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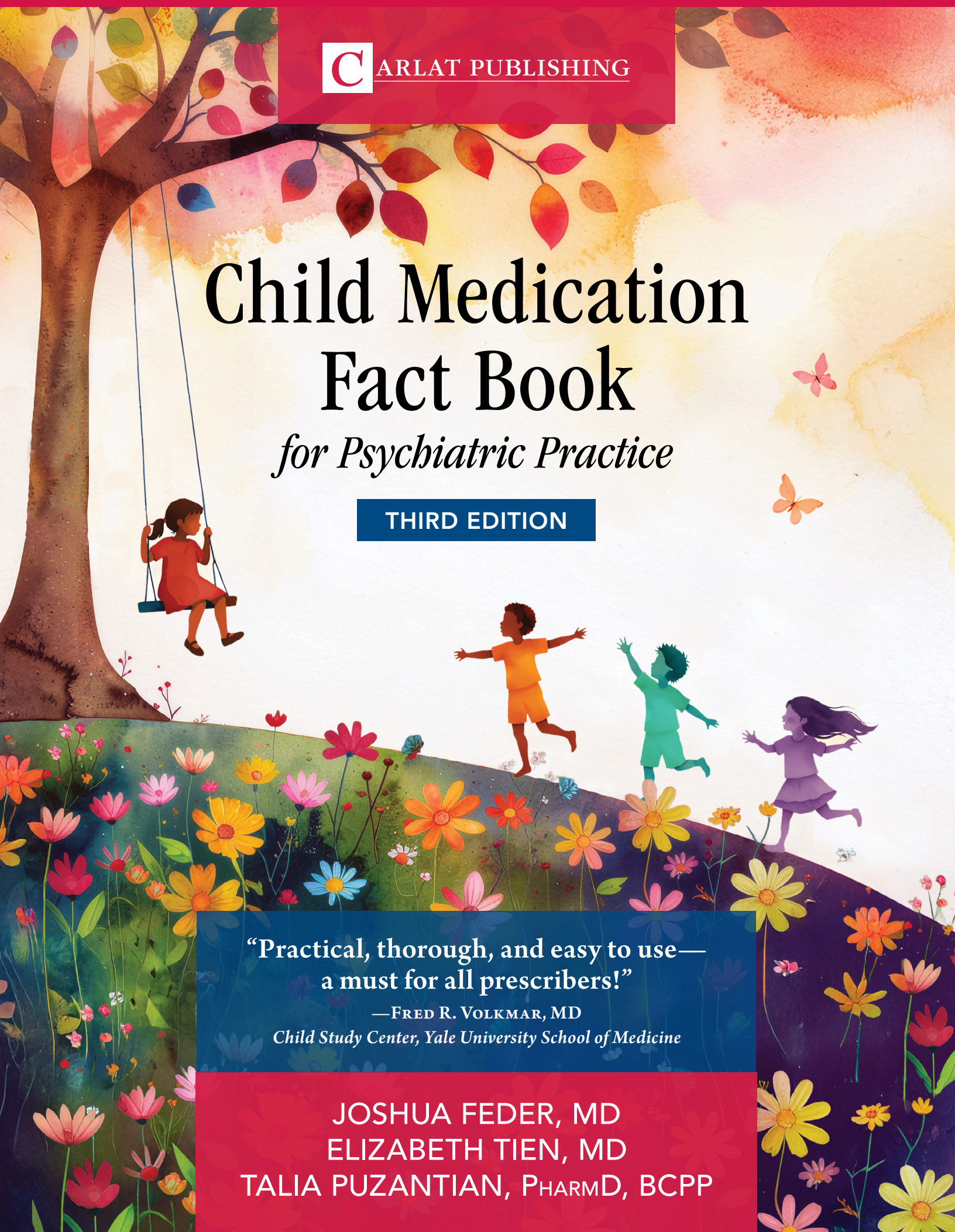

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Child Medication Fact Book

for Psychiatric Practice

THIRD EDITION

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Introduction

BEFORE YOU PRESCRIBE

Before you order a medication, ask: Do you need to medicate? For mental health care in children and adolescents, we generally favor the use of non-pharmacologic approaches. But we recognize both the necessity and, at times, the life-saving importance of medications. We also recognize that medications are often underprescribed but can also be overprescribed. To promote responsible care, clinicians should think carefully at the outset about what they are treating, the estimated time course of treatment, and the criteria for reducing and discontinuing medications when clinically possible.

GUIDING PERSPECTIVES

Several nested frameworks guide our approach to care:

- **Medical ethics:** Balancing the four main principles of beneficence (do good), nonmaleficence (do no harm), autonomy (support and respect the agency of the person), and justice (eg, ensure equitable access to care).
- **Evidence-based care:** Using our professional judgment and experience to offer families a range of care options based on the existing research (not only randomized controlled trials), and letting families choose among them based on their own culture and values.
- **The biopsychosocial model:** Considering every factor at every level and intervening where we can have the greatest impact.
- **A developmental, relationship-based perspective:** Supporting caregivers in helping youth with responsive, strength-based approaches that help them stay regulated and engaged in meaningful relationships and interactions that build trust, agency, communication, and resilience.
- **Trauma-informed care:** Across all our care, promoting a sense of safety, being trustworthy through authenticity and kindness, offering patients meaningful choices, and collaborating with patients to empower them to act on their own behalf.
- **Neurodiversity-affirming health care:** Recognizing that people think, speak, and learn in different ways, and focusing on real-life tools and supports that help each person do their best rather than treating these differences as deficits.

HOW TO USE THIS BOOK

We present medication information in four ways:

- **Chapter introductions:** These are guides to general therapeutic categories of child psychopharmacology. There is natural overlap between these areas; however, we hope that our groupings are convenient for quick reference in everyday office practice.
- **Treatment algorithms:** For some specific clinical situations, we've created maps to guide you in decision-making, with an aim to balance efficacy with safety.
- **Quick-scan medication tables:** These are located after the chapter introduction for each therapeutic category and list the very basics: generic and brand names, FDA-approved indications, available strengths, starting doses, and target doses. These tables contain most of the commonly prescribed psychiatric medications in pediatric practice.
- **Medication fact sheets:** In-depth prescribing information for select medications. There are 77 medication fact sheets in this book. We have included most of the commonly prescribed and newer medications for which there are data and experience in children.

