Drug Utilization Review (DUR) Newsletter

COLORADO
Department of Health Care Policy & Financing

Select HCPF Medication Use Policy Updates

SUMMER 2025

Table of Contents

Prescription Stimulant Use Disorder: Practical Considerations for the Clinician

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Overview

Prescription stimulants (amphetamine-type stimulants and methylphenidate), are controlled medications most commonly used to treat attention-deficit/hyperactivity disorder (ADHD). Over the past decade, stimulant prescriptions have increased by between 40-58% in the United States, particularly among adults aged 31 to 40 years and 71 to 80 years, as well as among women.[1] This surge has been associated with an increase in ADHD diagnoses among adults, which may be driven by increased awareness of the diagnosis, improved diagnostic tools, and wide availability of low-cost therapeutic options. Nonetheless, in 2025, prescription stimulant misuse remains a significant public health concern in the United States, especially among adults aged 18 to 64.

With the increase in prescription stimulants within the community, concerns have emerged, including the lack of clinical practice guidelines for adult ADHD, adult ADHD misdiagnosis, overdiagnosis, overprescribing, psychosis associated with high-dose prescription amphetamines, prescription stimulant misuse or diversion, and prescription stimulant use disorder (PSUD).[2-10] Long-term stimulant use, particularly at high doses, can cause significant damage to the brain and body, including cardiovascular problems (such as heart failure, hypertension and arrythmias); dangerous increases in core body temperature; seizures; mental health issues like paranoia and psychosis; and potentially long-lasting cognitive deficits. Furthermore, withdrawal from stimulants can be severe, including symptoms like depression, anxiety, fatigue, and intense cravings, which can persist for weeks. However, on the flip side, research also demonstrates protective effects of appropriate ADHD pharmacotherapy on mood disorder, suicidality, substance use disorders, criminality, accidents or injuries, and mortality.[2,3] Balancing risks and benefits remains a clinical challenge, especially those within primary care who may have limited resources and time.

dextroamphetamine molecule

Prescription stimulant use disorder (PSUD)

PSUD is defined as prescription stimulant use leading to clinically significant impairment or distress as measured by DSM-5 criteria (Table 1, page 2) and is associated with cocaine, methamphetamine, opioid, and other substance use, substance abuse disorders, overdoses, and premature mortality.[11-17] Importantly, if people have trouble accessing prescription stimulants, they may seek them illicitly through the dark web or on the black market. Counterfeit pills may contain unexpected substances (such as fentanyl), increasing overdose risk.[17] Using 2019-2022 IQVIA Total Patient Tracker, National Prescription Audit New to Brand databases, the 2021-2022 National Surveys on Drug Use and Health, Han et al found that among 83,762 prescription stimulant users (18-64 years) 25.3% reported misuse, and 9.0% had PSUD. Among those with PSUD, 72.9% solely used their own prescribed stimulants, 87.1% used amphetamines, 42.5% reported no misuse, and 63.6% had mild PSUD. The prevalence of misuse was 3.1 times higher and the prevalence of PSUD

Prescription Stimulant Use Disorder, continued from Page 1

was 2.2 times higher among those using prescription amphetamines than among those using methylphenidate.[18]

What can be done to prevent a potential stimulant abuse/misuse epidemic at the practitioner level? First, clinicians need to identify the potential for PSUD before prescribing a stimulant. Unfortunately, there are currently no known screening tools or assessments specifically for identifying prescription stimulant misuse outside of the DSM-V criteria for stimulant use disorder.

