B-QuiCK: Pharmacological management of ADHD in adults and children

- Methylphenidate, lisdexamfetamine or dexamfetamine are all first-line treatment options for adults with ADHD who have symptoms that significantly impact their daily lives
- Prescribe the most appropriate formulation based on the clinical situation, patient preference and medicine availability

Due to ongoing supply issues Pharmac advises prescribers to prioritise methylphenidate for children, adolescents and people with narcolepsy, and consider initiating newly diagnosed adults with ADHD on lisdexamfetamine or dexamfetamine (contraindicated in pregnancy).

Pre-treatment screening and investigations

- Review medical history and prescribed medicines to identify cautions and rule out any contraindications (see: Table 2 for contraindications and cautions)
- Record weight, check heart rate and blood pressure (CVD assessment)
- Consider ECG, cardiologist opinion or referral in the following situations:
  - Prescribed concurrent medicines that "may pose an increased cardiac risk"
    - Discuss with cardiologist if patient is prescribed any cardiac medicine
    - Arrange an ECG (at minimum) if taking any medicines with potential cardiovascular adverse effects, e.g. tricyclic antidepressants.
  - Hypertension - do a baseline ECG
  - A history of congenital heart disease, cardiac surgery or sudden cardiac-related death in a first-degree relative aged < 40 years
  - Shortness of breath or fainting on exertion
  - Heart palpitations
  - Suspected cardiac chest pain
  - Heart murmur on examination

Establish symptom and function baseline

- Provides a baseline for dose titration and measuring treatment response
- Can use a validated symptom questionnaire, e.g. Adult ADHD Self-Report Scale
- Identify areas in which symptoms have the most significant impact on life and collaboratively set treatment goals

Identifying and addressing co-morbidities is critical

- Assess for (and manage) co-morbid mental health conditions before initiating psychostimulant medicines, e.g. schizophrenia, bipolar disorder, suicidal ideation or substance misuse
- If previously diagnosed with a mental health condition, re-evaluate current treatment plan (for that condition) and check for medicine interactions

Psychostimulant medicines and eating disorders

- Generally, avoid psychostimulant medicines if there are any concerns about maintenance of body weight
- Otherwise, consider on a case-by-case basis, e.g. may be appropriate if the eating disorder is effectively treated, the patient has ongoing support and is maintaining their goal weight
- Close monitoring and potentially slower dose titration required

Psychostimulant medicines during pregnancy and breast-feeding

Pregnancy and breast-feeding are not outright contraindications to the use of psychostimulant medicines but there is limited data on these situations.

- Methylphenidate and lisdexamfetamine can be cautiously considered in pregnancy if the benefits are considered to outweigh the risks
  - Assess fetal growth, blood pressure and weight gain frequently throughout pregnancy
  - Closely monitor infant for irritability, difficulty sleeping and breathing problems after birth
- Dexamfetamine is contraindicated during pregnancy and breast-feeding by the manufacturer
- Manufacturers advise to avoid methylphenidate and lisdexamfetamine while breast-feeding but they can be considered if the benefits outweigh the risks
  - Monitor the infant for adverse effects, e.g. irritability, difficulty sleeping and feeding
  - Psychostimulant medicines may impact milk production, especially if lactation has not yet been established

Discuss any queries or concerns prior to initiation of psychostimulant medicines with a psychiatrist and have a low threshold for seeking advice for patients with concomitant mental health conditions. Do not manage patients with complex needs or high-risk clinical features in primary care; refer to psychiatric services.

Choosing a medicine – immediate- or modified-release?

Prescribe a formulation based on the clinical situation, desired duration of effect, patient preference and medicine availability (see: Table 2 for an overview of funded psychostimulant medicines).

