pulse, sedation, falls; taper gradually; IR clonidine is not automatically interchangeable.

Bupropion SR/XL (off-label ADHD option)

Age: Not FDA-approved for ADHD at any age. **Timing:** SR commonly morning and early afternoon; XL generally morning.

Mechanism/role: Norepinephrine/dopamine reuptake effects; may be considered in selected adults, especially with depression, but ADHD evidence is weaker than stimulants.

Adverse effects: Insomnia, dry mouth, anxiety, BP increase, lowered seizure threshold; suicidality warning for antidepressants in younger people.

Contraindications/interactions: Contraindicated with seizure disorder, current/prior bulimia or anorexia nervosa, abrupt alcohol/sedative withdrawal, MAOIs; strong CYP2D6 inhibition affects other drugs.

Monitoring: Review seizure risk, eating disorders, BP, mood, sleep and interactions.

7 | Comparisons: speed, duration, and clinical fit

Class	Onset / role	Key tradeoff
Methylphenidate stimulants	Same-day; IR to long-acting	Flexible forms; appetite/sleep/HR effects
Amphetamine stimulants	Same-day; IR to very long-acting	Some stronger response; similar risks
Atomoxetine	Weeks; all-day ongoing effect	No Schedule II status; CYP2D6 interactions
Viloxazine ER	Weeks; daily effect	CYP1A2 interactions; mood warning
Guanfacine ER	Days to weeks	Sedation, low BP; pediatric approval
Clonidine ER	Days to weeks	Sedation, low BP; pediatric approval

8 | Who is at higher risk? Screening before prescribing

• **All stimulants:** known serious structural heart disease, cardiomyopathy, significant arrhythmia or coronary disease; uncontrolled hypertension; history of stimulant-induced psychosis/mania; severe anxiety/agitation in some; active substance-use disorder/diversion risk; low weight/eating disorder; insomnia; tic vulnerability; pregnancy/lactation requires individualized discussion. Do not assume all are absolute contraindications—consult each label.

• **Atomoxetine:** youth with suicidal ideation risk; severe cardiovascular disease; hepatic disease; CYP2D6 poor metabolizers or strong inhibitors; bipolar disorder/mania risk.

• **Viloxazine:** suicidality risk, bipolar activation, complex CYP1A2 medication regimens (especially tizanidine), significant sleep problems.

• **Guanfacine/clonidine ER:** baseline hypotension, bradycardia, syncope, conduction abnormalities, falls, concurrent sedatives or antihypertensives, inconsistent adherence that increases rebound risk.

• **Bupropion:** seizure disorder, eating disorders, alcohol/benzodiazepine withdrawal, uncontrolled hypertension, bipolar activation risk.

9 | What tests are required, and when?

Required clinical baseline: confirm DSM-5-TR diagnosis and functional impairment; document current medications and interactions, psychiatric history including mania/psychosis/suicidality, substance-use risk, personal/family cardiovascular history, BP and pulse, height/weight/growth chart for youth, sleep and appetite, pregnancy considerations when relevant, and treatment goals. For controlled stimulants, check applicable state PDMP and legal requirements.

Routine labs are NOT required to diagnose ADHD or before every stimulant: CBC, CMP, TSH, ferritin/iron, B12, pregnancy testing, toxicology, or liver tests are selected based on symptoms, comorbidity, medication choice, or practice policy—not universal ADHD tests. **ECG:** not routinely needed with normal cardiac history/exam; obtain when indicated by symptoms/history or relevant co-medications, and refer to cardiology when warranted. **UDS:** risk-based or policy-based, with consent, appropriate interpretation and nonpunitive discussion. **Neuropsychological testing, CPT/QbTest/TOVA, EEG and imaging:** not required for routine diagnosis; refer when a specific diagnostic question warrants it.

During treatment: track symptom scales (ASRS, Vanderbilt, ADHD-RS), functioning, adverse effects, BP/pulse after dose changes and periodically, weight/appetite/growth, sleep, mood, diversion, and adherence. Atomoxetine: assess suicidality and signs of liver injury; alpha-2 agonists: monitor BP/pulse and taper; obtain targeted labs when indicated.

10 | Drug interactions and what to avoid

• **MAO inhibitors:** avoid concomitant use and observe the label-required washout (commonly 14 days) for stimulants, atomoxetine, viloxazine and bupropion as applicable.

• **Serotonergic medicines:** amphetamines with SSRIs/SNRIs, triptans, tramadol, linezolid or other serotonergic agents can increase serotonin-syndrome risk; monitor and review all agents. Do not automatically discontinue necessary treatments without individualized assessment.

• **Sympathomimetics:** pseudoephedrine, high caffeine/energy drink use, other stimulants and some weight-loss products may worsen tachycardia, hypertension, anxiety or insomnia.

• **CYP interactions:** atomoxetine with fluoxetine/paroxetine/bupropion (CYP2D6); viloxazine with CYP1A2 substrates including tizanidine; guanfacine with CYP3A4 inhibitors/inducers. Check up-to-date interaction resources for every prescription.