Table 1. Diagnostic and Statistical Manual of Mental Disorders (5th Edition) for Stimulant Use Disorder.[11]

STIMULANT USE DISORDER
A pattern of amphetamine-type substance, cocaine, or other stimulant use for **at least 1 year** leading to clinically significant impairment or distress, as **manifested by at least two of the following:** ☐ The stimulant is often taken in larger amounts or over a longer period than was intended. ☐ There is a persistent desire or unsuccessful efforts to cut down or control stimulant use. ☐ A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects. ☐ Craving or a strong desire or urge to use the stimulant. ☐ Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home. ☐ Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant. ☐ Important social, occupational, or recreational activities are given up or reduced because of stimulant use. ☐ Recurrent stimulant use in situations in which it is physically hazardous. ☐ Stimulant use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the stimulant. **Tolerance** is defined by either of the following: • A need for markedly increased amounts of the stimulant to achieve intoxication • The desired effect or a markedly diminished effect with continued use of the same amount of the stimulant. The **characteristic withdrawal syndrome** for the stimulant or the stimulant (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.[a]
MILD stimulant use disorder **2 or 3** of the above criteria
MODERATE stimulant use disorder **4 or 5** of the above criteria
SEVERE stimulant use disorder **6** or more of the above criteria

[a] Withdrawal signs and symptoms: cannabis= insomnia, anorexia, anxiety, irritability, restlessness, dysphoria, nightmares, nausea, or physical pain and discomfort when using less than usual (may persist for weeks or months in attenuated form for long-time users); opiates= gastrointestinal distress (e.g., abdominal cramps, diarrhea, nausea, and/or vomiting); flu-like symptoms (e.g., lacrimation, rhinorrhea, diaphoresis, shivering, and piloerection (goosebumps); sympathetic nerve and central nervous system arousal (e.g., mydriasis, mild hypertension, and tachycardia, anxiety and irritability, insomnia, agitation, restless leg syndrome, general restlessness, tremor, and, less frequently, low-grade temperature and tactile sensitivity); and other (e.g., yawning, sneezing, anorexia, dizziness, myalgias/arthralgias, and leg cramps; stimulant, specifically methamphetamines: acute (first 24 hours): dehydration, insomnia, nausea, headaches, irritability, sweating, mood swings; subacute (2 weeks-months): anxiety, paranoia, depression, cravings, increased eating and sleeping.

Prescription Stimulant Use Disorder, continued from Page 2

In their advisory, the Substance Abuse and Mental Health Services Administration includes prescription stimulant misuse as: using medication without a prescription of one's own, even if with therapeutic intent; using medication in greater amounts, more often, or longer than prescribed; using medication in any way other than directed by a prescriber (e.g., non-medical use); or using medication for recreational purposes or without therapeutic intent.[19] Additionally, a variety of general substance use, as well as, physical and behavioral health screeners and assessments are available for youth/adolescents and young adults/adults (Table 2, page 4).

Several psychological risk factors have also been found to be predictive of prescription stimulant misuse, including history of sexual abuse; social isolation or antisocial behavior; family conflicts; residing in neighborhoods where substance use is accepted; lack of peer connections; and symptoms of inattention, depression, anxiety , stress, internal impulsivity, and internal restlessness.[19] One meta-analysis found ADHD symptoms were significantly associated with prescription stimulant misuse.[20] Further, Van Eck et al. found disinhibition and conduct problems symptoms moderated the association between ADHD symptoms and misuse of prescription stimulants among college students.[21]

Second, prescribers of stimulant medications can make modifications to their current practices that may reduce diversion. These actions include: carefully considering the use, type, and formulation of stimulant medication for patients; limiting the frequency of prescription refills; obtaining signed agreements from patients and/or guardians; providing education and instructions on the proper use, administration, and storage of medication; providing counseling on the consequences of misuse and diversion; and carefully monitoring patients receiving stimulant medication using their state's prescription drug monitoring program (PDMP)—an electronic database that tracks certain prescription medications, including stimulants, and can help identify those who may be diverting or misusing their medications.

Prescribers of stimulant medications may also benefit from education and training in patient education and counseling, diversion prevention strategies, and effective medication monitoring to reduce the diversion of prescription stimulants. Educating all youth and young adults about the consequences of prescription stimulant misuse and dispelling myths may help deter this behavior.

