

Appendix II

DCF Psychotropic Medication Monitoring

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. This may include obtaining findings from the most recent physical examination or routine checkup.

DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
ALL STIMULANTS	Consider UCG/HCG Ht, Wt, BMI/BMI PERCENTILE, BP/P Assess for tics Assess personal & family cardiac history, if unable consider ECG Take seizure history	BP/ P, Ht, Wt, BMI/BMI PERCENTILE q3 month AIMS as indicated		Be aware of rebound symptoms & insomnia Caffeine may increase cardiac side effects <i>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.</i>

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
<u>Methylphenidate: Short Acting</u>				
Dexmethylphenidate (Focalin)			20mg/day	High fat meal may delay peak
Methylphenidate (Ritalin, Methylin)			60mg/day	Take 30-45 minutes before meals when possible
<u>Methylphenidate: Intermediate Acting</u>				
Methylphenidate (Metadate ER)			60mg/day	Take 30-45 minutes before meals when possible
<u>Methylphenidate: Long Acting</u>				
Dexmethylphenidate (Focalin XR)			30mg/day	High fat meal may delay peak 50%IR and 50% DR beads
Methylphenidate (Ritalin LA)			60mg/day	High fat meal may delay peak 50%IR and 50% DR beads
Methylphenidate (Metadate CD)			60mg/day	High fat meal may delay peak 30%IR and 70% DR beads
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 NTE 2mg/kg/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 (Daytrana)			30mg/day	Transdermal patch
<u>Amphetamine: Short Acting</u>				
Dextroamphetamine (Dexedrine, Zenzedi, ProCentra)			40mg/day	
Mixed amphetamine salts (Adderall)			40mg/day	Contains d-amphetamine and l-amphetamine salts in a 3:1 ratio
Amphetamine sulfate (Evekeo)			40mg/day	Contains d-amphetamine and l-amphetamine salts in a 1:1 ratio
<u>Amphetamine: Intermediate Acting</u>				
Dextroamphetamine (Dexedrine Spansule)			40mg/day	50% IR and 50% DR beads

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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	Contains d-amphetamine and l-amphetamine salts in a 3:1 ratio 50% IR and 50% DR beads
Amphetamine sulfate (Adzenys XR-ODT)			18.8mg/day	
Amphetamine sulfate (Dyanavel XR)			20mg/day	Contains d-amphetamine and l-amphetamine salts in a 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 beads
Lisdexamfetamine (Vyvanse)			70mg/day	Continuous release capsule High fat meal may delay peak

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
NON-STIMULANT ADHD MEDICATION				
Atomoxetine (Strattera)	UCG/HCG, Ht, Wt, BMI/BMI PERCENTILE, BP/P	Ht, Wt, BMI/BMI PERCENTILE, BP/P every 3 months.	Atomoxetine - 1.4mg/kg up to 70kg, 100mg if over 70kg	Be aware that atomoxetine may be associated with hepatic injury.
Bupropion (Wellbutrin, Wellbutrin XL, SR)	Bupropion: May need EEG if seizure history. Assess history of anorexia/bulimia.		Bupropion – 300mg	Be aware of tics and rash with bupropion. Do not use Wellbutrin with Zyban. Zyban contains the same medication as Wellbutrin.
Alpha-2 Agonists: Guanfacine (B) (Tenex, Intuniv) Clonidine (Catapres, Kapvay)	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. .	Guanfacine – IR: 4mg for children and adolescents ER: Target dose range is 0.05-0.12 mg/kg/day not to exceed: 4mg/day children 6-12 years of age and 7mg/day for 13-17 years of age Clonidine - 0.4mg for children and adolescents	Not 1 st line therapy for ADHD unless there is a contraindication to 1 st line agents or a co-morbidity. Be aware of rebound hypertension with abrupt discontinuation Adverse Drug Events increase significantly at doses >3mg.