CHANGES TO THE THIRD EDITION

We've updated the medication fact sheets, tables, and appendices with newer strengths, formulations, generics, and clinical data where available. We have two new fact sheets and a new appendix. Some medications have fallen out of relative favor, including diphenhydramine and, for some uses, valproate. In addition to our efforts to consider nonpharmacologic approaches, in this edition we've added more information about reducing and discontinuing medications when possible. As a brand-new feature in this edition, we have also added 33 online medication fact sheets for families.

CATEGORIES OF MEDICATIONS

We do our best to categorize medications rationally. However, sometimes a medication can fall into more than one therapeutic category. In such cases, we've placed the medication's fact sheet in the category for which it is most often used. If you're having trouble finding a medication in a particular section, look in the index to find its page number.

MORE ON THE MEDICATION FACT SHEETS

The goal of these fact sheets is to provide need-to-know information that can be easily and quickly absorbed during a busy day of seeing patients. An important goal, therefore, is that all the information should fit on a single page. You can also refer

to the *PDR (Physicians' Desk Reference)* or DailyMed and MedlinePlus from the United States National Library of Medicine when you need more in-depth information, as well as international sources such as the Canadian Drug Product Database (DPD), the United Kingdom Electronic Medicines Compendium (EMC), and the European Medicines Agency (EMA) database to give a broader perspective.

For the most part, each fact sheet contains the following information:

- Bottom line. We begin with a super-condensed summary, including our overall assessment of the drug's value in clinical practice. If you're in a rush, you can get the very basics from this alone.
- FDA-approved indications in kids and in adults.
- Off-label uses. We list the more common off-label uses, based on both the medical literature and our own clinical experience. Just because we list a potential use does not imply that we endorse a medication as being particularly effective in that capacity. We are simply alerting you to the fact that there is some evidence for efficacy or at least reports of use.
- Dosage forms, along with available strengths.
- Both the brand and generic names.
- Generic availability, denoted with a [G] or (G).
- Dosage guidance. We provide recommendations on how to dose medications; these are derived from a variety of sources, including package inserts, clinical trials, and common clinical practice. In other words, don't be surprised when our dosing instructions are at odds with what you find in the *PDR* or other sources such as RxList.
- Lab monitoring recommendations. We include the usual routine monitoring measures for each medication. Of course, you may need to think beyond the "routine" if the clinical picture warrants it.
- Cost information. Pricing information for a one-month supply of a common dosing regimen was obtained from the website GoodRx (www.goodrx.com), accessed in August 2026. These are the prices patients would have to pay if they had no insurance. Because of wide variations in price depending on the pharmacy, we list price categories rather than the price in dollars. The categories are:
  - $: Inexpensive: Under $50/month
  - $$: Moderate: $50–$100/month
  - $$$: Expensive: $100–$200/month
  - $$$$: Very expensive: $200–$500/month
  - $$$$$: Extremely expensive: Over $500/month

  Many patients have insurance and are not going to pay retail, but rather a co-pay, which is usually less expensive. However, off-label uses of medications in child psychiatry are often not covered by insurance. Also, even when medications are covered, their co-pays can be high, particularly for high-deductible insurance plans. With no clear source for accurately predicting a co-pay, you can use the retail price as a clue. Meds that are very inexpensive may require no co-pay, while the most expensive drugs will either require a very expensive co-pay or, more likely, will not be covered at all without an onerous pre-authorization process. We also recommend that families or pharmacies check online for coupon programs such as GoodRx or companies such as Mark Cuban's CostPlus Drug Company (https://costplusdrugs.com/medications/categories/mental-health/), which frequently offer the same medications at costs far below even the co-pay.
- Side effect information. We break down side effects into "most common" vs "serious but rare" side effects. We generally define "most common" side effects as those that occurred in at least 5% of patients in clinical trials and that occurred at least twice as often compared to the placebo group. Such information is usually found in tables in the drugs' package inserts. We also used post-marketing clinical experience as a guide in determining which side effects were common enough to make the list.
- Mechanism of action. While the mechanism of action is not well established for most psychiatric drugs, we thought it would be important to report the mechanisms most commonly cited. We do think clinicians and families often benefit from using a Neuroscience-based Nomenclature (NbN) approach to care, which can help with treatment planning and medication selection.
- Pharmacokinetics, with a focus on drug metabolism and/or half-life.
- Drug interactions.
- Evidence and clinical pearls. These typically comment on the evidence base for use in children and the advantages or disadvantages of a medication in comparison to others in its therapeutic category, tips for dosing or avoiding side effects, types of patients who seem to benefit the most, reports about off-label use, and so forth.
- Fun facts. Some people tell us that these might be the best part of the book.

APPENDICES

Please note that in these appendices we've included a number of medications that are not generally used in children—we list them anyway for completeness. In the appendices you'll find the following:

- Rating scales. Here we've listed a number of scales that you can use for assessment and tracking, covering autism screening, ADHD, anxiety, and mood problems.
- Abnormal Involuntary Movement Scale (AIMS). While we wish to avoid unneeded use of antipsychotic medications and other drugs that might cause tardive dyskinesia, the AIMS helps us to monitor for such side effects.