> Prescribers of stimulant medications
> can make modifications to their current practices that may reduce diversion

Similarly, youth and young adults (and their guardians, as applicable) who are prescribed stimulant medication should be educated on the use, administration, and storage of medication, as well as alternative or supplementary therapies (e.g., behavioral approaches to help manage ADHD). Youth and young adults with ADHD and/or those receiving prescription stimulants should be regularly screened for substance use disorder and/or behavioral health concerns by providers to help prevent the misuse of these medications.[19]

Finally, prescribers and other providers who care for youth and young adults with ADHD should consider practice changes to help prevent the misuse of prescription stimulants. These actions may include: confirm an ADHD diagnosis before prescribing stimulant medications; carefully consider medication, dose, and formulation (e.g., prescribing longer-acting formulations with lower abuse potential); provide detailed counseling and education to youth and young adults (and their guardians, as applicable) who are prescribed prescription stimulants; closely monitor all patients who receive prescription stimulant medications and regularly check those patients' histories in the state's PDMP; and screen all patients who have a diagnosis of ADHD and/or receive prescription stimulant medication for substance use disorders and other behavioral health conditions.[19]

Table 2. Substance Use and Physical and Behavioral Health Screeners and Assessments for Identifying Prescription Stimulant Misuse in Youth and Young Adults.

Screener/Assessment	Website
Adolescent Screeners	
Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)	https://nida.nih.gov/bstad/#/
Global Appraisal of Individual Needs-Short Screener (GAIN-22)	https://www.assessments.com/assessments_documentation/gain_ss/GAIN-SS%20Manual.pdf
Patient Health Questionnaire for Adolescents (PHQ-A)	https://www.childrenshospital.org/sites/default/files/2022-03/PHQ%20Form.pdf
Screening to Brief Intervention (S2B1)	https://nida.nih.gov/s2bi/#/
Adolescent Assessments	
CRAFTT	https://crafft.org/use-the-crafft/
Drug Abuse Screen Test (DAST-20: Adolescent version)	https://odh.ohio.gov/wps/wcm/connect/gov/db243c91-5fcc-4b6e-b421-2ff8d64b30b7/Substance+Abuse+Screen+%28DAST-20%29.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-db243c91-5fcc-4b6e-b421-2ff8d64b30b7-n5rNH7M
Adult Screeners	
Global Appraisal of Individual Needs-Short Screener (GAIN-SS)	https://portal.ct.gov/dcf/gain/gain-ss?language=en_US
NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)	https://nida.nih.gov/sites/default/files/pdf/nmassist.pdf
Patient Health Questionnaire (PHQ-9)	https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf
Tobacco, Alcohol, Prescription Medication, and other Substance Use (TAPS)	https://nida.nih.gov/taps2/#/
Adult Assessments	
Drug Abuse Screen Test (DASH-10)	https://gwep.usc.edu/wp-content/uploads/2019/11/DAST-10-drug-abuse-screening-test.pdf
NIDA Drug Use Screening Tool: Quick Screen (NMASSIST)	https://nida.nih.gov/sites/default/files/pdf/nmassist.pdf
Tobacco, Alcohol, Prescription Medication, and other Substance Use (TAPS)	https://nida.nih.gov/taps2/#/

Future Health First Colorado DUR Board Meetings

(all open sessions begin at 1:00 pm Mountain Time)

TENTATIVE DATES

November 4, 2025
February 10, 2026
May 5, 2026
August 11, 2026
November 10, 2026

For more information, visit https://hcpf.colorado.gov/drug-utilization-review-board

Announcement Column

Pharmacy Office updates

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New DUR Board Member

The Health First Colorado DUR Board welcomed Dr. Stephanie Cho as a new pharmacist member during its May 2025 meeting.

Dr. Cho is a residency-trained, board certified pharmacotherapy specialist with extensive experience in clinical pharmacy practice. Her background spans both primary care and dermatology, bringing a rich blend of experience and expertise to the Board.

The January 1, 2025
Colorado Preferred Drug List (PDL)
is available at
https://www.colorado.gov/hcpf/pharmacy-resources

Buprenorphine maximum daily dose allowance increased

Effective February 28, 2025, the maximum dose allowance for buprenorphine/naloxone sublingual film and buprenorphine sublingual tablets was increased from 24 mg buprenorphine/day to 32 mg/day.