Immediate-release formulations: Ritalin, Rubifen, Dexamfetamine (Noumed)

- Allows for simple dose titration
- Fast onset and short duration of action, therefore several doses throughout the day may be required
  - May lead to poor treatment adherence, dosing errors and adverse effects due to fluctuations in blood concentrations or rebound ADHD symptoms at the end of the medicines' duration of action (rapid "weaning off" effect)
- Prescribe immediate-release methylphenidate generically where appropriate (to allow brand change depending on supply)

Modified-release formulations: Rubifen SR, Ritalin LA, Concerta, Methylphenidate ER-Teva, Methylphenidate Sandoz XR, Vyvanse (lisdexamfetamine)

- Single-daily dosing is often more convenient and can improve adherence
- Lessens or avoids sharp blood concentration spikes and drop-offs, reducing the potential for adverse effects and rebound ADHD symptoms when the treatment wears off
- Modified-release formulations, e.g. Concerta, and lisdexamfetamine are less likely to be misused or abused because of the smaller immediate-release component and the delivery technology prevents tampering/makes other delivery methods ineffective
- Prescribe modified-release methylphenidate preparations by brand

Initiate psychostimulant medicines at a lower dose and titrate up; this is a trial and error process (see: Table 3 for initial dosing regimens).

Initial monitoring during dose titration

- Frequent monitoring is necessary during initial titration
- Check-ins can be via phone/virtual but an in-person clinical review is needed within two to four weeks of starting psychostimulant medicines
- Use standard scales to assess symptom improvement and measure treatment response, including personal treatment goals
- Consider slower dose titration, more frequent in-person monitoring or discussion with a psychiatrist for patients with other neurodevelopmental disorders, concomitant mental health conditions or any other condition that may be worsened while taking psychostimulant medicines, e.g. cardiovascular disease (including hypertension), epilepsy

Finding the right daily dosing regimen

- The optimal dose reduces core ADHD symptoms and improves functional outcomes with minimal adverse effects
- A treatment response is typically expected at doses of 0.5 – 1 mg/kg for methylphenidate (expert opinion)

At every follow-up, review:

1. Are core ADHD symptoms well controlled, i.e. low scores on symptom scales?
2. Does symptom control vary throughout the day (or from day to day) and does this variation present challenges?
3. Is the duration of action correct for the individual needs of that patient?
4. Are there any adverse effects that warrant a dose reduction?

Increase or decrease the dose of psychostimulant based on the responses to these questions

Switching to a modified-release formulation

- Patients initiated on immediate-release formulations of methylphenidate can be switched to the equivalent total dose (in milligrams) of a modified-release formulation, if appropriate
- Start patients initiated on dexamfetamine (who want to switch to lisdexamfetamine, and vice versa), on the lowest dose and titrate up again as amfetamines are not dose equivalent

Tailoring the psychostimulant regimen over time once the appropriate formulation and optimal dose have been established

- Immediate-release methylphenidate doses can be added to provide symptom control:
  - Before the effects of a modified-release formulation become apparent
  - When the effects of the modified-release formulation have decreased
- Doses may not need to be taken every day, e.g. medicine-free periods during the weekends or reduced doses on certain days to avoid adverse effects. N.B. Psychostimulant medicines should be taken consistently (i.e. every day) during titration to observe effects on all areas of the patient's life, before tailoring the regimen.

Monitoring and follow-up once stabilised on psychostimulant medicines

- Arrange regular follow-up to assess treatment response and monitor for adverse effects:
  - Six-monthly is reasonable if symptoms are mild to moderate and well controlled
  - More frequent review if severe symptoms, co-morbidities or other concerns
- Every review should include:
  - Evaluation of ongoing improvement in ADHD symptoms; use standard scales
  - Measurement of weight, heart rate and blood pressure. ECG or laboratory investigations only required if there is a clinical indication.
  - Assessment for, and addressing, any adverse effects, e.g. sleep disturbances, mood changes, changes in appetite or weight loss, increases in blood pressure or heart rate, tics, seizures, deteriorating mental health

Patients with any of the following concerns require discussion with, or referral to, a psychiatrist or other relevant specialist:

- Development of, or worsening, psychiatric symptoms, especially if signs of psychosis or mania (may necessitate urgent attention)
- Difficulty managing symptoms despite adequate medicines trials with optimised doses
- New-onset cardiovascular symptoms (that do not improve with dose reduction), or a change in cardiovascular diagnosis
- Unintentional body weight reduction of ≥ 5% (depending on the patient's starting BMI)
- Strong suspicion or confirmation of misuse or diversion of ADHD medicines