- Blood pressure parameters for children. A guide for clinicians, in particular for children on stimulant medications.
- Growth, body mass index, and head circumference charts. These are helpful as we track the growth and development of our patients and monitor for side effects.
- Lab monitoring for psychiatric medications. We've included a short quick-reference table listing the medications that require laboratory monitoring, along with the labs you should consider ordering.
- Informed consent guidelines. This topic can be particularly complicated in child and adolescent psychiatry, so here we've offered guidelines for clinicians to navigate this process.
- Mental health apps. Apps are often really helpful for you or for your patients, if you can tolerate the data privacy concerns. We've listed a few of our favorites.
- Drug interactions in psychiatry. While we've provided some information on drug interactions in the fact sheets, this appendix features a more extensive discussion of the topic, as well as a table of interactions for commonly prescribed drugs.
- Pregnancy and lactation risk information. The risks and benefits of using psychiatric medications in pregnancy and breastfeeding are not as simple or clear as the previously used "ABCDX" categories might suggest. The newer Pregnancy and Lactation Labeling Rule (PLLR) has been implemented by the FDA, resulting in a more detailed narrative describing available risk data instead of the letter category designation. Rather than putting this information in the fact sheets, we've placed a separate section in the appendices devoted to the topic.
- Schedules of controlled substances. Just in case you can't remember which drugs are in which DEA schedule or what each schedule means, we have you covered with a handy table.
- Pharmacogenetic testing recommendations. Although we do not feel that pharmacogenetic testing has reached a stage of routine clinical utility, we've added a brief section providing some basic information.
- Landmark studies. New for this edition, we've added an appendix of important studies in child and adolescent psychiatry. These cover lots of areas in addition to medications (remember: it's not all about the meds).

FINANCIAL DISCLOSURES

Drs. Feder, Tien, and Puzantian have disclosed that they have no relevant relationships or financial interests in any commercial company pertaining to the information provided in this book.

DISCLAIMER

The medication information in this book was formulated with a reasonable standard of care and in conformity with professional standards in the field of child and adolescent psychiatry where available. Medication prescribing decisions are complex, and you should use these fact sheets, tables, and algorithms as only one of many possible sources of clinical information. This information is not a substitute for informed medical care. This book is intended for use by licensed professionals only.

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General Tips on Child and Adolescent Psychopharmacology

Over the course of a career, most of us realize that pediatric psychopharmacology is more art than science, and that much of the knowledge we've acquired over the years has come from our work with patients after completing residency and fellowship. Here are some hard-won tips and pearls that you might find useful in your practice.

ASSESSMENT, DIAGNOSIS, AND CASE CONCEPTUALIZATION

- **Target symptoms are king.** Most patients come to us with mixed symptoms from several diagnostic categories. And many symptoms, such as anxiety, show up in attention-deficit/hyperactivity disorder (ADHD), depression, autism, and others. So while formal diagnosis is helpful for insurance and school advocacy, for treatment it is usually more practical to list and prioritize target symptoms. During the workup and ongoing follow-up, it is very helpful to have a running list of all the presenting and ongoing target symptoms, and to mark or prioritize your current focuses. For instance, in one patient, you might be targeting substance use, mood instability, and impulsivity, marking or prioritizing all three, while leaving issues of poor grades, tics, and peer relationships on the list but lower down—intending to focus on them a bit later. Another patient with the same set of symptoms might have different issues to target.
- **Collateral data is central to assessment.** We talk about the importance of speaking with parents, teachers, therapists, primary care providers, and other people involved in the lives of our young patients. You need to reach out to these people, even if it seems like you don't have the time. The reason is that their different perspectives, along with available medical, therapy, and educational records, give you the context to develop a rational set of differential diagnostic possibilities and an effective means of prioritizing care. Often this means starting with addressing aspects of the child's life, such as a bad school placement, before merely prescribing medications.
- **Start without meds, end without meds (if you can).** In many, or even most instances, you should avoid starting with medication. Environmental and therapy approaches are often effective and necessary to the plan. If you do use medication, start with the end in mind: Plan out a course of care with an intent to gently reduce and discontinue medications when possible. The goal is to provide good effective care with minimal side effects. There are certainly times when you may need to try medications sooner than later: ADHD, psychosis, mania, etc. But we do better by our patients through knowing when *not* to add medications.
- **Meds are the tail, not the dog.** Medications can be very helpful, even life-saving, but they cannot make up for an inadequate overall plan or placement. If a child is laboring under challenging or outright abusive situations at home or school, pills do not fix that. For instance, an autistic teen was brought in for a medication evaluation for irritability and "acting out." On evaluation, his treatment plan included "training for pre-vocational skills"—and his acting out turned out to be in part a rebellion from years of being subjected to tasks such as sorting silverware. The answer in this case was to rethink the goals that had been imposed on the patient as part of the treatment plan, and not to provide chemical intervention or restraint.
- **Informed consent is your friend.** Use informed consent—diagnosis, target symptoms, discussion of options, expectations, etc—to guide a rational and ongoing conversation with families. See the appendices for additional tips on this process.
- **Good care demands time.** You know this, and you are probably fighting for time—time to see the patient; talk to family, therapists, and teachers; review records; review labs; and whatever else you need to do to care for your patient. When we are taken to task about care, we are asked such things as: "Did you contact the school?" "Did you call the lab?" "How are the parents—are they suffering from mental health or other conditions?" We need time to do these things, and we deserve to be paid for that time too. Advocate for more time for all the elements of patient care.
- **Keep development in mind.** One of the joys of our field is that we have the opportunity to see the range of changes that occur developmentally and to explain to parents, teachers, and colleagues that these are not "symptoms." For example, an active toddler does not necessarily have ADHD. A school-aged child with a vivid fantasy life is usually not psychotic.
- **Always consider the possibility of abuse.** It is estimated that 1/4 to 1/3 of girls and 1/6 of boys are sexually abused before age 18; always assess for sexual and physical abuse as well as neglect. Ask about discipline and supervision as a part of your formal assessment. Parents often want help in managing their frustration (and perhaps their own difficulties with mood, substances, etc), and this is an opportunity to be of great assistance.
- **Drug and substance use are still common, despite recent downward trends.** We should always ask teens (and even tweens) about substance use. This includes the usual things like tobacco/nicotine, alcohol, cannabis products, hallucinogens like mushrooms, and other drugs; prescribed medications such as stimulants and opioids; over-the-counter (OTC) medications such as dextromethorphan, antihistamines, and pseudoephedrine; readily available inhalants such as glue, gasoline, and many others; non-prescribed opioids; and newer drugs of misuse. In addition, consider substances not yet or newly criminalized, such as kratom products, synthetic drugs, and others. As of this writing, opioid death rates have declined to pre-pandemic levels, but fentanyl, cychlorphine, and other deadly opioids are found in heroin and counterfeit


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ADHD Medications

Stimulants are one of the most effective medications in the field of medicine, with a very low number needed to treat (NNT). They have continued to show a robust effect in decreasing the symptoms of attention-deficit/hyperactivity disorder (ADHD), such as in the MTA (Multimodal Treatment of ADHD) study. In addition to frequent academic struggles, the wide range of health risks associated with ADHD (which include accidents, injuries, criminalization, and mortality) provide a strong case for medication management. Generally, in treating kids with ADHD, you should start with psychostimulants, since they are the most effective options. Second-line agents include alpha-agonists, followed by atomoxetine, viloxazine, and bupropion. Centanafadine is the newest FDA-approved ADHD medication (July 2026), but there's less experience with its place relative to established stimulants and non-stimulants.

