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ADHD Screening Guidelines for PCPs

Patient Age: 3-5

ADHD RATING SCALE IV - Preschool ADHD Assessment

Diagnostic Criteria

Scores > 93 percentile are suspicious for, but not diagnostic of, preschool ADHD.

Cutoff points are provided below for 93rd percentile according to sex and who is answering, parent or teacher:

	BOYS		GIRLS	
	PARENT	TEACHER	PARENT	TEACHER
INATTENTIVE SUBTYPE *(odd numbered items)*	14	18	12	11
HYPERACTIVE/IMPULSIVE SUBTYPE *(even numbered items)*	17	22	14	13
ADHD *(combination of even & odd numbered items)*	32	38	24	24

Treatment Protocol:

Monitor any treatment response via rating scales and appropriate health assessments

Step 1, First 12 Weeks: Parent management / skills training and / or other behavioral interevention at home and / or school,

Step 2: If after 12 weeks that is ineffective, initiate monotherapy with a Methylphenidate formulation.

Step 3: If methylphenidate is unsuccessful, could consider monotherapy with atomoxetine (Strattera).

Step 4: Consider amphetamine formulations which have FDA indication for ages 3 to 5 years old, but limited clinical trial evidence base.

Not Recommended:

- Antipsychotic medication to treat core symptoms of ADHD.
- Concurrent use of two or more alpha-2 agonists.

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ADHD Screening Guidelines for PCPs

Patient Age: 6-12

NICHQ Vanderbilt Assessment Scales

Inattentive subtype *(Q# 1-9):*

- Must score a 2 or 3 on 6 of the 9 questions
- Must score a 4 or 5 on any of the Performance Questions *(Q# 48-55)*

Hyperactive subtype *(Q#10-18)*:

- Must score a 2 or 3 on 6 of the 9 questions
- Must score a 4 or 5 on any of the Performance Questions *(Q# 48-55)*

To meet the criteria for ADHD, the criteria must be met for both subtypes

Patient Age: 6-18

SNAP-IV ADHD Screening Form

You will need 2 copies: parent & teacher

Inattentive subtype *(Q#1-9):* >13/26 for inattention

Hyperactive subtype *(Q#10-18)*: >13/26 for hyperactivity / impulsivity

Treatment Protocol:

Monitor any treatment response via rating scales and appropriate health assessments

Step 1: Psychostimulant monotherapy:

- methylphenidate or amphetamine, either short or long-acting. *If first choice is ineffective*, try monotherapy with another stimulant. If supplementing short & long-acting together, stay within same class of drug; *OR*
- Extended-release alpha-2 agonist monotherapy

Step 2:

- Combination psychostimulant with extended-release alpha-2 agonist; *OR*
- Atomoxetine

Step 3: If ineffective, consider immediate-release alpha-2 agonist monotherapy or in combination with another psychostimulant

Cont'd on next page

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Autism & ADHD: extended-release alpha-2 agonist

ADHD with signifcant history of trauma: : extended-release alpha-2 agonist

ADHD with comorbid substance abuse: Atomoxetine

Not Recommended:

- Antipsychotic medication to treat core symptoms of ADHD.
- Concurrent use of two or more alpha-2 agonists.
- Concurrent use of two different stimulant classes.
- Desipramine due to safety concerns.

For specific dosage initiation recommendations see ***Florida Medicaid best practice medication guidelines***.

DSM-V

Classification of symptoms of ADHD:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.

Moderate: Symptoms or functional impairment between "mild" and "severe" are present.

Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

For more information see *NV PAL's ADHD complete ADHD guide*.

https://nvpal.org

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