Trial a different psychostimulant if treatment response is insufficient

- If insufficient (or no) improvement in ADHD symptoms after a six-week trial of a psychostimulant at an appropriate dose (e.g. 0.5 – 1 mg/kg) switch to another formulation or medicine
- **Before switching:**
  - Determine that the medicine is being taken as prescribed
  - Confirm that the agreed upon treatment goals are realistic and align with the expected effects of psychostimulant medicines
  - Assess whether the most appropriate ADHD symptoms are being measured to evaluate treatment response
  - Identify co-morbidities or other modifiable factors that may impact treatment goals, e.g. psychiatric co-morbidities, family or social circumstances. Address these where possible.
  - Reconsider if the ADHD diagnosis is correct

General principles for switching psychostimulant formulations

- **Establish a baseline for symptoms** and daily functioning to guide dose titration. Re-evaluation for substance misuse or diversion may also be appropriate.
- Previously trialled brands of methylphenidate, or amfetamines, that resulted in a good treatment response and were well tolerated should be the first choice
- Ideally, select another brand that is most similar to the current medicine. However, be aware that some patients may not respond/experience the same effect even with a similar brand.
- Theoretically, all brands of methylphenidate have daily dose equivalence but start the new brand at a reduced dose, to evaluate treatment response before titrating back up
  - If switching from a modified-release (or prodrug) formulation to divided doses of an immediate-release formulation, warn patients that they may experience variations in symptom control because of peaks and troughs in plasma levels
- Methylphenidate and amfetamines are not considered dose equivalent; if switching between these, start at the lowest dose and slowly increase based on treatment response and adverse effects (see: Table 3 for initial dosing regimens)
  - Dexamfetamine doses are typically half of methylphenidate doses (expert opinion)
- **Close monitoring is required;** evaluate treatment response and adverse effects one to two weeks after any change in formulation or dose
- Consider dosing adjustments before switching again. Confirm that any new adverse effects are not related to the duration of action.
- Trial a second alternative within the same class before switching to a different medicine, e.g. trial two brands of methylphenidate before switching to an amfetamine, or trial both types of amfetamine before switching to a methylphenidate formulation

Regularly revisit the need for treatment

- Continue treatment as long as the patient is experiencing benefit; this may be life-long in some cases
- Regularly discuss preferences for continuing or stopping treatment, including:
  - Confirmation that a clinical indication remains
  - The patient's (or caregiver's) opinion on whether they are still experiencing a therapeutic benefit
  - The development of any new adverse effects
  - The impact of missed doses or dose reductions on the patient's day-to-day life
- A treatment holiday or a period of treatment at a reduced psychostimulant dose can be helpful to assess ongoing need

Stopping psychostimulant treatment for ADHD

- Psychostimulant medicines can generally be stopped abruptly without adverse effects
- Consider a gradual taper if the patient is stabilised on a high dose, or has previously reported discontinuation symptoms during a treatment holiday
- Discuss factors that may prompt restarting psychostimulant medicines in the future

ADHD treatment: special considerations for children and adolescents

Methylphenidate is the first-line treatment option for children with ADHD. Review at least every six months with more frequent assessment if severe symptoms or co-morbidities, insufficient growth or medicines adherence or abuse/diversion concerns. Additional points for monitoring ADHD treatment in children include:

- Use child-specific scales to measure ADHD symptoms and therapeutic effect over time, e.g. Strengths and Weaknesses of ADHD Symptoms and Normal Behaviour Scale (SWAN). Generally completed by parents/caregivers (with additional information from teachers, where possible).
- Common adverse effects of psychostimulant medicines in children include headaches, abdominal pain, sleep disturbances, appetite suppression, aggression and mood changes, e.g. anxiety or irritability.
  - Will often improve with time; consider a dose reduction if intolerable or persistent
  - Melatonin may be considered for sleep disturbances (unapproved indication in children)
- Some children become subdued and avoid social interaction when taking psychostimulant medicines; switching to a different psychostimulant or non-psychostimulant medicine should be discussed with a paediatrician/psychiatrist
- Measure weight and height at three and six months after initiation of treatment and then every six months thereafter. Consider a treatment holiday if weight is not being maintained. Discuss with, or refer to, a paediatrician if growth rate changes are identified.
- Measure heart rate and blood pressure and compare results with accepted normal values for children based on age and sex. Persistently elevated values warrant discussion with, or referral to, a paediatrician.
- As appropriate, periodically reassess risk of diversion and misuse