STIMULANT RECOMMENDATIONS

When choosing a stimulant, the first decision is between an amphetamine or methylphenidate preparation. More recent data have suggested that, based on safety and efficacy, methylphenidates are a better choice in kids and adolescents whereas amphetamine-class agents are better in adults. Yet even in adults, we generally recommend going with a methylphenidate preparation first based on lower side effect and misuse potential. The second decision is choosing between a long-acting or short-acting stimulant. Different products can have different release curves and half-lives, which makes the variety of products an advantage when trying out different medications for any particular patient. There are many longer-acting methylphenidate preparations. Deciding what to try can be difficult; however, cost is often a deciding factor. Two good options are Concerta and Ritalin LA, available as generics.

For kids who don't like swallowing pills, there are various options. Some long-acting stimulants can be opened and sprinkled on food. There are also short- and long-acting liquid, chewable, and disintegrating brand-name options—though they are expensive and often require pre-authorization. Finally, another option for the pill-phobics is the Daytrana or Xelstrym patch.

When initiating a trial of stimulant medication, titrating the dose on a weekly basis optimizes the response efficiently, with the added benefit of limiting the use of additional medications with their associated side effects. Commonly used rating scales can be used to help track symptoms during this titration process, including Conners', Vanderbilt, and SNAP-IV (see Appendix A). While valproate and risperidone have been demonstrated to be effective for aggression with ADHD, you will rarely need them if you prioritize stimulant titration, with alpha-agonists used as an adjunct prior to trialing valproate and risperidone given their severity of side effects.

The Case for Long-Acting Stimulants

- More practical: It's easier to take a single dose that lasts through the school day.
- Addresses acute tachyphylaxis: Response to stimulants diminishes rapidly, but most newer long-acting stimulants release an increasing amount of drug over the dose's course (6–12 hours), which most people need for the medication to be effective. This avoids the need for multiple short-acting dosage bursts to maintain continued response.
- Decreased stimulant rebound: People sensitive to rebound irritability or worsening of ADHD symptoms often report a more attenuated rebound with long-acting stimulants.

The Case for Short-Acting Stimulants

- For situations where a child only requires a few hours of effect, such as a half day of school, an afternoon of completing homework, or a weekend activity.
- Minimizes appetite suppression during meals.
- May be less likely to interfere with sleep.

DOSE EQUIVALENTS

Some kids may need to try different stimulants, or stimulant formulations, before settling on the one that works best for them. The dose equivalents are, luckily, fairly easy to remember.

1. **From one amphetamine to another amphetamine**
   - With the exception of Vyvanse, all amphetamines, including Adderall immediate-release and extended-release, are roughly equivalent in potency. For example, if a child is taking Dexedrine 10 mg TID, you can switch this to Adderall 15 mg BID or Adderall XR 30 mg QD. That said, some people believe that Dexedrine, being 100% dextroamphetamine, might be more potent than Adderall, which is 75% dextroamphetamine and 25% levoamphetamine (eg, Dexedrine 30 mg/day may be closer to 40 mg/day of Adderall). In reality, the effect is likely negligible in most people.
   - Vyvanse is composed of both lysine and amphetamine, with amphetamine making up only about 30% of the drug. This means that Vyvanse is much less potent than straight Dexedrine. So when switching from another amphetamine to Vyvanse, you have to at least *double the dose,* and sometimes more.
2. **From one methylphenidate to another methylphenidate**
   - With the exception of Concerta and Focalin, all methylphenidate preparations are roughly equivalent in potency.

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ADHD Treatment Algorithm for Children and Adolescents

*Denotes off-label

Psychoeducation and behavioral parent training such as Triple P, Incredible Years, PMT, PCIT for preschool to preteen children

Psychopharmacologic treatments indicated and school and behavioral strategies are insufficient

School collaboration—consider accommodations, interventions, 504, IEP, use of teacher rating scales

Are stimulants contraindicated?

no

Start with long-acting methylphenidate such as methylphenidate ER capsule 50% IR/50% DR, dexmethylphenidate ER capsule, methylphenidate ER tab

- If unable to swallow pills: Try methylphenidate ER capsule 50% IR/50% DR, dexmethylphenidate ER capsule, methylphenidate ER suspension
- If patient has trouble swallowing: Try methylphenidate transdermal, methylphenidate ER suspension
- If side effect concerns: Try another long-acting methylphenidate or consider switching to a short-acting methylphenidate
  - If failed ≥2 methylphenidate trials, switch to a long-acting amphetamine such as lisdexamfetamine capsule, dextroamphetamine/amphetamine ER capsule
    - If limited effectiveness, side effects, or maximum dose achieved, try adding an alpha-agonist such as guanfacine, clonidine
      - If severe aggression concerns remain: Try adding omega-3s; as a last resort, consider adding risperidone or valproate*

yes

Stimulant is contraindicated/use with caution if:

1. Cardiac concerns (exercise intolerance, family history of sudden cardiac death, structural cardiac abnormalities, adoption history, or unknown family history): Obtain cardiology clearance
2. Substance use, diversion concerns
3. Untreated psychosis, hypomania, mania
4. Appetite, weight, growth issues
5. Insomnia

- If no comorbidity concerns: Try atomoxetine, viloxazine, clonidine, guanfacine
- If comorbid depression or tobacco/nicotine use: Try bupropion*
- If insomnia, tic, PTSD, anxiety, appetite concerns: Try guanfacine, clonidine

Key

PMT – Parent management training
PCIT – Parent-child interaction therapy
IEP – Individualized educational plan

