CONNECTICUT MEDICAL ASSISTANCE PROGRAM
DEPARTMENT OF SOCIAL SERVICES
&
HEALTH INFORMATION DESIGNS, INC.

Schedule Change for Carisoprodol

Effective January 11, 2012, carisoprodol (Soma®) was changed to a Schedule IV controlled substance in all states under the federal Controlled Substances Act (CSA). The U.S. Drug Enforcement Agency (DEA) enforces the CSA. The CSA, along with state laws, dictates the details of the manufacturing, prescribing, and dispensing of controlled substances.

The CSA assigns five different schedules of controlled substances. The drug's abuse potential, history of abuse and current pattern of abuse, significance of abuse, and whether the substance is a precursor of another substance that is already scheduled are considered when determining the schedule of a drug.

Schedule I controlled substances have a high potential for abuse, lack data on safe use in humans, and have no currently accepted medical use in the United States. Schedules II through V are commonly prescribed and dispensed drugs and have an accepted medical use in the United States. Schedule II drugs have the highest potential for psychological dependence or addiction and abuse. Schedule V drugs have the lowest potential for abuse and addiction.

Examples of Schedule I drugs include heroin and marijuana. Examples of Schedule II drugs are oxycodone, fentanyl, methylphenidate and methadone. Hydrocodone, codeine and buprenorphine are Schedule III drugs. Benzodiazepines are Schedule IV. Schedule V drugs have smaller quantities of narcotics such as cough preparations with codeine.

Carisoprodol abuse has increased in the last decade. Carisoprodol is FDA approved for the relief of discomfort associated with acute, painful musculoskeletal conditions. Carisoprodol metabolizes to meprobamate, a Schedule IV controlled substance. The FDA calculated that carisoprodol is being abused at a rate similar to diazepam which is a Schedule IV benzodiazepine.

The FDA found that patients who are abusing carisoprodol are typically abusing opioids, benzodiazepines, cocaine, and marijuana.

In 2009, the National Survey on Drug Use and Health (NSDUH) data suggested that more than 100,000 12 to 17 year olds reported using carisoprodol for non-medical reasons and that almost one million 18-25 year olds reported using carisoprodol for non-medical reasons.

The DEA reports that carisoprodol is one of the most commonly diverted drugs. Doctor shopping and prescription forgery are very common diversion methods for carisoprodol. As of March 2011, street prices for carisoprodol ranged from $1 to $5 per tablet.

AAP Updates ADHD Guidelines

The American Academy of Pediatrics (AAP) recently updated guidelines to help In the diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD) in children and adolescents. The AAP first published clinical recommendations for the diagnosis and evaluation of ADHD in children in 2000. Recommendations for treatment followed in 2001.

After a thorough literature review evaluating new evidence, the new guidelines were developed to replace the previous guidelines and recommendations published in 2000 and 2001. The previous guidelines addressed diagnosis and treatment for children 6 through 12 years of age. The new guidelines expand the age range and include children 4 through 18 years of age.

Recommendations for evaluation and diagnosis:

- The primary care clinician should evaluate any child 4 through 18 years of age

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who displays academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.

- The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria must be met to make a diagnosis of ADHD. Information should primarily be obtained from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care.
- The primary care clinician should assess the child for other conditions that may coexist with ADHD, including emotional or behavioral, developmental, and physical conditions.
- The primary care clinician should recognize ADHD as a chronic condition and consider children with ADHD as having special healthcare needs. These children should be managed according to the principles of the chronic care model and the medical home.

Recommendations for treatment:

- For children ages 4 to 5 years, first-line treatment should be evidence-based parent- or teacher-administered behavior therapy. If behavioral interventions do not provide significant improvement, methylphenidate may be prescribed.
- For children ages 6 to 11 years, the primary care clinician should prescribe FDA-approved ADHD medications and/or evidence-based parent- and/or teacher administered behavior therapy. The evidence is particularly strong for stimulant medications. Evidence is sufficient, but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine.
- For adolescents ages 12 to 18 years, the primary care clinician should prescribe FDA-approved ADHD medications with the agreement of the adolescent and may also prescribe behavior therapy. It is preferred that the clinician prescribe both.
- Doses of the ADHD medication should be titrated to achieve maximum benefit with minimum adverse effects.

References
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