Best Practice Tip: If dosing adjustments are required, suggest that caregivers make the change at the start of the weekend to allow time to monitor the child's response before they return to school on Monday.

Clinician resources

- Local HealthPathways
- New Zealand Clinical Principles Framework for Attention Deficit Hyperactivity Disorder (2025)
- Adult ADHD GP Masterclass (2025): series of webinars presented by Dr Sidhesh Phaldessai, a senior psychiatrist with a special interest in adult ADHD, in conjunction with the RNZCGPP (costs may apply).
- Goodfellow Unit. Webinars and e-learning resources (costs may apply) including Adult ADHD: From diagnosis to long-term management presented by Dr David Codyre, and Adult ADHD: Assessment and management featuring Dr David Chinn, Dr David Codrye and Dr Hinemoa Elder.
- Safe, comprehensive, and equitable ADHD care (2025). The Royal Australian and New Zealand College of Psychiatrists Position Statement on ADHD care.
- Australian Evidence-Based Clinical Practice Guideline for ADHD (2022), endorsed by the Royal Australian and New Zealand College of Psychiatrists, and the Royal Australasian College of Physicians.
- NICE guidelines (2018; updated 2019)
- Canadian ADHD Practice Guidelines (2020)
- Adult ADHD Assessment Quality Assurance Standard (UK; 2024)
- Skirrow, P. Practice Standards for the Assessment of ADHD: A Synthesis of Recommendations From Eight International Guidelines. JNZCCP 2025; 35: 96– 116. Summary of international guidelines on ADHD diagnosis with the goal of establishing the minimum safe practice standards for diagnostic assessments.

Patient and family/whānau resources

- Changes to the Rules for Prescribing Medicines for ADHD – Information sheet (2025). A patient information handout produced by the Ministry of Health, Manatū Hauora, Pharmac and Medsafe that covers frequently asked questions about the regulatory and medicines funding criteria changes.
- Healthify has patient information for ADHD in adults and children and medicines used to treat ADHD
- ADHD New Zealand is national advocacy group that provides practical information and support for people living with ADHD and their families/whānau, including New Zealand-specific resources, information relating to managing medicine supply shortages and a directory of ADHD healthcare professionals.
- Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) is an American website providing evidence-based information and support for people living with ADHD and their families

N.B. Ask the patient what their preferred medium for receiving health information is, e.g. websites, podcasts or books may be more be helpful than conventional printed leaflets

Table 2. Overview of funded psychostimulant medicines available for managing ADHD in adults and children aged six years and over as of 1st February, 2026.[1, 2, 23, 25, 30, 35–43] N.B. The data in this table are compiled from the New Zealand Formulary (and New Zealand Formulary for Children), the ADHD Prescribing Guide for Australian Healthcare Professionals, New Zealand data sheets and expert opinion, and should only be used as guide.