Pharmacies submitting prescription claims for Health First Colorado members will receive payment, with no prior authorization requirement, for doses of up to 32 mg buprenorphine per day.

DUR Spotlight

by Diane Lee
PharmD Candidate
DUR Intern

Gina Moore, PharmD, MBA

Dr. Gina Moore is an integral member of the DUR team. Both Dr. Moore and Dr. Robert Page are original members of the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences Colorado Evidence-based DUR group and have worked closely with the Board and HCPF for over eleven years.

As Senior Associate Dean for Operations and Regulatory Affairs at the University of Colorado SSPPS, her leadership is recognized at the local and national level.

In 2024, Dr. Moore was named president of the American Society for Pharmacy Law. As a past-president of the Colorado Pharmacists Society, she continues to be involved as legislative chair and faculty advisor, facilitating the annual Day at the Capitol event in downtown Denver.

Originally from the San Francisco Bay area, Dr. Moore received her PharmD from the University of the Pacific. While her path initially took her to industry, a residency in nutrition support brought her to the University of Colorado where she also completed her MBA. When asked what factors might have shaped her career trajectory, she shares that her passions for pharmacy, business, and advocacy remained constant, guiding her professional pursuits.

Looking ahead, Dr. Moore expects that new drugs entering the market will grow increasingly complex (and costly). Current pharmacy benefit managers (PBMs) and reimbursement models pose a major challenge for pharmacists and their practice, especially in rural and other critical settings.

Pharmacy, however, is an ever-changing landscape and with the help of appropriate regulation, Dr. Moore hopes that the profession can support evolving healthcare needs.

Dr. Moore loves all the warm sunshine and vibrant outdoors that Colorado has to offer. In her free time, you may find her playing golf, cooking, or traveling.
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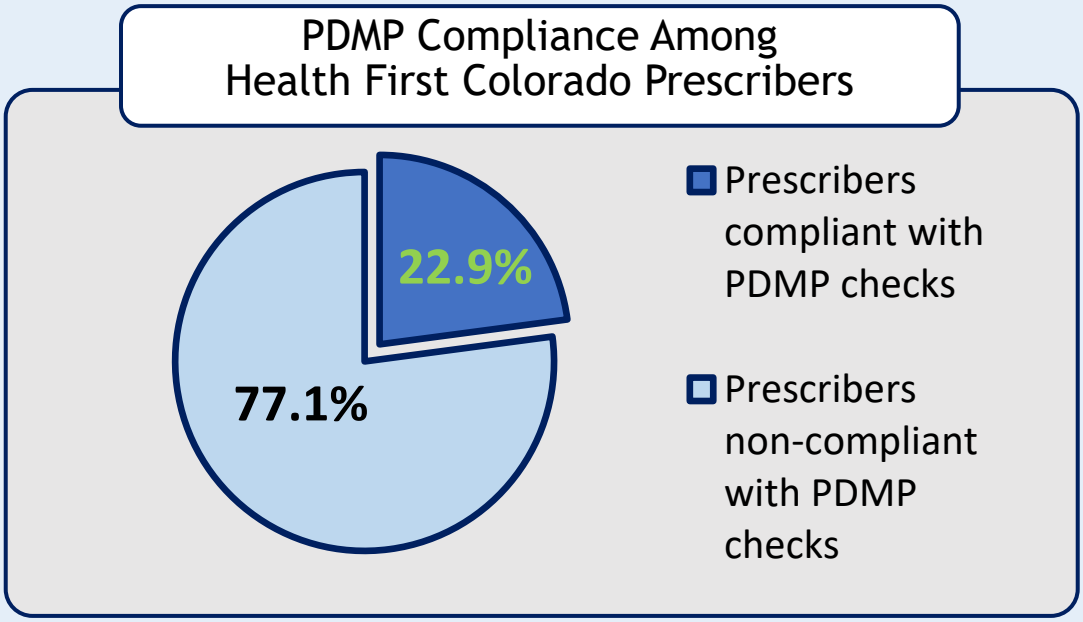
Check the PDMP before you prescribe controlled substances!

