



Advocating for extended release stimulants in children under 6

Following published guidelines and after trials of behavioral interventions, TECC recommends starting young children on immediate release stimulant (methylphenidate or amphetamine formulation) and titrating to a tolerable and effective dose. When that dose is established, transitioning to extended release is recommended as the standard of care.

In Louisiana, the Medicaid Managed Care Organizations do not include extended release stimulant on formulary and advocating for appropriate treatment for children under 6 requires specific approaches for each individual child. This handout is intended to support clinicians in advocating for extended release stimulants.

1. Recognize the first PA review is done by someone who cannot overturn the rejection because the prescription is indeed off formulary. The faster you move past this step, the better. Asking to speak with the PharmD right away can be effective.

Talking points for the appeal

1. Child has tolerated immediate release mph at an equivalent dose. If there are any rebound symptoms, highlight that as an indicator of adverse effects and an extra indication to go to extended release, but this should not be a required component..
2. To date, the only guideline published in a major peer reviewed journal about preschool psychopharmacology recommends use of long acting stimulants in children who are in school (see attached, you may need to fax it to them, despite the length). Reference: Gleason et al. (2007) J Am Acad Child Adolesc Psychiatry.46(12):1532-72; <https://www.jaacap.org/article/S0890-8567%2809%2961867-0/abstract>) The American Academy of Pediatrics guidelines do not address it explicitly, but there is no prohibition against it. (AAP (2011) Pediatrics. 128:00; <http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654>;
3. The best data for treatment ADHD in preschoolers is on methylphenidate. (Greenhill et al 2006). They used immediate release mph primarily because the extended release were not as available when they did the study. Data are clear, though, that adherence decreases with every extra dose per day. Switching to an extended release formulation is advisable for improved adherence and effectiveness of the treatment Amerigroup is paying for.
4. THERE IS NO REASONABLE SAFETY CONCERN IN SWITCHING FROM IR TO ER! There are no data indicating that extended release is detrimental to the child and the planned dose change is to provide mg/day dose that is already established in this child. There is no physiologic reason that the same dose in a different formulation should necessarily offer more safety concern. Specifically, this planned change is to allow you to give the child the same mg/day dose with higher rates of adherence, less risk of inconsistent coverage through the day, less risk of bullying and stigma related to going to the nurse's office, and less chance of rebound.
5. Again, highlight any rebound symptoms as an indication of medical necessity.