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
ALL LITHIUM PRODUCTS				
Lithium Carbonate (<i>D</i>) Lithium Citrate (<i>D</i>) (Eskalith, Eskalith CR Lithobid)	UCG/HCG, CBC, Lytes, BUN/Cr, TSH U/A EKG Ht, Wt, BMI/BMI PERCENTILE, BP/P	CBC, Lytes, 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 Blood levels per MD, at each dose change, then every 3 months x 1yr then every 6 months, and as clinically indicated.	<ul style="list-style-type: none"> • <12 yo: safety and efficacy not established • if under 25kg: 600mg • 25-39kg: 900mg • 40-50kg: 1200mg • >50kg: 1500mg • Maximum dose should be guided by serum levels and clinical response <p>Therapeutic Range = 0.6-1.2 mEq/L</p>	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	<p>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 symptoms (DRESS) that can include fever, rash, eosinophilia and involvement with multiple internal organs.</p> <p>AHS is a diagnosis of exclusion and is underreported; therefore, requiring a high index of suspicion.</p>			
				<p>Monitor for suicidal ideation/behaviors and activation particularly at initiation of medication, dose changes, and discontinuation of medication.</p> <p>Ongoing assessment for pregnancy risk</p>
Valproic Acid (<i>D</i>) (Depakote, Depakene)	<p>UCG/HCG and/or assess pregnancy risk, CBC with platelets, LFT's, Lytes, BUN/Cr, TSH, UA</p> <p>Ht, Wt, BMI/BMI PERCENTILE, BP/P</p>	<p>CBC with platelets, LFT'S at 3 months and 6 months, then every 6 months if WNL.</p> <p>Ammonia if symptoms of encephalopathy.</p> <p>Amylase & Lipase if GI symptoms.</p>	<p>Valproic Acid</p> <ul style="list-style-type: none"> • <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 2500 	<p>For Valproic Acid: Due to the risk of polycystic ovarian syndrome (PSOS) consider alternative in girls.</p>

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		<p>Blood levels per MD, at each dose change, then every 3 months x 1yr then every 6 months, and as clinically indicated.</p> <p>Ht, Wt, BMI/BMI PERCENTILE, BP/P at 1 month then every three months.</p>	<ul style="list-style-type: none"> final dose should be guided by serum levels <p>Therapeutic Range = 50-125 mcg/ml</p>	

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Carbamazepine (<i>D</i>) (Tegretol)	<p>UCG/HCG and/or assess pregnancy risk, CBC with platelets, LFT's, Lytes, BUN/Cr, TSH, UA</p> <p>Ht, Wt, BMI/BMI PERCENTILE, BP/P</p> <p>HLA-B 1502 antigen for Asian population</p>	<p>CBC with platelets, Lytes, BUN/Cr, LFT's, BP/P, Free T4, TSH yearly</p> <p>Blood levels at 1 month then every three months and as clinically indicated.</p>	<p>Carbamazepine < 6 yo: 35mg/kg/day 6-15 yo: 1000mg/day 16-18 yo: 1200mg/day</p> <p>Therapeutic Range = 4-12 mcg/ml</p>	<p>For Carbamazepine: Birth control pills may decrease effectiveness. Be aware of any rash-notify MD. The risk of rash increases when used in combination with valproic acid.</p>
Lamotrigine (Lamictal, Lamictal XR)			<p>Lamotrigine <u>2-12 Years of age</u> Taking VPA 200mg Taking other AEDs* but NOT VPA: 400mg NOT taking AEDs: 300mg</p> <p><u>Older than 12 Years</u> Taking VPA: 200mg Taking other AEDs but NOT VPA: 500mg NOT taking AEDs: 375mg</p>	<p>For Lamictal XR: Not considered first line therapy. Safety and efficacy in children <13yrs old have not been established. Be aware of risk of aseptic meningitis. Please consult the full prescribing information for titration and tapering regimens.</p>

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
ANTIHYPERTENSIVES				
Beta-Blockers: Propranolol (Inderal)	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.
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 >6years of age	Be aware of rebound hypertension with abrupt discontinuation.

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
ANTIDEPRESSANTS				<p>Monitor for suicidal ideation/behaviors and activation particularly at initiation, dose changes, and discontinuation of medication.</p> <p>Use caution upon discontinuation. Withdrawal symptoms have been observed.</p>
<p>Tricyclics Amitriptyline (<i>D</i>) (Elavil) Clomipramine (Anafranil) Desipramine (<i>UD</i>) (Norpramin) Imipramine (Tofranil) Nortriptyline (<i>D</i>) (Aventyl, Pamelor)</p>	<p>UCG/HCG, LFTs EKG Ht, Wt, BMI/BMI PERCENTILE, BP/P</p>	<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.</p>	<p>Amitriptyline 3mg/kg for children, 200mg for adolescents.</p> <p>Clomipramine 3mg/kg or 200mg (whichever is less) for children & adolescents.</p> <p>Desipramine 5mg/kg for children, 150mg for adolescents.</p>	<p>CAUTION: These medications are generally NOT considered first line.</p> <p>There is marginal evidence to support the use of tricyclic medications in the treatment of depression in children and adolescents.</p> <p>Be aware of drug/drug interactions, especially for medications that prolong QTc interval.</p>

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
		Blood level needed for nortriptyline. (Therapeutic window = 50-150ng/ml)	Imipramine 5mg/kg for children, 300mg for adolescents. Nortriptyline 150mg for adolescents.	
<u>SSRI's</u> Citalopram (Celexa) Fluoxetine (Prozac, Sarafem) 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.

