FDA approvals for psychotropic medications used in children with mental health disorders
http://reference.medscape.com/drugs/psychiatrics

Medication Class	Medication Name	FDA Indications
ANTIDEPRESSANTS		
SSRI	Prozac/Sarafem, fluoxetine	**MDD**: >8 years: 10-20 mg PO qDay, initially; Start at 10 mg/day in lower weight children, may gradually increase dose after 1 week; not to exceed 20 mg qDay **OCD:** >7 years: 10 mg PO qDay, initially; may gradually increase dose after 2 weeks to 20 mg qDay; further increases may be considered after several weeks**;** Adolescents and higher-weight children: Typical dosage range 20-60 mg qDay**;** Lower-weight children: Typical dosage range 20-30 mg qDay
SSRI	Luvox, fluvoxamine	**OCD**: <8 years: Safety and efficacy not established; Ages 8-17 years: 25 mg PO qHS initially; may titrate by 25 mg/day increments every 4-7 days to 50-200 mg/day
SSRI	Zoloft, sertraline	**OCD**: <6 years: Safety and efficacy not established; 6-12 years: 25 mg PO qDay initially; 12-17 years: 50 mg PO qDay initially; May increase by 50 mg qDay at 1-week intervals to no more than 200 mg qDay; give qHS if somnolence experienced
SSRI	Lexapro, escitalopram	**MDD**: ≥12 years: 10 mg PO qDay; may increase dose after at least 3 weeks; not to exceed 20 mg/day
TCA's	Elavil, Levate, amitriptyline	**Depression:** Adolescents**;** Initial: 25-50 mg/day PO in divided doses**; I**ncrease gradually to 100 mg/day in divided doses
TCA's	Anafranil, clomipramine	**OCD:** <10 years: Safety and efficacy not established**;** ≥10 years: 25 mg PO qDay initially**;** Gradually increase to maximum 3 mg/kg/day or 100 mg/day, whichever is less; May further increase to maximum 3 mg/kg/day or 200 mg/day, whichever is less; may give as single dose qHS once tolerated
TCA's	Norpramin, desipramine	Adolescents; <12 years: Safety and efficacy not established; Initial: 25-50 mg PO qDay; may gradually increase if needed to 100 mg/day PO qDay or divided q8-12hr; No more than 150 mg/day
TCA's	Vivactil, protriptyline	**Depression:** <12 years: Safety and efficacy not established**;** ≥12 years: 15-20 mg PO qDay
TCA's	Surmontil, Trimip, Tripramine, trimipramine	**Depression:** <12 years: Safety and efficacy not established**;** ≥12 years: 50 mg/day initially; titrate to 100 mg/day**;** Administer lowest effective dose for maintenance
ANTIPSYCHOTIC AGENTS		
Antimanic agents, 2nd generation antipyschotic	Abilify, Abilify Maintena, Aristada, aripiprazole	**Schizophrenia:** 13-17 years: 2 mg/day PO initially; increased to 5 mg/day after 2 days; increased to recommended dosage of 10 mg/day after additional 2 days; may subsequently be increased by 5 mg/day; maintenance: 10-30 mg/day **Bipolar Mania:** Acute manic or mixed episodes, either as monotherapy or as adjunct to lithium or valproate 10-17 years: 2 mg/day PO initially; increased to 5 mg/day after 2 days; increased to recommended dosage of 10 mg/day after additional 2 days; may subsequently be increased by 5 mg/day; maintenance: 10-30 mg/day **Autism:** Irritability associated with autistic disorder; <6 years: Safety and efficacy not established**;** 6-17 years: 2 mg/day PO initially; increased gradually at intervals ≥1 week to target dosage of 5 mg/day; may gradually be further increased PRN to 10 mg/day or higher; not to exceed 15 mg/day

