A novel approach in pediatric ADHD (ages 6-17)...

The only NCE approved for the treatment of ADHD in over a decade!¹,²

Less chaos...

More control¹,³

Supernus proudly supports the 2022 APSARD Annual Meeting.

INDICATION
Qelbree is indicated for the treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in pediatric patients ages 6 to 17.

IMPORTANT SAFETY INFORMATION

WARNING: SUICIDAL THOUGHTS AND BEHAVIORS
In clinical studies, higher rates of suicidal thoughts and behaviors were reported in pediatric patients with ADHD treated with Qelbree than in patients treated with placebo. Closely monitor all Qelbree-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors.

CONTRAINDICATIONS
- Concomitant administration of a monoamine oxidase inhibitor (MAOI), or dosing within 14 days after discontinuing an MAOI, because of an increased risk of hypertensive crisis
- Concomitant administration of sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range

WARNING & PRECAUTION
- Suicidal Thoughts and Behaviors: Closely monitor all Qelbree-treated patients for clinical worsening and emergence of suicidal thoughts and behaviors, especially during the initial few months of drug therapy, and at times of dosage changes

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; APSARD, American Professional Society of ADHD and Related Disorders; NCE, new chemical entity


Please see the brief summary of full Prescribing Information, including Boxed Warning, on adjacent pages, or visit QelbreeHCP.com.
Qelbree™ (vilazodone extended-release capsules), for oral use

BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION

For full prescribing information see package insert.

**WARNING: SUICIDAL THOUGHTS AND BEHAVIORS**

In clinical studies, higher rates of suicidal thoughts and behavior were reported in pediatric patients with ADHD treated with Qelbree than in patients treated with placebo. Closely monitor all Qelbree-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors.

**CONTRAINDICATIONS**

Qelbree is contraindicated in patients receiving concomitant treatment with monoamine oxidase inhibitors (MAOIs), or within 14 days following discontinuation of an MAOI, because of an increased risk of hypertensive crisis.

Qelbree should not be taken when receiving concomitant administration of serotonergic CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range.

**WARNINGS AND PRECAUTIONS**

**Suicidal Thoughts and Behaviors (See Above)**

Among 1019 patients exposed to Qelbree 100 mg to 400 mg in short-term trials, a total of nine patients (0.9%) reported suicidal ideation (N=6), behavior (N=1) or both (N=2). Eight patients reported suicidal ideation or behavior on the C-OBA SuicideSeverity Rating Scale (C-SSRS), a validated scale that assesses suicide risk. An additional patient treated with Qelbree reported suicidal behavior during the clinical trials, but did not report it on the C-SSRS. Among 463 patients treated with placebo in these studies, two patients (0.4%) reported suicidal ideation on the C-SSRS. No patients treated with placebo reported suicidal behavior.

**Effects on Blood Pressure and Heart Rate**

Qelbree can cause an increase in heart rate and diastolic blood pressure. In a clinical study in patients 6 to 11 years of age, 54/154 (22%) of patients treated with Qelbree 100 mg daily had a 20 mg/mm Hg or larger increase in heart rate at any time point in the clinical trial, compared to 6/154 (4%) of patients who received placebo. This finding was observed in 64/631 (10%) who received the 200 mg dose, compared to 39/262 (15%) of patients in the placebo group, and in 28/103 (27%) of patients who received the 400 mg dose, compared to 24/103 (23%) of patients who received placebo.

In a clinical study in patients 12 to 17 years of age, 22/99 (22%) of patients treated with Qelbree 100 mg daily had a >20 bpm increase in heart rate at any time point in the clinical trial, compared to 15/99 (15%) of patients who received placebo. This finding was observed in 68/626 (11%) who received the 200 mg dose, compared to 32/626 (5%) who received the 400 mg dose, compared to 35/291 (12%) of patients in the placebo group. In patients aged 12 to 17 years, 52/205 (25%) of patients treated with Qelbree 100 mg daily had a >15 mm Hg increase in diastolic blood pressure at any time in the clinical trial, compared to 24/205 (12%) of patients in the placebo group. Assess heart rate and blood pressure prior to initiating treatment with Qelbree, following increases in dosage, and periodically while on therapy.

**Activation of Mania or Hypomania**

Nonamphetamine drugs, such as Qelbree, may induce a mania or mixed episode in patients with bipolar disorder. Prior to initiating treatment with Qelbree, closely monitor any manic or mixed episodes of mania or hypomania in patients.

**Somnolence and Fatigue**

Somnolence can cause insomnia and fatigue. In the short-term, placebo-controlled clinical trials in pediatric patients with ADHD, somnolence (including drowsiness and sedation) was reported in 14% of Qelbree-treated patients compared to 8% of placebo-treated patients. Fatigue was reported in 8% of Qelbree-treated patients compared to 5% of placebo-treated patients.

**ADVERSE REACTIONS**

**Clinical Trials Experience**

The safety of Qelbree was evaluated in 1119 patients 6 to 17 years of age with ADHD exposed to one or more doses in short-term (6 to 8 weeks), randomized, double-blind, placebo-controlled trials. A total of 662 pediatric patients were treated for at least 6 months, and 347 pediatric patients for at least 12 months with Qelbree.