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
<p>Others Bupropion (Wellbutrin, Wellbutrin XL or SR, Zyban)</p> <p>Mirtazapine (Remeron)</p> <p>Trazodone (Desyrel)</p> <p>Venlafaxine (Effexor, Effexor XR)</p> <p>Duloxetine (Cymbalta)</p>	<p>UCG/HCG</p> <p>Ht, Wt, BMI/BMI PERCENTILE, BP/P</p> <p>Bupropion: May need EEG if Seizure history.</p> <p>Mirtazapine: CBC & LFTs</p> <p>Duloxetine: LFTs</p>	<p>Ht, Wt, BMI/BMI PERCENTILE, BP/P every 3 months.</p>	<p>Bupropion 300mg for children, 450mg for adolescents.</p> <p>Mirtazapine - 45mg</p> <p>Trazodone 6mg/kg for 6-18 years of age, not to exceed 200mg per day</p> <p>Venlafaxine Not approved for use in children. 225mg for adolescents</p> <p>Duloxetine 120mg for children and adolescents 7-17 years of age</p>	<p>Be aware of tics and rash with bupropion.</p> <p>Do not use Wellbutrin with Zyban. Zyban contains the same medication as Wellbutrin.</p> <p>Be aware of priapism with trazodone.</p> <p>Duloxetine is approved for GAD. It has not been shown to be effective in MDD.</p> <p>Withdrawal symptoms have been observed upon discontinuation of duloxetine and venlafaxine. A gradual dose reduction is recommended whenever possible.</p>

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
ANTIPSYCHOTICS				If persistent elevations of prolactin occur (>1year), consider switching antipsychotic to avoid decreased bone density.
<p>“Typicals” Chlorpromazine (<i>UD</i>) (Thorazine) Fluphenazine (<i>UD</i>) (Prolixin) Haloperidol (Haldol) Perphenazine (Trilafon)</p> <p>Trifluoperazine (Stelazine) Thiothixene (<i>UD</i>) (Navane)</p>	<p>UCG/HCG, fasting lipid profile, FBS or HgA1c, CBC, LFTs, prolactin</p> <p>EKG if clinically indicated</p> <p>AIMS</p> <p>Ht, Wt, BMI/BMI PERCENTILE, BP/P</p>	<p>FBS or HgA1c, CBC and LFT’s every 6 months</p> <p>EKG annually or if clinically indicated</p> <p>AIMS every 6 months</p> <p>Prolactin level if symptoms observed or suspected (no menses, galactorrhea, breast pain or tenderness, bone fracture)</p> <p>BP/pulse, HT, Wt, BMI/BMI PERCENTILE q</p>	<p>Chlorpromazine 200mg for children 400mg for adolescents</p> <p>Fluphenazine 5mg for children 10mg for adolescents</p> <p>Fluphenazine decanoate >13yrs old 100mg every 2-4 weeks.</p> <p>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.</p>	<p>APs may lower seizure threshold</p> <p>Use sun block and be aware of hyperthermia in hot weather</p> <p>Be aware of menses & bowel movements</p>

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
		monthly for 3 months then q3months	Haloperidol Decanoate >13yrs old: 200mg every 4 weeks. Perphenazine 12mg for children 32mg for adolescents Trifluoperazine 10mg for children 15mg for adolescents Thiothixene 7mg for children 20mg for adolescents	
“Atypicals” Asenapine (Saphris) Aripiprazole (Abilify) Lurasidone (Latuda) Olanzapine (Zyprexa, Zydys) Paliperidone (Invega) Quetiapine (Seroquel) Risperidone (Risperdal, Consta) Ziprasidone (Geodon)	UCG/HCG, fasting lipid profile, FBS or HgA1c, CBC, LFTs, prolactin EKG if clinically indicated AIMS Ht, Wt, BMI/BMI PERCENTILE, BP/P	Fasting lipid profile at 3 months, 6 months, and 12 months then every 5 years if levels are normal. FBS or HgA1c, CBC and LFT's at 3 months then yearly. Prolactin every 6 months, if normal at 1-year repeat level only if symptoms exist (e.g. no	Asenapine 20mg for children and adolescents 10-17yrs old (Not approved for children <10yoa) Aripiprazole 30mg for children and adolescents Lurasidone 80mg for children and adolescents	For 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. For Lurasidone: Take with food.