		Tourette Disorder: Indicated for treatment of Tourette disorder**;** <6 years: Safety and efficacy not established years (<50 kg);Initiate at 2 mg/day PO with a target dose of 5 mg/day after 2 days; The dose can be increased to 10 mg/day in patients who do not achieve optimal control of tics; Dosage adjustments should occur gradually at intervals of no less than 1 week; 6-18 years (≥50 kg); Initiate at 2 mg/day PO for 2 days, and then increase to 5 mg/day for 5 days, with a target dose of 10 mg/day on day 8; The dose can be increased up to 20 mg/day for patients who do not achieve optimal control of tics; Dosage adjustments should occur gradually in increments of 5 mg/day at intervals of no less than 1 week
1st generation antipsychotics	Haldol, Haldol Decanoate, Haloperidol LA, Peridol, haloperidol	**Schizophrenia, Psychosis/Sedation:** <3 years: Safety and efficacy not established**;** 3-12 years (15-40 kg): 0.25-0.5 mg/day PO divided q8-12hr initially; may be increased by 0.5 mg/day every 5-7 days PRN; maintenance: 0.05-0.15 mg/kg/day PO divided q8-12hr; 6-12 years: Lactate (prompt-acting): 1-3 mg IM q4-8hr PRN; not to exceed 0.15 mg/kg/day; >12 years: Moderate disease, 0.5-2 mg PO q8-12hr initially; severe disease, 3-5 mg PO q8-12hr; not to exceed 30 mg/day **Tourette Disorder:** <3 years: Safety and efficacy not established; 3-12 years: 0.5 mg/day PO initially; dose increased by 0.5 mg every 5-7 days until therapeutic effect achieved, then reduced to lowest effective maintenance level of 0.05-0.075 mg/kg/day PO divided q8-12hr, >12 years: 0.5-2 mg PO q8-12hr initially; if severe symptoms necessitate increased dosage, titrate upward to 3-5 mg PO q8-12hr; if patient remains inadequately controlled, daily doses up to 100 mg have been used (safety not determined) **Behavioral Disorders:** <3 years: Safety and efficacy not established**;** 3-12 years: 0.5 mg/day PO initially; dose increased PRN by 0.5 mg every 5-7 days until therapeutic effect achieved, then reduced to lowest effective maintenance level of 0.05-0.075 mg/kg/day PO divided q8-12hr **Acute Agitation:** <12 years: Safety and efficacy not established**;** >12 years: 0.5-3 mg PO, repeated in 1 hour PRN; alternatively, 2-5 mg IM, repeated in 1 hr PRN
1st generation antipsychotics	Navane, thiothixene	**Schizophrenia:** <12 years**,** Not recommended; >12 years**;** Mild-Moderate: initial: 2 mg PO q8hr; may increase to 15 mg/day; Severe: initial 5 mg PO q12hr; Maintenance: 20-30 mg/day; no more than 60 mg/day PO divided q8-12hr
1st generation antipsychotic	Orap, pimozide	**Tourette Disorder:** < 2 years**;** Safety & efficacy not established**;** 2-12 years**;** Initial: 0.05 mg/kg/day PO qHS; Can be increased q3Days to 0.2 mg/kg/day PO qHS; Maintenance dose: 2-4 mg/day; not to exceed 10 mg/day**;** >12 years**;** Initial 1-2 mg PO qDay ; increase every other day; not to exceed 10 mg/day**;** Maintenance: <0.2 mg/kg/day or 10 mg/day, choose lowest dose
1st generation antipsychotics	Trilafon, perphenazine	**Schizophrenia:** <12 years, Not recommended by manufacturer**;** >12 years**;** Hospitalized patients: 8-16mg PO q6-12hr**;** Hospitalized patients: Not to exceed 64 mg/day divided q6-12hr**;** Outpatients: 4-8mg PO q8hr; reduce as soon as possible to minimum effective dose
1st generation antipsychotics	Stelazine, trifluoperazine	**Schizophrenia/Psychosis;** Inpatient**;** <6 years: Safety and efficacy not established**;** 6-12 years old: 1 mg PO qDay or q12hr; not to exceed 15 mg/day**;** 12 years old: 2-5 mg PO q12hr
2nd generation antipsychotic	Saphris, asenapine	**Bipolar Disorder:** Indicated as monotherapy for acute treatment of manic or mixed episodes associated with bipolar I disorder**;** <10 years: Safety and efficacy not established**;** 10-17 years: 2.5 SL q12hr initially; may increase to 5 mg SL q12hr after 3 days and to 10 mg SL q12hr after 3 additional days