- Use non-pharmacologic approaches first when possible to help reduce use of medication
- See text and tables for specific age-related guidance
- If using antidepressants, discuss potential side effects, including rare but possible increase in behavioral activation or suicidal thinking
- If using antipsychotics, check weight and labs (lipids, HbA1c, others as indicated) at baseline, 12 weeks, and yearly or sooner; check AIMS at baseline and every 6 months or sooner; and consider ECG at baseline and yearly or sooner
- If using antipsychotics, check weight at baseline and at weeks 2, 4, and 6; consider starting metformin if you see weight gain during those early weeks
- Omega-3s thus far have inconsistent efficacy, but they do not carry the metabolic and neurotoxic risks of risperidone or the teratogenic risks of valproate
- May consider discontinuing medication if goals and symptom reductions are sustained after 6–12 months; however, the majority of children who benefit from stimulant medication continue to do so into their late teens and early 20s
- Centanafadine is too new to recommend it as part of usual practice

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CENTANAFADINE (Simtriyo) Fact Sheet

BOTTOM LINE:
This newest ADHD medication is a novel option but not necessarily a first-line replacement for stimulants or existing non-stimulants. Centanafadine may be considered in kids who haven't responded well or tolerated other agents or when a lower misuse potential is wanted.

PEDIATRIC FDA INDICATIONS:
Attention-deficit/hyperactivity disorder (ADHD) (children age 6 and older).

ADULT FDA INDICATIONS:
ADHD.

OFF-LABEL USES:
None.

DOSAGE FORMS:
Extended-release capsules: 140 mg, 210 mg, 280 mg.

PEDIATRIC DOSAGE GUIDANCE:
- Children ages 6–12 and 20–34 kg: Start and maintain 140 mg once daily in the morning.
- Children ages 6–12 and 35–50 kg: Start and maintain 210 mg once daily in the morning.
- Children ages 6–12 and over 50 kg, or adolescents ages 13–17 and over 20 kg: Start and maintain 280 mg once daily in the morning.

MONITORING: Blood pressure, pulse, liver function tests.

COST: $$$$

SIDE EFFECTS:
- Most common: Headache, abdominal pain, decreased appetite, fatigue, nausea, insomnia, rash.
- Serious but rare: Class warnings for suicidal ideation in children and teens and for potential for abuse, misuse, and dependence.

MECHANISM, PHARMACOKINETICS, AND DRUG INTERACTIONS:
- Norepinephrine, dopamine, and serotonin reuptake inhibitor (NDSRI), or "triple reuptake inhibitor."
- Metabolized primarily by liver (non-P450); half-life: 5.2 hours.
- Avoid use with monoamine oxidase inhibitors, all other antidepressants, and stimulants.

EVIDENCE AND CLINICAL PEARLS:
- Extended-release capsules may be opened but should not be crushed or chewed.
- Approval was based on four trials: two in adults, one in adolescents, and one in children with ADHD.
- Post-hoc analyses have shown improvements in executive function and emotional dysregulation.
- Centanafadine is classified as a Schedule III controlled substance.
- A study found centanafadine was better tolerated than stimulants, atomoxetine, and viloxazine in adults with ADHD, but it was an indirect comparison and an industry-funded study.

FUN FACT:
Centanafadine has not been studied in depression, but is an enantiomer of amitifadine, which is under investigation for depression with positive trials.


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TABLE 3: Antidepressants

Generic Name (Brand Name) Year FDA Approved *[G] denotes generic availability*	Relevant FDA Indication(s) **(Pediatric indications in bold)**	Available Strengths (mg)	Usual Dosage Range (starting–max) (mg) *Pediatric unless specified*
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Citalopram [G] (Celexa) 1998	MDD	10, 20, 30, 40, 10/5 mL	10–40
Escitalopram [G] (Lexapro) 2002	**MDD (12+ yrs), GAD (7+ yrs)**	5, 10, 20, 5/5 mL	5–20
Fluoxetine [G] (Prozac) 1987	**MDD (8+ yrs), OCD (7+ yrs),** panic disorder, bulimia, PMDD	10, 20, 40, 60, 20/5 mL	10–60
Fluoxetine DR [G] (Prozac Weekly) 2001	MDD maintenance	90 DR	90 Q week (adults)
Fluvoxamine [G] Luvox brand discontinued; generic only 1994	**OCD (8+ yrs)**	25, 50, 100	50–300
Fluvoxamine ER [G] (Luvox CR) 2008	OCD	100, 150 ER	100–300
Paroxetine [G] (Paxil) 1992 (Brisdelle) 2013	MDD, OCD, panic disorder, social anxiety, GAD, PTSD, PMDD, menopausal hot flashes (as Brisdelle)	7.5 (Brisdelle), 10, 20, 30, 40, 10/5 mL	10–60
Paroxetine CR [G] (Paxil CR) 1999	MDD, panic disorder, social anxiety, PMDD	12.5, 25, 37.5 ER	12.5–62.5
Sertraline [G] (Zoloft) 1991	MDD, **OCD (6+ yrs),** panic disorder, PTSD, PMDD, social anxiety	25, 50, 100, 150, 200, 20/mL	12.5–200
Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)			
Desvenlafaxine [G] (Pristiq) 2008	MDD	25, 50, 100 ER	50–100 (adults)
Duloxetine [G] (Cymbalta) 2004 (Drizalma Sprinkle) 2019	MDD, **GAD (7+ yrs)** (also diabetic peripheral neuropathy, fibromyalgia, chronic musculoskeletal pain)	20, 30, 40, 60 DR	30–120
Venlafaxine [G] 1993 Effexor brand discontinued; generic only	MDD	25, 37.5, 50, 75, 100	37.5–75
Venlafaxine ER [G] (Effexor XR) 1997	MDD, GAD, social anxiety disorder, panic disorder	37.5, 75, 112.5, 150, 225 ER	37.5–225
Tricyclic Antidepressants (TCAs)			
Amitriptyline [G] Elavil brand discontinued; generic only 1961	MDD	10, 25, 50, 75, 100, 150	25–200
Clomipramine [G] (Anafranil) 1989	**OCD (10+ yrs)**	25, 50, 75	25–200
Desipramine [G] (Norpramin) 1964	MDD	10, 25, 50, 75, 100, 150	25–150
Imipramine [G] Tofranil brand discontinued; generic only 1984	MDD	10, 25, 50, 75, 100, 125, 150	10–100


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FLUOXETINE (Prozac, Prozac Weekly) Fact Sheet [G]

BOTTOM LINE:
Consider fluoxetine a first-line agent for kids with depression, anxiety disorders, and OCD.