Medicine	**Methylphenidate**								**Dexamfetamine** *(unapproved indication in adults)*	**Lisdexamfetamine**
Special Authority application form:	SA2590 *(Rubifen LA will be included on this form if funded)*						SA2591		SA2587	SA2588
Brand:	Ritalin	Rubifen	Rubifen SR	Methylphenidate ER - Teva	Methylphenidate Sandoz XR *(provisionally approved until September, 2027)*	Rubifen LA *(proposed to be funded from 1st July, 2026)*	Ritalin LA	Concerta	Dexamfetamine (Noumed)	Vyvanse
Medicine type:	Innovator	Generic (of Ritalin)	Generic (of Ritalin SR)	Generic (of Concerta)	Generic (of Concerta)	Generic (of Ritalin LA)	Innovator	Innovator	Generic	Innovator
Formulation and strengths available:	Tablet 10 mg	Tablet 5 mg 10 mg 20 mg	Modified-release tablet 20 mg	Modified-release tablet 18 mg 27 mg 36 mg 54 mg	Modified-release tablet 18 mg 27 mg 36 mg 54 mg	Modified-release capsule 10 mg 20 mg 30 mg 40 mg 60 mg	Modified-release capsule* 10 mg 20 mg 30 mg 40 mg	Modified-release tablet 18 mg 27 mg 36 mg 54 mg	Tablet 5 mg	Capsule† 30 mg 50 mg 70 mg
Onset of action:	20 minutes – 1 hour	20 minutes – 1 hour	1 – 2 hours	1 – 2 hours	1 – 2 hours	1 – 2 hours‡	1 – 2 hours	1 – 2 hours	20 minutes – 1 hour	60 – 90 minutes
Duration of action:	3 – 5 hours	3 – 5 hours	Up to 8 hours	Up to 12 hours	Up to 12 hours	6 – 8 hours	6 – 8 hours	Up to 12 hours	4 – 6 hours	8 – 14 hours
Contraindications (for the full list of contraindications, see the NZF or New Zealand data sheets):	▪ Acute severe depression, uncontrolled bipolar disorder, suicidal ideation or psychosis – patient should be stabilised first (involving specialist care) ▪ Anorexia nervosa ▪ Uncontrolled substance dependence or alcohol misuse (including in family and caregivers), however, expert opinion is that treatment could be carefully considered as part of a complete treatment plan if this is well-controlled or in remission (under specialist supervision) ▪ Hyperthyroidism ▪ Pre-existing cardiovascular disease, e.g. advanced arteriosclerosis, heart failure, myocardial infarction, arterial occlusive disease, cardiomyopathy, moderate to severe hypertension, arrhythmias, structural cardiac abnormalities ▪ Cerebrovascular disorders including aneurysm, vasculitis, vascular abnormalities, stroke — due to effects on heart rate and blood pressure ▪ Acute angle-closure glaucoma ▪ Hypersensitivity to the active ingredient Note: Modified-release tablets should not be prescribed to patients with dysphagia or restricted size of gastro-intestinal lumen, e.g. gastric bypass									▪ Tics (but see caution)