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
	Request PCP consultation if at risk of being overweight (>85 th percentile for BMI).	<p>menses, galactorrhea, breast pain or tenderness, bone fracture). Only required for risperidone and paliperidone.</p> <p>EKG annually or if clinically indicated</p> <p>AIMS every 6 months</p> <p>Ht, Wt, BMI/BMI PERCENTILE monthly for 3 months then every 3 months. BP/P every 3 months.</p> <p>Electrolytes, CBC, renal function annually and as clinically indicated</p> <p>Request PCP consultation if at risk of being overweight</p>	<p>Olanzapine 12.5mg for children 20mg for adolescents</p> <p>Paliperidone 6mg for adolescents <51kg 12mg for adolescents >51kg</p> <p>Quetiapine 600mg for children 800mg for adolescents</p> <p>Risperidone 4mg for children 6mg adolescents</p> <p>Risperidone Consta >13yrs old 50mg every 2 weeks (consider MDD of 25mg for those patients being treated with fluoxetine or paroxetine).</p> <p>Ziprasidone 160mg for children</p>	<p>For Quetiapine: Monitor for abuse.</p> <p>For Ziprasidone: Take with food.</p>

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DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
		(>85 th percentile for BMI) Monitor menses & bowel movement.	180mg for adolescents Divided doses are preferred.	
Clozapine (B) (Clozaril)	UCG/HCG, fasting lipid profile, FBS, CBC, LFTs EKG if clinically indicated AIMS Ht, Wt, BMI/BMI PERCENTILE, BP/P, temperature EEG if clinically indicated	CBC follow up per FDA requirements. Fasting lipid profile at 3 months, 6 months, and 12 months then every 5 years if levels are normal. FBS and LFT's at 3 months then yearly. EKG as clinically indicated AIMS weekly until dose stabilized for at least 2 weeks after introduction and for 2 weeks after any significant	300mg for children 600mg for adolescents	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

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		<p>dose change.</p> <p>Ht, Wt, BMI/BMI PERCENTILE, BP/P monthly for 3 months then every 3 months</p> <p>Electrolytes, renal function annually and as clinically indicated</p>		
OTHER ANTIANXIETY MEDICATIONS OR SLEEP AIDS				
Diphenhydramine (<i>B</i>) (Benadryl)		Monitor for diminished mental alertness.	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.

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<p>Hydroxyzine HCl (Atarax) Hydroxyzine pamoate (Vistaril)</p> <p>Buspirone (B) (Buspar)</p>		<p>Monitor bowel movements & urination.</p> <p>Buspirone: Monitor for sedation, lightheadedness, headache, fatigue, nervousness, and stomachache.</p>	<p>Hydroxyzine - <5yrs old: Not approved for use. 5yrs-<12yrs old: 50mg. ≥12yrs old: 100mg</p> <p>Buspirone – 40mg for children 60mg for adolescents</p>	<p>Nervousness, excitability, and difficulty sleeping can occur in some patients.</p> <p>Delirium, hallucinations, seizures and tremors can occur with high doses.</p> <p>Hydroxyzine: Be aware of drug/drug interactions with medications that prolong QTc interval.</p> <p>Buspirone: This is a maintenance medication only; it is not effective for PRN use.</p> <p>Avoid grapefruit juice. Medication may be given with food or on an empty stomach, however; administration must be consistent.</p>

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<p>BENZODIAZEPINES (D) Clonazepam (Klonopin) Diazepam (Valium) Lorazepam (Ativan)</p> <p><i>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.</i></p>	UCG/HCG	Monitor for behavioral disinhibition. Monitor for drowsiness, dizziness, sedation, and cognitive blunting.	<p>Clonazepam – 2mg Diazepam – 10mg Lorazepam – 4mg</p>	<p>Not recommended in children and adolescents. Use with caution.</p> <p>Consider potential for dependence and addiction.</p> <p>Requests should include indication for use and/or target symptom(s).</p> <p>Short-term use is recommended. All requests should include expected length of therapy. Requests will not be approved for greater than 30 days at a time.</p> <p>Discontinuation requires gradual tapering to avoid risk of seizures or withdrawal symptoms. All requests should include the plan for discontinuation</p>

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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. Trihexyphenidyl - 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.

BOLDED = MANDATORY

March 2020

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All Medications are Pregnancy Category C unless otherwise noted in parenthesis next to the medication name; UD denotes that the Pregnancy Category is undetermined

Appendix II DCF Psychotropic Medication Monitoring

DCF APPROVED MEDICATIONS	BASELINE STUDIES	FOLLOW-UP STUDIES & MONITORING	MAXIMUM DAILY DOSE	SPECIAL CONSIDERATIONS
Opioid Antagonist Medication for Self- Injurious Behavior Naltrexone	Baseline LFTs	Annually and as clinically indicated.	3mg/kg/day	

BOLDED = MANDATORY

March 2020

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All Medications are Pregnancy Category C unless otherwise noted in parenthesis next to the medication name; UD denotes that the Pregnancy Category is undetermined