PEDIATRIC FDA INDICATIONS:
Major depression (age 8 and up); **obsessive-compulsive disorder (OCD)** (age 7 and up).

ADULT FDA INDICATIONS:
Major depression; OCD; panic disorder; bulimia.

OFF-LABEL USES:
Posttraumatic stress disorder; social anxiety disorder; cataplexy; premenstrual dysphoric disorder (previously indicated as Sarafem, now withdrawn).

DOSAGE FORMS:
- **Capsules (G):** 10 mg, 20 mg, 40 mg.
- **Tablets (G):** 10 mg, 20 mg, 60 mg.
- **Delayed-release capsules (Prozac Weekly, [G]):** 90 mg.
- **Oral solution (G):** 20 mg/5 mL.

PEDIATRIC DOSAGE GUIDANCE:
- Ages 6–7: Start 5 mg once daily in the morning; increase by 5 mg/day increments weekly. Maximum 30 mg/day.
- Ages 8–17: Start 10 mg once daily in the morning; increase by 10 mg/day increments weekly. Maximum 60 mg/day.
- Many children and adolescents will show good treatment response at 10 mg/day.
- Most will respond best to morning dosing given its activating effects.

MONITORING: No routine monitoring recommended unless clinical picture warrants.

COST: $

SIDE EFFECTS:
- Most common: Nausea, insomnia, anxiety, sexual side effects, apathy, headache.
- Serious but rare: Hyponatremia, mainly in the elderly; gastrointestinal bleeding, especially when combined with nonsteroidal anti-inflammatory drugs such as ibuprofen.

MECHANISM, PHARMACOKINETICS, AND DRUG INTERACTIONS:
- Selective serotonin reuptake inhibitor (SSRI).
- Metabolized primarily through CYP2D6; potent 2C9/2C19 and 2D6 inhibitor; half-life: 4–6 days (9 days for norfluoxetine metabolite).
- Avoid use with monoamine oxidase inhibitors (MAOIs) (allow a five-week washout period if switching to MAOI); avoid other serotonergic agents (serotonin syndrome). Caution with substrates of 2C9/2C19 and 2D6.

EVIDENCE AND CLINICAL PEARLS:
- Most studied SSRI in kids and the only antidepressant approved for treating depression in younger children.
- Two large randomized double-blind placebo-controlled trials that showed significantly greater efficacy for depression compared to placebo led to FDA indication in kids 8 and older.
- A recently published reappraisal of meta-analyses and Cochrane reviews still supports fluoxetine as having the strongest pediatric evidence base and remaining first line for depression; however, it also suggests the difference between fluoxetine and escitalopram may not be as dramatic as in earlier analyses (Lyus R et al, *medRxiv* 2025;25334757 [Epub ahead of print]).
- Fluoxetine is favored in patients who could use some activation; it is most likely to cause insomnia, anxiety, and decreased appetite.
- Generally, higher doses of SSRIs are required for treating OCD.

FUN FACT:
According to *National Geographic*, shrimp exposed to traces of fluoxetine swim in brighter areas, making them more vulnerable to predators. This fact is not so fun for the shrimp.

CARIPRAZINE (Vraylar) Fact Sheet

BOTTOM LINE:
The newest approved second-generation antipsychotic for use in pediatric patients, cariprazine is a partial dopamine agonist similar to aripiprazole and brexpiprazole. Some preliminary data (in adults) suggest it might be effective for negative symptoms, but it's too soon to tell. Beyond that, it appears similar to the other two with regard to akathisia and decreased weight gain. Like brexpiprazole, there is no generic and it's much more expensive than the generic aripiprazole.

PEDIATRIC FDA INDICATIONS:
Schizophrenia (ages 13 and older); **bipolar mania (ages 10 and older).**

ADULT FDA INDICATIONS:
Schizophrenia; bipolar mania; bipolar depression; major depression (as adjunct).

OFF-LABEL USES:
Negative symptoms of schizophrenia; bipolar maintenance.

DOSAGE FORMS:
Capsules: 0.5 mg, 0.75 mg, 1.5 mg, 3 mg, 4.5 mg, 6 mg.

PEDIATRIC DOSAGE GUIDANCE:
- Schizophrenia (ages 13 and up) and bipolar mania (ages 10 and up): Start 0.5 mg once daily; increase to 1.5 mg once daily on day 3; may be increased based on response to 3 mg once daily starting on day 5, and to 4.5 mg once daily starting on day 8. Maximum 4.5 mg once daily.
- Dose timing: Either morning or night; many patients experience restlessness that can interfere with sleep, in which case morning is preferred.

MONITORING: Weight, waist circumference, lipids, fasting glucose, abnormal movements.

COST: $$$$$

SIDE EFFECTS:
- Most common: Extrapyramidal symptoms, akathisia, weight gain, sedation.
- Serious but rare: Rare reports of reversible pathologic gambling and other impulse control problems (eating, spending, sexual).

MECHANISM, PHARMACOKINETICS, AND DRUG INTERACTIONS:
- Dopamine D2 and D3 and serotonin 5-HT1A receptor partial agonist; serotonin 5-HT2A receptor antagonist.
- Metabolized primarily by CYP3A4; half-life: 2–4 days for cariprazine (1–3 weeks for active metabolites).
- Caution with 3A4 inhibitors; 50% dose reduction may be necessary. Avoid use with 3A4 inducers.