As of October 1, 2021, Medicaid providers permitted to prescribe controlled substances must query the Colorado Prescription Drug Monitoring Program (PDMP) database before prescribing controlled substances to Medicaid members. This is in accordance with Section 5042 of the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act." Checking the PDMP is required. This practice enhances safe medication use, identifies therapeutic duplications, and reduces the risk of overlapping drug therapies.

Although the checking the PDMP is legally required for most cases of controlled substance prescribing, the requirement DOES NOT APPLY when a member:

- Is receiving the controlled substance in a hospital, skilled nursing facility, residential facility, or correctional facility
- Has been diagnosed with cancer and is experiencing cancer-related pain
- Is undergoing palliative care or hospice care
- Is experiencing post-surgical pain that, because of the nature of the procedure, is expected to last more than 14 days
- Is receiving treatment during a natural disaster or during an incident where mass casualties have taken place
- Has received only a single dose to relieve pain for a single test or procedure

In the case that a provider is not able to check the PDMP before prescribing a controlled substance, despite a good faith effort, the State shall require the provider to document the effort, including the reasons why the provider was not able to conduct the check. Upon request, the State may require the provider to submit documentation such documentation.



This figure shows the average PDMP compliance rate per provider for Federal Fiscal Year 2024 (October 1, 2023—September 30, 2024) based on the proportion of dispensations (including cash pay transactions) that were preceded by a PDMP search.

Therapeutic Class Review Schedule

Q1 February DUR (January P&T) *Effective 4/1*

Non-Opioid Analgesics, Oral & Topical

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Oral/Non-Oral

Opioids, Short-Acting

Opioids, Long-Acting

Fentanyl Preparations

Buprenorphine, Injectable

Anticonvulsants, Oral

Newer Generation Antidepressants

Monoamine Oxidase Inhibitors (MAOIs)

Tricyclic Antidepressants (TCAs)

Anti-Parkinson's Agents
- Dopa decarboxylase inhibitors, dopamine precursors, Combos, MAO-B Inhibitors, Dopamine Agonists, Other Parkinson's Agents

Benzodiazepines (non-sedative hypnotic)

Anxiolytics, non-Benzodiazepine

Atypical Antipsychotics
- Oral And Long-acting Injectable

Lithium Agents

Neurocognitive Disorder Agents

Sedative Hypnotics, Non-Benzodiazepines

Sedative Hypnotics, Benzodiazepines

Movement Disorder Agents

Skeletal Muscle Relaxants

Stimulants and Related Agents

Triptans, Ditans, and Other Migraine Agents
- Oral and Non-Oral

Calcitonin Gene-Related Peptide Inhibitors (CGRPis)

Multiple Sclerosis Agents
- Disease Modifying Therapies, Symptom Management Therapies, Dopamine Agonists

Ophthalmic, Allergy

Ophthalmics, Immunomodulators

Ophthalmics, Anti-Inflammatory
- NSAIDs and Corticosteroids

Ophthalmics, Glaucoma Agents
- Beta Blockers, Carbonic Anhydrase Inhibitors, Prostaglandin Analogues, Alpha-2 adrenergic agonists, Other ophthalmic, glaucoma and combinations

Q2 May DUR (April P&T) *Effective 7/1*

Cardiovascular Agents
- Alpha Blockers
- Beta Blockers & Combinations
- Beta Blockers, Antiarrhythmic
- Calcium Channel Blockers & Combinations
- Calcium Channel Blockers, Dihydropyridine (DHPs)
- Calcium Channel Blockers, Non-Dihydropyridine

Angiotensin modulators and combinations
- ACEIs, ACEI Combinations, ARBs, ARB Combinations
- Renin Inhibitors & Combinations