• **Alcohol, cannabis and sedatives:** can impair cognition and complicate symptom assessment; alcohol and CNS depressants add sedation with guanfacine/clonidine. Counsel against misuse and sharing.

• **Administration:** do not crush extended-release tablets or alter patches/capsules except as explicitly permitted in product labeling; do not double missed doses; do not abruptly stop alpha-2 agonists.

11 | What if the medication does not work?

Step 1—Reassess: confirm diagnosis, functional target, adherence, timing, adequate trial/dose, sleep deprivation, untreated anxiety/depression/trauma, bipolar disorder, learning disorder, substance use, adverse effects and realistic expectations. **Step 2—Optimize:** titrate gradually within label and tolerability; adjust formulation/coverage; measure symptom and functional change. **Step 3—Switch:** if inadequate response or intolerable effects, consider a different formulation or switch from methylphenidate to amphetamine family (or vice versa), then nonstimulant or adjunct as clinically indicated. **Step 4—Complex cases:** specialist consultation for multiple failures, diagnostic uncertainty, severe comorbidity, cardiac concerns, or misuse.

Switching principles: Do not assume milligram equivalence across brands or stimulant classes. A direct next-day switch may be feasible between some stimulants, but the new agent generally begins at its own recommended starting dose and is titrated based on response. Atomoxetine/viloxazine need weeks for a fair trial; a clinician may use an individualized transition or overlap plan with monitoring. Guanfacine ER and clonidine ER must be tapered rather than abruptly stopped; cross-titration requires BP/pulse monitoring. Avoid duplicate stimulants or combined agents unless explicitly planned and documented.

12 | Why stimulants are controlled substances

Most prescription ADHD stimulants are US **Schedule II** controlled substances because they have accepted medical use but a high potential for abuse and dependence. They can produce reinforcement and euphoria when misused, particularly at supratherapeutic doses or via nonprescribed routes. This does **not** mean appropriately prescribed ADHD treatment is equivalent to addiction. Discuss safe storage, no sharing, theft prevention, disposal, refill rules, PDMP review, and substance-use screening. Schedule II prescriptions cannot be refilled; separate prescriptions may be issued when legally permitted. Telemedicine prescribing must follow current DEA and state rules.

13 | Psychotherapy and behavioral treatment: delivery and goals

ADHD-focused CBT

How delivered: Typically structured weekly sessions: identify one functional target; map avoidance and unhelpful beliefs; teach calendar/task capture, breaking tasks into steps, time estimates, problem solving, and behavioral experiments; assign between-session practice; review outcomes. **Goal:** Reduce procrastination, improve task initiation/completion and coping.

Parent training in behavior management

How delivered: Train caregivers in specific praise, predictable routines, clear instructions, token/reward systems, consistent consequences and daily report cards; practice and review logs. Especially first-line for preschool ADHD. **Goal:** Improve child functioning and reduce disruptive interactions.

Organizational skills training

How delivered: Use backpack/homework systems, planners, reminder cues, color-coded materials, rehearsal and school collaboration; monitor assignment completion. **Goal:** Improve academic organization and independence.

DBT-informed skills

How delivered: Teach mindfulness, STOP/pause skills, emotion labeling, distress tolerance and interpersonal effectiveness; rehearse during triggering situations. **Goal:** Improve emotional regulation and impulsive responses; adjunct, not primary ADHD cure.

Family and school collaboration

How delivered: Jointly establish measurable targets, classroom reinforcement, 504/IEP assessment referrals where appropriate, sleep routines and caregiver/teacher feedback. **Goal:** Generalize gains across home, school and relationships.

Adult executive-function coaching / occupational support

How delivered: Create external reminders, time-blocking, task sequencing, accountability and workplace accommodations; monitor actual outcomes. **Goal:** Support daily function; supplement rather than replace evidence-based care.

14 | Proposed 24-7 Shalom Psychiatry clinical workflow

Initial evaluation: full psychiatric/developmental history, DSM-5-TR assessment, impairment and collateral data, rating scales, comorbidity/safety evaluation, medication reconciliation, vitals and shared treatment choice. **Medication initiation:** document target symptoms, selected product/formulation, label-based starting dose, rationale, benefits/risks, counseling, PDMP and monitoring. **Titration:** reassess at clinically appropriate short intervals, especially after changes; obtain teacher/caregiver reports for youth. **Maintenance:** periodically reassess function, adverse effects, growth/vitals, misuse risk and need for behavioral treatment. **Escalation:** urgent assessment for chest pain, syncope, severe palpitations, psychosis/mania, suicidality, or suspected serotonin syndrome.

15 | Selected clinical and regulatory references

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Clinical caution: This document summarizes medication families and common US formulations; it is not an exhaustive formulary of every manufacturer or strength. FDA-approved ages, contraindications, dosing instructions, warnings and availability must be confirmed for the exact product before use. Individualized decisions and clinical documentation govern treatment.