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Medicine	Methylphenidate								Dexamfetamine	Lisdexamfetamine
	Ritalin	Rubifen	Rubifen SR	Methylphenidate ER - Teva	Methylphenidate Sandoz XR	Rubifen LA	Ritalin LA	Concerta	Dexamfetamine (Noumed)	Vyvanse
Cautions (for the full list of cautions, see the NZF or New Zealand data sheets):	Psychostimulant medicines may precipitate or worsen: ■ Anxiety or agitation ■ Epilepsy ■ Mild hypertension (or other cardiovascular conditions that may be compromised by increases in blood pressure or heart rate) ■ Psychiatric disorders, e.g. bipolar disorder, or aggressive behaviour ■ Tics – an association between psychostimulant medicine and development of tics was previously established but evidence now suggests this effect is no greater than placebo (or tic-specific treatments).[44] The development of tics may be related to the emotions surrounding initiating treatment and the fluctuating nature of tics (caution is also recommended if the patient has a family history of Tourette syndrome). Caution is also recommended when prescribing psychostimulants to patients with: ■ Past history of disordered eating or difficulty maintaining weight ■ Past history of substance or alcohol dependence or misuse (including in family and caregivers)									
Key interactions (for the full list of interactions, see the NZF or New Zealand data sheets):	■ Monoamine oxidase inhibitors, e.g. tranylcypromine, moclobemide – Concurrent use can lead to hypertensive crisis – do not use within 14 days ■ Tricyclic antidepressants – Concurrent use may increase plasma concentrations of tricyclic antidepressants and increase the risk of adverse effects, e.g. cardiovascular effects ■ Selective serotonin reuptake inhibitors (SSRIs) and serotonin and noradrenaline reuptake inhibitors (SNRIs) – Concurrent use may increase the risk of serotonin syndrome ■ Medicines that influence blood pressure – Blood pressure control may be affected in patients taking antihypertensives, e.g. amlodipine, losartan, quinapril – Increased risk of hypertension with concurrent use of pseudoephedrine, phentermine								■ Opioids, e.g. codeine, tramadol – May increase analgesic effect ■ Antipsychotics, e.g. chlorpromazine – May reduce the effect of amfetamines	
Key adverse effects (for the full list of adverse effects, see the NZF or New Zealand data sheets):	Common: ■ Insomnia ■ Nausea and stomach discomfort, reduced appetite ■ Sweating ■ Hypertension, tachycardia and palpitations ■ Anxiety, agitation, depressed mood, dysphoria, headache, irritability, tics – establishing baseline symptoms before initiating treatment is critical to distinguish adverse effects of psychostimulant treatment Rare: ■ Hepatic dysfunction ■ Angina, myocardial infarction, supraventricular tachycardia ■ Psychosis ■ Cerebrovascular disorders, e.g. vasculitis, haemorrhage, cerebral arteritis, and vascular occlusion ■ Tourette syndrome (in pre disposed individuals) ■ Seizures ■ Angle-closure glaucoma									
Starting dose:	5 mg, two to three times daily	5 mg, two to three times daily	20 mg, once daily in the morning	18 – 36 mg, once daily in the morning	18 – 36 mg, once daily in the morning	20 mg, once daily in the morning	20 mg, once daily in the morning	18 – 36 mg, once daily in the morning	2.5 mg, two to three times daily	20 – 30 mg, once daily in the morning
Suggested titration based on response:	Increase dose by 5 mg, weekly	Increase dose by 5 mg, weekly	Increase dose by 20 mg, weekly	Increase dose by 18 mg, weekly	Increase dose by 18 mg, weekly	Increase dose by 20 mg, weekly (in adults)	Increase dose by 20 mg, weekly (in adults)	Increase dose by 18 mg, weekly	Increase dose by 5 mg, weekly	Increase dose by 10 – 20 mg, at a minimum of weekly intervals

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Medicine	Methylphenidate								Dexamfetamine	Lisdexamfetamine
	Ritalin	Rubifen	Rubifen SR	Methylphenidate ER - Teva	Methylphenidate Sandoz XR	Rubifen LA	Ritalin LA	Concerta	Dexamfetamine (Noumed)	Vyvanse
Maximum dose: Discussion with, or referral to, a psychiatrist recommended if higher doses are being considered	60 mg, divided over two to three doses, daily	60 mg, divided over two to three doses, daily	60 mg, once, daily	72 mg, once daily	72 mg, once daily	80 mg, once daily	80 mg, once daily	72 mg, once daily	20 mg, divided over two to three doses, daily, however, doses of 30 mg per day are commonly used (up to 40 mg/day required in some children)	70 mg, daily
Excipients with known effects or derived from **animal sources**:	Gelatine, gluten, lactose	None	Lactose	Lactose	Lactose	Gelatine	Gelatine	Lactose	Lactose	Gelatine
Comments:	Can be taken with or without food	Can be taken with or without food	Should be taken with food – onset of action is faster when taken with a high-fat meal Fewer fluctuations in plasma concentrations compared to multiple doses of immediate release methylphenidate	Can be taken with or without food	Can be taken with or without food	Can be taken with or without food Capsules can be opened, and beads can be sprinkled on **cold** food if required for administration	Can be taken with or without food Capsules can be opened, and beads can be sprinkled on **cold** food if required for administration	Can be taken with or without food	Can be taken with or without food	Capsules can be opened and contents dissolved in water or juice, or mixed through food if required for administration

* 60 mg Ritalin LA capsules are also available but not funded

† 20 mg, 40 mg and 60 mg lisdexamfetamine capsules are also available but not funded

‡ Rubifen LA is a generic of Ritalin LA and assumed to have the same onset and duration of action as the innovator