Pulmonary Arterial Hypertension (PAH) Therapies
- Phosphodiesterase Inhibitors, Endothelin Antagonists, Prostacyclin Analogues and Receptor Agonists, Guanylate Cyclase (sGC) Stimulators

Lipotropics
- Bile Acid Sequestrants, Fibrates, Other Liptropics

Statins & Statin Combinations

Movement Disorder Agents

Acne Agents, Topical

Acne Agents, Oral Isotretinoins

Antipsoriatics, Oral and Topical

Immunomodulators, Topical
- Atopic Dermatitis and Antineoplastic Agents

Tetracyclines

Rosacea Agents

Topical Steroids
- Low Potency, Medium Potency, High Potency
- Very High Potency

Bile Salts

Antiemetics, Oral and Non-Oral

GI Motility, Chronic

***H. pylori* Treatments**

Hemorrhoidal and Related Anorectal Agents

Pancreatic Enzymes

Proton Pump Inhibitors (PPIs)

Non-Biologic Ulcerative Colitis Agents
- Oral and Rectal

Anticoagulants
- Oral and Parenteral

Antiplatelet Agents

Colony Stimulating Factors

Erythropoiesis Stimulating Agents (ESAs)

Q3 August DUR (July P&T) *Effective 10/1*	**Q4 November DUR** (October P&T) *Effective 1/1*
Bone Resorption Suppression and Related Agents Bisphosphonates Non-Bisphosphonates **Androgenic Agents – Topical, Injectable, Oral** **Estrogen Agents** Injectable Oral/Transdermal **Contraceptives,** Topical **Diabetes Management Classes, Insulins** Rapid-Acting, Short-Acting, Intermediate-Acting, Long-Acting, Concentrated, Mixtures **Diabetes Management Classes, Non-Insulin** Amylin Biguanides DPP-4is & Combinations GLP-1 Analogues Meglitinides & Combinations TZDs & Combinations Other Hypoglycemic Combinations SGLT-2is & Combinations **Glucagon, Self-Administered** **Overactive Bladder Agents** **Phosphate Binders** **Benign Prostatic Hypertrophy (BPH) Agents** **Antihyperuricemic Agents**	**Antibiotics, Inhaled** **Anti-herpetic Agents,** Oral and Topical **Fluoroquinolones, Oral** **Hepatitis C Virus Treatments** Direct-Acting Antivirals (DAAs), Ribavirin Products **HIV Treatments, Oral** **Immune Globulins** **Newer Generation Antihistamines** **Antihistamine/Decongestant Combinations** **Intranasal Rhinitis Agents** **Leukotriene Modifiers** **Methotrexate Products** **Targeted Immune Modulators (TIMs)** Rheumatoid Arthritis, all other Arthritis (*except psoriatic arthritis and Ankylosing Spondylitis)*, Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease and Ulcerative Colitis, Asthma, Atopic Dermatitis, Other indications **Epinephrine Products** **Newer Hereditary Angioedema (HAE) Agents** **Respiratory Agents** Inhaled Anticholinergics & Combinations, Short-Acting & Long-Acting Beta-Agonists, Inhaled Corticosteroids & Combinations, Phosphodiesterase Inhibitors (PDEIs)

Retrospective Drug Utilization Review (RDUR) Educational Interventions

To help ensure safe and effective therapy, patient-specific letters based on retrospective analyses are prepared and mailed to Health First Colorado prescribers on a quarterly basis

Current educational interventions

- Adults with claims for 2 or more benzodiazepines covering at least 90 out of 180 days
- Members less than 18 years of age with claims for 3 or more psychotropic medications (antidepressant, mood stabilizer, anxiolytic, stimulant, antipsychotic) for at least 30 days/quarter
- Adults with concomitant claims for an opioid plus a benzodiazepine plus a muscle relaxant
- Members with one or more claims for clonazepam 2 mg oral or orally disintegrating tablets for at least 30 days/quarter *(Excluded: members with diagnoses of epilepsy/recurrent seizures, convulsions, or recurring panic disorder)*
- Members with claim(s) for triazolam tablets covering at least 30 days during the quarter

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Images

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