2nd generation antipsychotic	Invega, Invega Sustenna, Invega Trinza, paliperidone	**Schizophrenia:** <12 years: Safety and efficacy not established**;** ≥12 years (<51 kg): 3 mg/day PO initially; may be increased if necessary in increments of 3 mg/day at intervals ≥5 days; not to exceed 6 mg/day**;** ≥12 years (≥51 kg): 3 mg/day PO initially; may be increased if necessary in increments of 3 mg/day at intervals ≥5 days; not to exceed 12 mg/day

2nd generation antipsychotic	Zyprexa, Zyprexa Relprevv, Zyprexa Zydis, olanzapine	**Bipolar I Disorder (Manic or Mixed Episodes):** <13 years: Safety and efficacy not established**;** 13-17 years: 2.5-5 mg/day PO initially; target dosage, 10 mg/day; adjust by increments/decrements of 2.5-5 mg; dosage range, 2.5-20 mg/day **Schizophrenia:** <13 years: Safety and efficacy not established**;** 13-17 years: 2.5-5 mg/day PO initially; target dosage, 10 mg/day; adjust by increments/decrements of 2.5-5 mg; dosage range, 2.5-20 mg/day
2nd generation antipsychotics, antimanic agent	Seroquel, Seroquel XR, quetiapine	**Schizophrenia:** <12 years**,** Safety and efficacy not established**;** >12 years (monotherapy, immediate release)**;** Day 1: 50 mg/day PO divided q12hr**,** Day 2: 100 mg/day PO divided q12hr**,** Day 3: 200 mg/day PO divided q12hr**,** Day 4: 300 mg/day PO divided q12hr**,** Day 5: 400 mg/day PO divided q12hr; further adjustments should be in increments ≤100 mg/day**;** Dosage range: 400-800 mg/day**;** Depending on response and tolerance, daily dose may be divided q8hr >12 years (monotherapy, extended release); Day 1: 50 mg/day PO once daily, Day 2: 100 mg/day PO once daily, Day 3: 200 mg/day PO once daily, Day 4: 300 mg/day PO once daily, Day 5: 400 mg/day PO once daily; further adjustments should be in increments ≤100 mg/day **Bipolar I Disorder, Mania:** <10 years**,** Safety and efficacy not established**;** >10 years (monotherapy, immediate release; Day 1: 50 mg/day PO divided q12hr**,** Day 2: 100 mg/day PO divided q12hr**,** Day 3: 200 mg/day PO divided q12hr**,** Day 4: 300 mg/day PO divided q12hr**,** Day 5: 400 mg/day PO divided q12hr; further adjustments should be in increments ≤100 mg/day**,** Dosage range: 400-600 mg/day**,** Depending on response and tolerance, daily dose may be divided q8hr**;** >10 years (monotherapy, extended release)**,** Day 1: 50 mg/day PO once daily**,** Day 2: 100 mg/day PO once daily**,** Day 3: 200 mg/day PO once daily**,** Day 4: 300 mg/day PO once daily**,** Day 5: 400 mg/day PO once daily; further adjustments should be in increments ≤100 mg/day**;** Dosage range: 400-600 mg once daily
2nd generation antipsychotics, antimanic agent	Risperdal, Risperdal Consta, Risperdal M-Tab, risperidone	**Schizophrenia:** <13 years: Safety and efficacy not established**;** >13 years: 0.5 mg/day PO in morning or evening initially; may be increased in increments of 0.5-1 mg/day at intervals ≥24 hr to recommended dosage of 3 mg/day; dosage range: 1-6 mg/day (dosages >3 mg/day have not been proved more effective and are associated with increased incidence of adverse effects)**;** If persistent somnolence occurs, daily dose may be divided q12hr **Bipolar Mania:** <10 years: Safety and efficacy not established; >10 years: 0.5 mg/day PO in morning or evening initially; may be increased in increments of 0.5-1 mg/day at intervals ≥24 hr to recommended dosage of 2.5 mg/day; dosage range: 0.5-6 mg/day (dosages >2.5 mg/day have not been proved more effective and are associated with increased incidence of adverse effects)**;** If persistent somnolence occurs, daily dose may be divided q12hr **Autism:** Irritability associated with autistic disorder in children aged 5-16 years**;** <5 years: Safety and efficacy not established**;** 5-16 years (<20 kg): 0.25 mg/day PO initially; may be increased after ≥4 days to recommended dosage of 0.5 mg/day**;** 5-16 years (≥20 kg): 0.5 mg/day PO initially; may be increased after ≥4 days to recommended dosage of 1 mg/day
Phenothiazine	Thorazine, chlorpromazine	**Behavioral Disorders, Hyperactivity:** <6 months: Safety and efficacy not established**;** >6 months: 50-100 mg/day PO/IM; 200 mg/day or more may be necessary for older hospitalized patients; for outpatients, may administer 0.55 mg/kg q4-6hr PRN
Phenothiazine	Compazine, prochlorperazine	**Psychotic Disorder:** <2 years: Not recommended**;** 2-6 years: 2.5 mg PO/PR q8-12hr initially; not to exceed 20 mg/day; not to exceed 10 mg on the first day**;** 6-12 years: 2.5 mg PO/PR q8-12hr initially; not to exceed 25 mg/day; not to exceed 10 mg on the first day
Phenothiazine	Mellaril, thioridazine	**Schizophrenia:** <2 years: Safety and efficacy not established**;** 2-12 years: 0.5-3 mg/kg/day divided q8hr PO, no more than 3 mg/kg/day; >12 years: Initial 50-100 mg PO q8hr; titrate to 200-800 mg/day PO divided q6-12hr**;** Potential toxic dose <6 years old: 3 mg/kg
ADHD AGENTS		
Stimulant	Adderal, amphetamine /dextroamphetamine	**ADHD**: <3 years: Not recommended; Age 3-6 years: 2.5 mg/day; may increase by 2.5 mg qWeek; not to exceed 40 mg qDay or divided q8hr; use intervals of 4-6 hr between additional doses; >6 years: 5 mg PO qDay or q12hr; may increase by 5 mg qWeek; not to exceed 40 mg qDay or divided q8hr; use intervals of 4-6 hr between additional doses

		Narcolepsy <6 years: Safety and efficacy not established; 6-12 years: 5mg/day PO initially in divided doses; may increase by 5 mg/day qWeek; not to exceed 60 mg qDay or divided doses with intervals of 4-6 hr between doses; >12 years: 10 mg/day PO initially; may increase by 10 mg/day qWeek; not to exceed 60 mg given qDay or divided doses with intervals of 4-6 hr between doses
Stimulant	Adderal XR, amphetamine /dextroamphetamine	**ADHD**: >6 years: Initial, 5-10 mg PO qAM if needed; may increase by 5-10 mg/day qWeek; not to exceed 30 mg/day; 13-17 years: Initial, 10 mg PO qAM; may increase to 20 mg/day after 1 week if symptoms not controlled; doses up to 60 mg/day used but no evidence that higher doses increase effectiveness
Stimulant	Adzenys XR-ODT, Dyanavel XR, Evekeo, amphetamine	**ADHD:** Evekeo**,** <3 years: Safety and efficacy not established**;** 3-5 years: 2.5 mg PO qDay initially; may increase daily dose by 2.5-mg increments at weekly intervals until optimal response is obtained**;** ≥6 years: 5 mg PO qDay initially; may increase daily dose by 5-mg increments at weekly intervals until optimal response is obtained; only in rare cases will it be necessary to exceed 40 mg/day**;** Administer first dose on awakening; give additional doses (1 to 2) at intervals of 4-6 hr**;** Dyanavel XR**,** <6 years: Safety and efficacy not established**;** ≥6 years: Initial: 2.5-5 mg qDay in AM**;** May increase dose in increments of 2.5-10 mg/day q4-7 days; not to exceed dose of 20 mg/day**;** Shake suspension well before measuring dose with a calibrated measuring device**;** Do not substitute for other amphetamine products on a milligram-per-milligram