EVIDENCE AND CLINICAL PEARLS:
- Newly approved pediatric indications (schizophrenia, bipolar mania) are based on unpublished data. Approval was not based on traditional randomized controlled efficacy trials; instead, it was supported by a phase I open-label study evaluating pharmacokinetics, safety, and tolerability in pediatric patients with schizophrenia or bipolar I disorder. Exploratory efficacy analyses showed improvements, compared to usual primary efficacy outcomes.
- One 8-week placebo-controlled study and a long-term open-label study in patients ages 5–17 show potential for reducing irritability, aggression, and self-injurious behaviors associated with autism; risperidone remains preferred as it has more data and experience. However, it is often possible to avoid using any antipsychotic if other underlying issues are addressed such as sensory, motor, and co-occurring anxiety; attention-deficit/hyperactivity disorder; depression; or environmental and relationship stressors such as school placement, bullying, or family dynamics (see Autism Support algorithm).
- Most closely similar to aripiprazole with partial D2 agonism. Manufacturer suggests D3 activity may improve negative symptoms (one adult study found better results vs risperidone).
- Because of cariprazine's very long half-life, monitor for side effects for several weeks after starting and with each dose increase. The long half-life may make this a good choice in patients with partial or irregular medication adherence.

FUN FACT:
Cariprazine was developed by a Hungarian pharmaceutical company, Gedeon Richter, which was founded in 1901 by a pharmacist. Gedeon Richter initially processed extracts from plants to produce herbal remedies.

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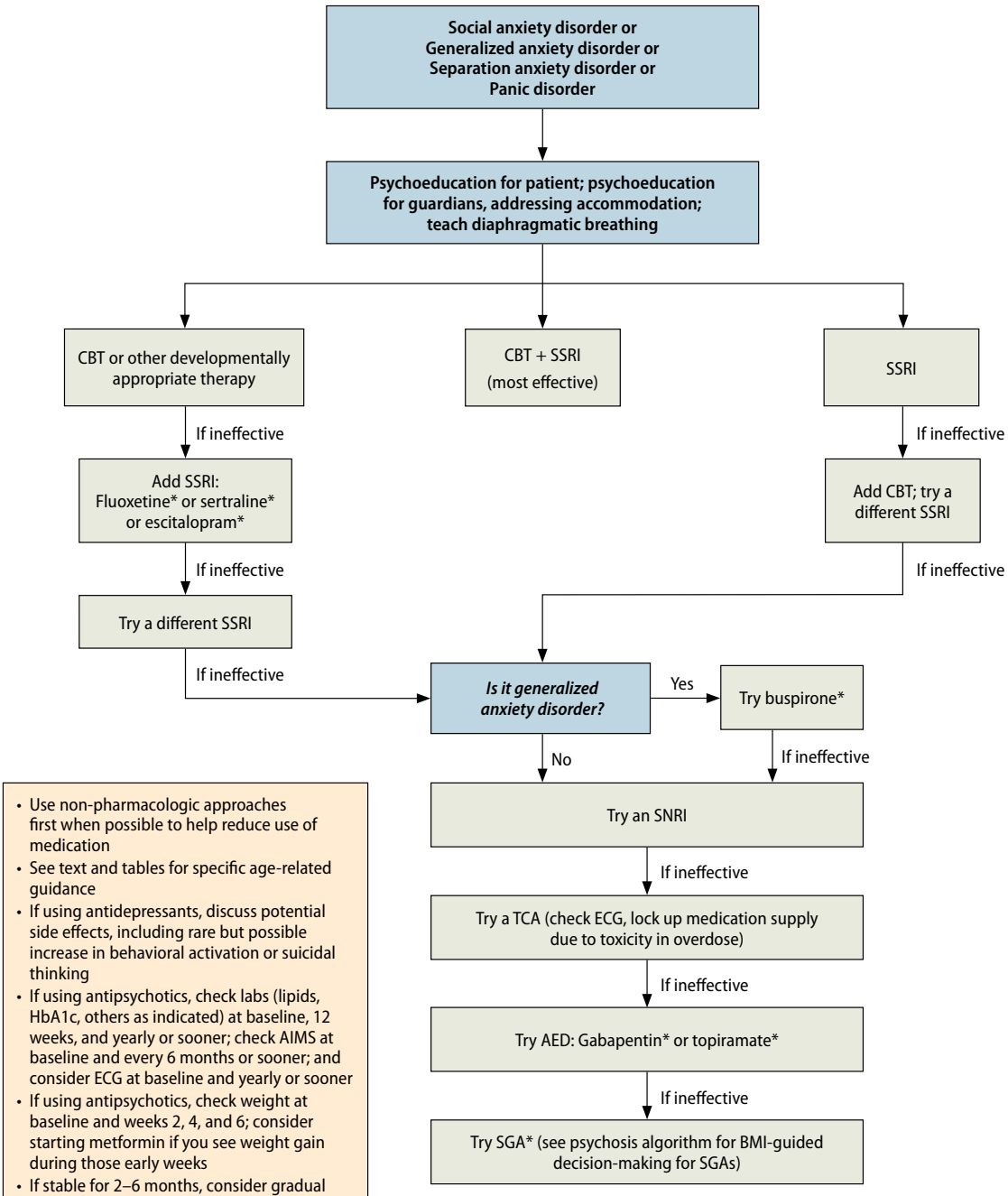
Anxiety Disorders Treatment Algorithm for Children and Adolescents

*Denotes off-label



- Use non-pharmacologic approaches first when possible to help reduce use of medication
- See text and tables for specific age-related guidance
- If using antidepressants, discuss potential side effects, including rare but possible increase in behavioral activation or suicidal thinking
- If using antipsychotics, check labs (lipids, HbA1c, others as indicated) at baseline, 12 weeks, and yearly or sooner; check AIMS at baseline and every 6 months or sooner; and consider ECG at baseline and yearly or sooner
- If using antipsychotics, check weight at baseline and weeks 2, 4, and 6; consider starting metformin if you see weight gain during those early weeks
- If stable for 2–6 months, consider gradual taper and discontinuation of medications
- Valproate has been removed in this edition of the algorithm because reproductive risks outweigh the benefits for anxiety

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APPENDIX L: LANDMARK STUDIES IN CHILD AND ADOLESCENT PSYCHIATRY

Anxiety Disorders and Obsessive-Compulsive Disorder

Child/Adolescent Anxiety Multimodal Extended Long-Term Study (CAMELS)

- Ginsburg GS, Becker-Haimes EM, Keeton C, Kendall PC, Iyengar S, Sakolsky D, Albano AM, Peris T, Compton SN, Piacentini J. Results from the Child/Adolescent Anxiety Multimodal Extended Long-Term Study (CAMELS): Primary anxiety outcomes. *J Am Acad Child Adolesc Psychiatry*. 2018 Jul;57(7):471–480. doi: 10.1016/j.jaac.2018.03.017. Epub 2018 May 9. PMID: 29960692.