Best Practice Tip: Caution is recommended when switching between brands of methylphenidate and close monitoring and more frequent follow-up is advised. Generic medicines have demonstrated comparable bioavailability to innovator medicines and are considered bioequivalent by Medsafe.[25] However, some patients may experience differences in effect when switching between innovator and generic medicines due to the medicine's therapeutic index, variation in pharmacokinetics or patient populations, or patient factors, e.g. the nocebo effect.[25] Clinicians with experience in prescribing these medicines have observed that differences in effect can occur when switching between formulations of methylphenidate, which is also noted in the New Zealand Formulary.[30]

Table 3. Example initial dosing regimens for funded psychostimulant medicines in an adult patient in a primary care setting. N.B. This table is intended as a guide and starting doses are conservative; prescribers with more experience titrating psychostimulant medicines may be more confident starting at higher doses or increasing doses more quickly (see prescriber notes). The optimal dose varies substantially between individuals, and the titration process may take months in some cases.

Prescriber notes:

- Effective titration and follow-up when initiating psychostimulant medicines is critical and may influence long-term efficacy and treatment adherence
- Treatment effects are usually evident very early after a dose change, i.e. the day of the dose increase, however, a delay of up to one week before increasing to the next dose is suggested to ensure response is not related to other life changes occurring at the same time
- Depending on clinician confidence, shorter periods between dose increases may be appropriate, e.g. many psychiatrists favour increasing the dose every three to four days (if well tolerated) or starting at higher doses (a total daily dose of 10 – 20 mg immediate-release methylphenidate in a healthy adult with no cautions or contraindications)
- Phone consultations can be useful for follow-up during dose titration, but an in-person clinical review should occur within two to four weeks of starting treatment
- The optimal dose of a psychostimulant medicine reduces core ADHD symptoms and improves functional outcomes with minimal adverse effects. Ideally this is the lowest effective dose and with regular review, is generally apparent within eight weeks.
- Avoid increasing the dose when target symptoms are responding well and adverse effects are not present or mild, i.e. stopping dose titration after two or three weeks if an acceptable dose has been reached
- A reduction in symptom control with dose increase indicates the dose may be too high and warrants a dose decrease

Week	Morning	Midday
Immediate-release methylphenidate, e.g. Rubifen, Ritalin		
1	5 mg	5 mg
2	10 mg	5 mg
3	15 mg	5 mg
4	20 mg	5 mg
5	25 mg	5 mg
Maximum daily dose	60 mg (in two to three doses)	
Modified-release methylphenidate (up to eight hours duration of action), e.g. Rubifen SR, Ritalin LA *(or Rubifen LA: proposed to be funded)*		
1	20 mg	–
2	40 mg	–
3	60 mg	–
Maximum daily dose	80 mg, daily (60 mg for Rubifen SR)	
Modified-release methylphenidate (up to 12 hours duration of action), e.g. Concerta, Methylphenidate ER - Teva, Methylphenidate Sandoz XR		
1	18 mg	–
2	36 mg	–
3	54 mg	–
Maximum daily dose	72 mg, once daily	
Dexamfetamine (a single dose of dexamfetamine in the morning may provide sufficient effect for some people as the duration of action can be up to six hours)		
1	5 mg	–
2	5 mg	5 mg
3	10 mg	5 mg
4	10 mg	10 mg
Maximum daily dose	20 mg (in divided doses), however, doses up to 30 mg/day are commonly used in clinical practice	
Lisdexamfetamine*		
1	30 mg	–
2	50 mg	–
3	70 mg	–
Maximum daily dose	70 mg, once daily	
If adverse effects develop, advise patient to return to the previous dose where symptoms were controlled and adverse effects were not present. Continue at this dose until the next in-person follow-up.		

* 20 mg, 40 mg and 60 mg capsules are available (but not funded) and can be used for a more gradual titration in patients who experience adverse effects and are able to meet the cost of self-funding

B-QuiCK provides short clinical summaries from some of the full articles available on our website. Relevant sections from these resources have been condensed into "notepad pages" or algorithms designed to offer rapid access to practical clinical advice and knowledge. It is strongly recommended to review the original resource at your convenience for full details of recommendations and evidence. See full article here: bpac.org.nz/2026/adhd.aspx

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