basis, because of different amphetamine base compositions and differing pharmacokinetic profiles**;** Adzenys XR-ODT**;** <6 years: Safety and efficacy not established**;** 6-17 years (initial dose): 6.3 mg PO qDay in AM**;** Maximum dose**;** 6-12 years: 18.8 mg qDay**;** 13-17 years: 12.5 mg qDay **Narcolepsy:** Seldom occurs in children younger than 12 yr; however, when it does, amphetamine may be prescribed 6-12 years: 5 mg/day PO initially; daily dose may be increased by 5-mg increments at weekly intervals until optimal response obtained; ≥12 years: 10 mg/day PO initially; daily dose may increase by 10-mg increments at weekly intervals until optimal response is obtained; Administer in divided doses according to individual response; Administer first dose on awakening; give additional doses (5-10 mg) at intervals of 4-6 hr **Obesity:** Indicated as a short term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction for patients refractory to alternative therapy (eg, repeated diets, group programs, and other drugs)**;** <12 years: Safety and efficacy not established**;** ≥12 years: Usual dosage is up to 30 mg daily, taken in divided doses of 5-10 mg, 30-60 minutes before meals
Stimulant	Ritalin (Ritalin SR, Ritalin LA, Aptensio XR, Concerta, Daytrana, Metadate, Metadate CD, Metadate ER, Methylin, Quillivant XR, QuilliChew ER), Amphetamine /Methylphenidate	**ADHD:** <6 years: Safety and efficacy not established**;** ≥6 years: Methylin, Ritalin (immediate-release tablets, chewable tablets, and oral solution): 5 mg PO BID 30-45 minutes before breakfast and lunch initially; may increase by 5-10 mg/day at weekly intervals; not to exceed 60 mg/day divided BID/TID**;** Metadate ER, Methylin ER, and Ritalin SR: May be given in place of immediate-release products once the daily dose is titrated and the titrated 8-hour dosage corresponds to SR or ER tablet size; not to exceed 60 mg/day**;** Metadate CD, Ritalin LA: Initial, 20 mg PO qAM; may increase by 10 mg (Ritalin LA) or 10-20 mg (Metadate CD) qWeek to not to exceed 60 mg/day**;** Quillivant XR (6-12 years): 20 mg PO qAM initially; may titrate at weekly intervals by weekly 10- to 20-mg increments; not to exceed 60 mg/day**;** Aptensio XR: 10 mg PO qDay in AM; may increase weekly by 10-mg increments; not to exceed 60 mg/day QuilliChew ER (chewable extended-release tablets): 20 mg PO qAM initially; may be titrated up or down weekly in increments of 10 mg, 15 mg or 20 mg, not to exceed 60 mg/day; Immediate-release weight-based dosing; Initial: 0.3 mg/kg/dose PO before breakfast and lunch; may increase by 0.1 mg/kg/dose qWeek ; Maintenance: 0.3-1 mg/kg PO before breakfast and lunch; not to exceed 2 mg/kg/day PO divided q12hr; Concerta (methylphenidate-naïve); Trilayer core tablets; extended-release core with immediate release; Initial: 18 mg PO qDay; dosage may be increased by 18 mg/day at weekly intervals; Do not exceed 54 mg/day in children (6-12 years) and 72 mg/day in adolescents (13-17 years); Concerta (patients taking methylphenidate); 18 mg PO qAM (if switching from methylphenidate 5 mg PO q8-12hr); 36 mg PO qAM (if switching from