Child/Adolescent Anxiety Multimodal Study (CAMS)

- Piacentini J, Bennett S, Compton SN, Kendall PC, Birmaher B, Albano AM, March J, Sherrill J, Sakolsky D, Ginsburg G, Rynn M, Bergman RL, Gosch E, Waslick B, Iyengar S, McCracken J, Walkup J. 24- and 36-week outcomes for the Child/Adolescent Anxiety Multimodal Study (CAMS). *J Am Acad Child Adolesc Psychiatry*. 2014 Mar;53(3):297–310. doi: 10.1016/j.jaac.2013.11.010. Epub 2013 Nov 28. PMID: 24565357; PMCID: PMC3982864.

Pediatric OCD Treatment Study (POTS)

- Pediatric OCD Treatment Study (POTS) Team. Cognitive-behavior therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: the Pediatric OCD Treatment Study (POTS) randomized controlled trial. *JAMA*. 2004 Oct 27;292(16):1969–1976. doi: 10.1001/jama.292.16.1969. PMID: 15507582.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Multimodal Treatment Study of Children with ADHD (MTA)

- Arnold LE, Abikoff HB, Cantwell DP, Conners CK, Elliott G, Greenhill LL, Hechtman L, Hinshaw SP, Hoza B, Jensen PS, Kraemer HC, March JS, Newcorn JH, Pelham WE, Richters JE, Schiller E, Severe JB, Swanson JM, Vereen D, Wells KC. National Institute of Mental Health collaborative multimodal treatment study of children with ADHD (the MTA). Design challenges and choices. *Arch Gen Psychiatry*. 1997 Sep;54(9):865–870. doi: 10.1001/archpsyc.1997.01830210113015. PMID: 9294378.
- The MTA Cooperative Group. A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Arch Gen Psychiatry*. 1999;56(12):1073–1086. doi: 10.1001/archpsyc.56.12.1073. PMID: 10591283.

Preschool Attention-Deficit/Hyperactivity Disorder Treatment Study (PATS)

- Blader JC, Pliszka SR, Kafantaris V, Foley CA, Carlson GA, Crowell JA, Bailey BY, Sauder C, Daviss WB, Sinha C, Matthews TL, Margulies DM. Stepped treatment for attention-deficit/hyperactivity disorder and aggressive behavior: A randomized, controlled trial of adjunctive risperidone, divalproex sodium, or placebo after stimulant medication optimization. *J Am Acad Child Adolesc Psychiatry*. 2021 Feb;60(2):236–251. doi: 10.1016/j.jaac.2019.12.009. Epub 2020 Jan 30. PMID: 32007604; PMCID: PMC7390668.
- Greenhill L, Kollins S, Abikoff H, McCracken J, Riddle M, Swanson J, McGough J, Wigal S, Wigal T, Vitiello B, Skrobala A, Posner K, Ghuman J, Cunningham C, Davies M, Chuang S, Cooper T. Efficacy and safety of immediate-release methylphenidate treatment for preschoolers with ADHD. *J Am Acad Child Adolesc Psychiatry*. 2006 Nov;45(11):1284–1293. doi: 10.1097/01.chi.0000235077.32661.61. Erratum in: *J Am Acad Child Adolesc Psychiatry*. 2007 Jan;46(1):141. PMID: 17023867.
- Riddle MA, Yershova K, Lazzaretto D, Paykina N, Yenokyan G, Greenhill L, Abikoff H, Vitiello B, Wigal T, McCracken JT, Kollins SH, Murray DW, Wigal S, Kastelic E, McGough JJ, dosReis S, Bauzó-Rosario A, Stehli A, Posner K. The Preschool Attention-Deficit/Hyperactivity Disorder Treatment Study (PATS) 6-year follow-up. *J Am Acad Child Adolesc Psychiatry*. 2013 Mar;52(3):264–278.e2. doi: 10.1016/j.jaac.2012.12.007. Epub 2013 Feb 8. PMID: 23452683; PMCID: PMC3660093.

Autism

Autism Care

- Cullinane DA, Binns AV, Feder JD, Graham T, Mahoney GJ, Naber FBA, Robinson RG, Schertz HH, Solomon RM, Whitehouse AJO, Wieder S. Developmental relationship-based interventions for autistic children. *Topics in Early Childhood Special Education*. Epub 2024 Dec 24. doi: 10.1177/02711214241303695.
- Sandbank M, Bottema-Beutel K, Crowley S, Cassidy M, Dunham K, Feldman JI, Crank J, Albarran SA, Raj S, Mahbub P, Woynaroski TG. Project AIM: Autism intervention meta-analysis for studies of young children. *Psychol Bull*. 2020 Jan;146(1):1–29. doi: 10.1037/bul0000215. Epub 2019 Nov 25. PMID: 31763860; PMCID: PMC8783568.
- Sandbank M, et al. Autism intervention meta-analysis of early childhood studies (Project AIM): Updated systematic review and secondary analysis. *BMJ*. 2023 (PubMed 37963634). It updates the original 2020 *Psychological Bulletin* meta-analysis.

Early Adversity, Trauma, and Developmental Epidemiology

- Coleman E, Radix AE, Bouman WP, Brown GR, de Vries ALC, Deutsch MB, Ettner R, Fraser L, Goodman M, Green J, Hancock AB, Johnson TW, Karasic DH, Knudson GA, Leibowitz SF, Meyer-Bahlburg HFL, Monstrey SJ, Motmans J, Nahata L, Nieder TO, Reisner SL, Richards C, Schechter LS, Tangpricha V, Tishelman AC, Van Trotsenburg MAA, Winter S, Ducheny K,

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