ASD Medication Management

Children with autism may experience co-morbidities such as ADHD, insomnia, irritability/dysregulation, tics, and anxiety. Sometimes referral to specialists such as developmental medicine, neurology, or behavioral health is needed, but often PCPs can safely provide medication management in the medical home. In the autism smart set, there is a medication section with pearls and dosing recommendations that providers can reference for assistance. Please see **ASD post diagnosis note template and smart set module** for how to save that smart set as a favorite so you can easily access the dosing recs at each autism follow up visit and at any visit for a child with autism where you would like to manage these medications. Below are some key takeaways:

**General pearls for medication prescribing:**

* For mild side effects, try a lower dose. For serious side effects, stop immediately.
* Call 615-205-9367 to reach the VHAN Behavioral Consult Line (Mon-Fri, 8 am-4 pm) for clinical guidance from a licensed clinical social worker who can connect you with a Child & Adolescent Psychiatrist if needed
* Check TennCare Preferred Drug list to ensure insurance coverage if applicable to patient

**ADHD**

* Stimulants
	+ Overall considered first line/most effective
	+ Methylphenidate preferred for children with autism
	+ Consider starting with short acting (on weekend) to assess tolerability/adverse effects
	+ **SEE ADHD medication guide module** for dose comparison when switching within the same class
	+ See adhdmedcalc.com for dose comparison when switching between classes
* Alpha-2 agonists
	+ Typically use long-acting version for better control of ADHD symptoms
	+ Clonidine more sedating than guanfacine
	+ Require wean off when discontinuing (affect blood pressure)
	+ In addition to ADHD can be used to treat insomnia, irritability, tics, anxiety
* Norepinephrine reuptake inhibitors
	+ FDA approved for ages 6 yrs +
	+ Require wean off when discontinuing
	+ Black box warning for suicidal ideation
	+ In addition to ADHD, can be used to treat anxiety

**Insomnia**

* Consider sleep study if OSA symptoms
* Consider iron deficiency if restless leg symptoms
* First line treatment is melatonin. Start 1 mg QHS. Increase by 1mg weekly if needed to a max of 5mg for 2-5 yr and 10mg for 6 yr+
* Alternate treatment options include: clonidine, gabapentin, trazodone, hydroxyzine

**Irritability/Dysregulation**

* In patients with autism, may present as aggression, tantrums, self-injury
* Rule out medical causes such as constipation or otitis media
* First line treatment is alpha-2 agonists
* Alternate treatment is with atypical antipsychotics such as Risperdal/Abilify, these require lab monitoring

**Tics**

* Tics present between 5-7 years, often associated with distress
* Autism-related stereotyped movements present <2 years old, typically more enjoyable
* Consider diagnosis of Tourette’s if motor and vocal tics > 12 months duration
* If has comorbid ADHD, helpful to know that stimulants do not cause tics but can unmask them
* First line treatment is alpha-2 agonists
* If alpha-2 agonists not effective, refer to neurology for consideration of treatment with typical antipsychotics

**Anxiety**

* In patients with autism, anxiety can present as increased rigidity, irritability, or separation issues
* Medication class options for treatment include:
	+ Selective serotonin reuptake inhibitors
	+ Alpha-2 agonists
	+ Hydroxyzine prn for situational anxiety 6 yrs+