		methylphenidate 10 mg q8-12hr); 54 mg PO qAM (if switching from methylphenidate 15 mg PO q8-12hr); 72 mg PO qAM (if switching from methylphenidate 20 mg PO q8-12hr); Transdermal patch (Daytrana); Indicated for children aged 6-12 years and adolescents aged 13-17 years; Recommended starting dose for patients new to or converting from another formulation of methylphenidate is 10 mg; Apply patch on hip 2 hours before desired onset; remove after 9 hours; alternate application site; Dose titration, final dosage, and wear time should be individualized according to the needs and response of the patient; Titrate to effect for best results, following are Manufacturer's recommendations; Week 1: 10 mg (12.5 cm^2 patch); releases 1.1 mg/hr, Week 2: 15 mg (18.75 cm^2 patch); releases 1.6 mg/hr, Week 3: 20 mg (25 cm^2 patch); releases 2.2 mg/hr, Week 4: 30 mg (37.5 cm^2 patch); releases 3.3 mg/hr **Narcolepsy:** <6 years**;** Safety & efficacy not established; ≥6 years**;** Methylin, Ritalin (immediate-release tablets, chewable tablets, and oral solution): 5 mg PO q12hr; may increase by 5-10 mg/day weekly; not to exceed 60 mg/day**;** Metadate ER, Methylin ER, and Ritalin SR: May be given in place of immediate-release products once the daily dose is titrated and the titrated 8-hour dosage corresponds to SR or ER tablet size; not to exceed 60 mg/day
	Strattera, atomoxetine	**ADHD:** >6 years and ≤70 kg: 0.5 mg/kg PO once daily; increased after ≥3 days to target dosage of ~1.2 mg/kg PO once daily or divided q12hr; total daily dose not to exceed 1.4 mg/kg or 100 mg, whichever is less; no benefit observed with higher doses; >70 kg: 40 mg PO once daily initially; increased after ≥3 days to 80 mg PO once daily or divided q12hr; if necessary, may be increased after 2-4 additional weeks to 100 mg PO once daily**;** Dosing considerations: When drug is co-administered with strong CYP2D6 inhibitors (eg, paroxetine, fluoxetine, quinidine) or used in patients known to be poor CYP2D6 metabolizers, decrease dosage**;** ≤70 kg: 0.5 mg/kg/day initially; increased to usual target dosage of 1.2 mg/kg/day only if symptoms fail to improve after 4 weeks and initial dosage is well tolerated**;** >70 kg: 40 mg/day initially; not to exceed 80 mg/day
Alpha 2 Antagonist, Central Acting	Catapres, Dur aclon, Jenloga, Kapvay, Nexiclon XR, clonidine	**ADHD:** <6 years old: Not established**;** ≥6 years old (extended-release tablets, Kapvay): 0.1 mg PO qHS initially; may adjust dose by increments of 0.1 mg/day at weekly intervals until desired response; not to exceed 0.4 mg/day**;** When discontinuing, taper gradually by decrements not to exceed 0.1 mg q3-7Days**;** Dosing considerations: May be given as monotherapy or as adjunctive therapy with stimulants**;** Extended-release not interchangeable with immediate-release product
Stimulant	Dexedrine, ProCentra, Ze nzedi, dextroamphet amine	**ADHD:** <3 years: Safety and efficacy not established**;** 3-5 years**,** Initial: 2.5 mg PO qDay; may increase by 2.5 mg/day qWeek**;** ≥6 years**:** Initial: 5 mg PO qDay or BID (4-6 hr apart); may increase by 5 mg/day qWeek until optimal response**;** Maintenance: 5-15 mg PO q12hr OR 5-10 mg PO q8hr**;** May substitute with qDay dosing of extended-release capsules**;** Rarely necessary to exceed 40 mg/day **Narcolepsy:** >12 years: 10 mg PO qDay initially; may increase by 10 mg qWeek to optimal response
Stimulant	Focalin, Focalin XR, dexmethylph enidate	**ADHD:** <6 years, Safety and efficacy not established**;** ≥6 years (Focalin); Initial: 2.5 PO twice daily; may increase in 2.5- to 5-mg increments qWeek if warranted**;** Not to exceed 20 mg/day**;** ≥6 years (Focalin XR)**;** Not taking Focalin or methylphenidate: 5 mg PO qDay initially; may increase in 5-mg increments qWeek if warranted; not to exceed 30 mg/day**;** Switch from Focalin: Administer the same total daily dose as Focalin but administer qDay; Switch from methylphenidate: Initiate with half total daily dose of methylphenidate and administer qDay; not to exceed 30 mg/day
Alpha 2 Adrenergic Antagonists	Intuniv, Tenex, guanfacine	**ADHD:** Intuniv: Monotherapy for ADHD or adjunct to stimulant; <6 years: Safety and efficacy not established 6-18 years; Intuniv: 1 mg/day PO initially; may adjust dose using increasing increments (not exceeding 1 mg/wk); Take once daily, either in the morning or evening, at approximately the same time each day; To balance the exposure-related potential benefits and risks, the recommended target dose range depending on clinical response and tolerability is0.05-0.12 mg/kg/day PO initially; Aged 6-12 years: Doses >4 mg/day not evaluated; Aged 13-17 years: Doses >7 mg/day not evaluated; Adjunctive trials with psychostimulants: Doses >4 mg/day not evaluated; Target dose range by weight; 25-33.9 kg: 2-3 mg/day, 34-41.4 kg: 2-4 mg/day, 41.5-

		49.4 kg: 3-5 mg/day, 49.5-58.4 kg: 3-6 mg/day, 58.5-91 kg: 4-7 mg/day, >91 kg: 5-7 mg/day
Stimulant	Vyvanse, lisdexamfetamine	**ADHD:** Starting/switching treatment: 30 mg PO qAM; Dose adjustment: Increase by 10- to 20-mg/day increments approximately qWeek**;** Not to exceed 70 mg qDay **Binge Eating Disorder:** Indicated for moderate-to-severe binge eating disorder (BED) in adults**;** Starting dose: 30 mg/day PO, THEN**;** Target dose: Titrate in increments of 20 mg at ~1 week intervals to achieve the recommended target dose of 50-70 mg/day**;** Not to exceed 70 mg/day**;** Discontinue if BED does not improve
SNRI's, Antidepressant	Effexor, Effexor XR, venlafaxine	**ADHD:** <40 kg: 12.5 mg/day PO initially; increase by 12.5 mg/week; not to exceed 50 mg/day divided twice daily**;** ≥40 kg: 12.5 mg/day PO initially; increase by 25 mg/week; not to exceed 75 mg/day divided three times daily
ANTIANXIETY AGENTS		
Benzodiazepine	Librium, chlordiazepoxide	**Anxiety:** <6 years: Safety and efficacy not established**;** >6 years: 0.5 mg/kg/day divided PO q6-8hr, OR 5 mg PO q6-12hr; may increase dose to 10 mg PO q8-12hr; >12 years: 25-50 mg IV/IM q6-8hr
Muscle Relaxants, Benzodiazepine	Valium, Diastat, diazepam	**Sedative/Muscle Relaxant:** Potentially toxic dose in patients <6 years: >0.5 mg/kg**;** <6 months: Not recommended >12 years; 0.12-0.8 mg/kg/day PO divided q6-8hr, OR ; 0.04-0.2 mg/kg IV/IM q2-4hr; no more than 0.6 mg/kg within 8 hours
Non-benzodiazepine	meprobamate	**Anxiety:** <6 years old: Not recommended**;** 6-12 years old: 100-200 mg PO q8-12hr**;** >12 years old: 1200-1600 mg/day PO divided q8-12hr; not to exceed 2.4 g/day
Anxolyctics, Benzodiazepine	Serax, oxazepam	**Anxiety:** <6 years: Not recommended**;** 6-12 years: Not established; use with caution**;** >12 years**:** Mild/moderate: 10-15 mg PO q6-8hr PRN**;** Severe, agitation or assoc with depression: 15-30 mg PO q6-8hr PRN
SNRI's, Antidepressants	Cymbalta, duloxetine	**Generalized Anxiety Disorder:** <7 years: Safety and efficacy not established**;** 7-17 years: 30 mg PO qDay initially; after 2 weeks, may consider increasing dose to 60 mg/day**;** Recommended dosage range: 30-60 mg/day**;** Some patients may benefit from doses >60 mg/day; if increased beyond 60 mg/day, use increments of 30 mg/day**;** Maximum dose studied was 120 mg/day; safety of doses >120 mg/day has not been evaluated
OPIOID ANTAGONISTS		
Opioid Reversal Agent	Narcan, Evzio, naloxone	**Opioid Reversal;** Postanesthesia (acute) opioid reversal**:** Neonates: 0.01 mg/kg IV into umbilical vein/IM/SC; give subsequent dose of 0.1 mg/kg if needed **;** Children: 0.01 mg/kg IV x1; may repeat with 0.1 mg/kg **Therapeutic opioid dosing:** 0.00-0.015 mg/kg/dose IV/IM/SC/ET; may repeat PRN **Acute opioid overdose:** ≤20 kg or <5 years: 0.1 mg/kg/dose IV/IM/SC/ET; if needed, repeat q2-3min PRN; not to exceed 2 mg/dose; >20 kg or ≥5 years: 2 mg IV/IM/SC/ET; if needed, repeat q2-3min PRN **Opioid Overdose** (Evzio Auto-Injector): Indicated for immediate administration as emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression 0.4 mg or 2 mg IM/SC into anterolateral aspect of the thigh (through clothing if necessary); if child is <1 yr, pinch the thigh muscle while administering the dose; Seek emergency medical care immediately after use; Additional doses may be administered q2-3min until EMS arrives
SEDATIVES/HYPNOTICS		
Barbiturates	Amytal Sodium, amobarbital	**Sedative:** <6 years: Safety and effectiveness not established**;** 6-12 years: 65 mg-500 mg IV/IM >12 years: 30-50 mg IV q8-12hr **Hypnotic:** Used as a hypnotic, for short-term treatment of insomnia; effectiveness for sleep induction and sleep maintenance is lost after 2 weeks**;** <6 years: Safety and effectiveness not established**;** 6-12 years: 2-3 mg/kg; not to exceed 500 mg IV/IM; >12 years: 65-200 mg IV qHS
Barbiturates	Nembutal, pentobarbital	**Hypnotic:** 2-6 mg/kg IM once; not to exceed 100 mg

Barbiturates	Seconal, secobarbital	**Sedative:** 6 mg/kg PO divided q8hr
STIMULANTS		
CNS Stimulants	Adipex P, Lomaira, phentermine	**Obesity:** Short-term (few weeks) adjunctive use as part of weight-reduction regimen based on exercise, behavioral modification, and caloric restriction in management of exogenous obesity for patients with initial BMI ≥30 kg/m² or ≥27 kg/m² in presence of other risk factors (eg, controlled hypertension, diabetes, hyperlipidemia)**;** <16 years: Safety and efficacy not established**;** ≥16 years: Adjust dosing according to patient's needs to achieve adequate response with lowest effective dosage**;** Adipex P or generic**:** 15-37.5 mg/day PO in single daily dose or divided q12hr before breakfast or 1-2 hr after breakfast**;** Lomaira**:** Typical dose is 8mg PO TID 30 minutes before meals
CNS Stimulants	Desoxyn, methamphetamine	**ADHD:** <6 years: Safety and efficacy not established**;** ≥6 years: 5 mg PO qDay or q12hr, may increase daily dose at weekly intervals of 5 mg/day until optimal response (ususally 20-25 mg/day)**;** Daily dose may be divided q12hr **Obesity:** <12 years: Safety and efficacy not established**;** ≥12 years: As adults; 5 mg PO q8hr 30 minutes before each meal
CSN Stimulants	diethylpropion	**Obesity;** <16 years**:** Safety & efficacy not established**;** > 16 years**:** Immediate release: 25 mg PO q8hr AC**;** Controlled release: 75 mg PO qDay, swallowed whole, in midmorning
	Provigil, modafinil	**Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS):** <16 years**:** Not recommended**;** ≥16 years**:** 200 mg PO qAM; not to exceed 400 mg **Narcolepsy:** <16 years**:** Not recommended; ≥16 years**:** 200 mg PO qAM; not to exceed 400 mg **Shift Work Sleep Disorder:** <16 years**:** Not recommended**;** ≥16 years**:** 200 mg PO 1 hr prior to patient's work shift
Repertory stimulants	Cafcit, NoDoz, ReCharge, Vivarin, caffeine	**Drowsiness or Fatigue:** < 12 years: Not recommended**;** >12 years: 100-200 mg PO q3-4hr; not later than 6 hours before bedtime**;** Potential toxic dose <6 years old: 15 mg/kg **Neonatal Apnea:** Load: 10-20 mg/kg IV/PO once**;** Maintenance: 5-10 mg/kg IV/PO qDay**;** Potential toxic dose <6 years old: 15 mg/kg