The data described below reflect exposure to Qelbree in 356 patients who participated in randomized, double-blind, placebo-controlled trials with doses ranging from 100 mg to 400 mg. The population (N=356) was 65% male, 35% female, 54% White, 45% Black, 4% multis, and 1% other races.

**Adverse Reactions Leading to Discontinuation of Qelbree Treatment**

Approximately 3% of the 356 patients receiving Qelbree in clinical studies discontinued treatment due to an adverse reaction. The adverse reactions most commonly associated with discontinuation of Qelbree were somnolence, nausea, headache, irritability, back pain, fatigue, and decreased appetite.

**Most Common Adverse Reactions (occurring at 5% or at least twice the placebo rate for any dose) are: somnolence, decreased appetite, fatigue, nausea, vomiting, insomnia, and irritability.**

Listed here are adverse reactions that occurred in at least 2% of patients treated with Qelbree, and in 1% or more of placebo-treated patients. Data represents pooled data from pediatric patients aged 6 to 17 years who were enrolled in randomized, placebo-controlled trials of Qelbree in the placebo-treated patients. Data represents pooled data from pediatric patients aged 6 to 17 years who were enrolled in randomized, placebo-controlled trials of Qelbree.

**Adverse Reactions Occurring in 2% or More of Pediatric Patients**


*The following terms were combined: Somnolence, somnolence, lethargy, sedation, Headache, headache, migraine, migraines with aura, tension headaches. Upper respiratory tract infection: Rhinopharyngitis, pharyngitis, sinusitis, upper respiratory tract infection, Upper respiratory tract infection, Abdominal pain: abdominal discomfort, abdominal pain, abdominal pain lower, abdominal pain upper, Insomnia: initial insomnia, insomnia, middle insomnia, poor quality sleep, sleep disorder, terminal insomnia.

**Effects on Weight**

In short-term, controlled studies (6 to 8 weeks), Qelbree-treated patients 6 to 11 years of age gained an average of 0.2 kg, compared to a gain of 0.1 kg in same-aged patients who received placebo. Qelbree-treated patients 12 to 17 years of age lost an average of 0.2 kg, compared to a weight gain of 0.5 kg in same-aged patients who received placebo. In a long-term, open-label extension safety trial, 1097 patients received at least 1 dose of Qelbree. Among the 353 patients evaluated at 12 months, the mean change from baseline in weight was 2.5 kg in Qelbree patients and 1.2 kg in placebo patients. In the absence of a control group, it is unclear whether the weight change observed in the long-term open-label extension was attributable to the effect of Qelbree.

**DRUG INTERACTIONS**

Drugs Having Clinically Important Interactions with Qelbree

**Monoamine Oxidase Inhibitors (MAOIs)**

Clinical Impact: Concomitant use of Qelbree with an MAOI may lead to a potentially life-threatening hypertensive crisis.

**Intervention:** Concomitant Use of Qelbree with an MAOI or within 2 weeks after discontinuing an MAOI is contraindicated.

**Examples:** Selegiline, isocarboxazid, p-chlorophenylalanine, tranylcypromine, benzphetamine, rasagiline

**Sensitive CYP1A2 Substrates or CYP1A2 Substrates with a Narrow Therapeutic Range**

Clinical Impact: Vilazodone is a strong CYP1A2 inhibitor. Concomitant use of vilazodone significantly increases the total exposure, but not peak exposure, of sensitive CYP1A2 substrates, which may increase the risk of adverse reactions associated with these CYP1A2 substrates.

**Intervention:** Coadministration with vilazodone is contraindicated.

**Examples:** Acselon, dextasone, ramelteon, tamsulosin, trazadone

**Moderate Sensitive CYP1A2 Substrates**

Clinical Impact: Vilazodone is a strong CYP1A2 inhibitor. Concomitant use of vilazodone significantly increases the total exposure, but not peak exposure, of sensitive CYP1A2, which may increase the risk of adverse reactions associated with these CYP1A2 substrates.

**Intervention:** Not recommended for coadministration with vilazodone. Dose reduction may be warranted if coadministration.
Drugs Having Clinically Important Interactions with Ceplene®

**Mildly Sensitive CYP1A2/Substrate**

- *Examples: Clozapine, perphenazine*

**CYP2D6 Substrates**

- **Clinical Impact:** Vloxezone is a weak inhibitor of CYP2D6, and increases the exposure of CYP2D6 substrates when coadministered.
- **Intervention:** Monitor patients for adverse reactions and adjust dosages of CYP2D6 substrates, as clinically indicated.

- *Examples:Atomoxetine, desmopramine, domperidone, nortryptiline, metoprolol, nebivolol, perphenazine, tolterodine, verapamil, and trazodone*

**CYP3A4 Substrates**

- **Clinical Impact:** Vloxezone is a weak inhibitor of CYP3A4, which increases the exposure of CYP3A4 substrates when coadministered.
- **Intervention:** Monitor patients for adverse reactions and adjust dosages of CYP3A4 substrates, as clinically indicated.

- *Examples: Alenil, amlodipine, buspirone, conivaptan, delafloxacin, deruvase, eszopiclone, etizolam, famotidine, felbamate, flucainide, lidocaine, nimodipine, nisoldipine, omeprazole, ranolazine, selinexor, simvastatin, stavudine, tiopronin, trazodone, verapamil, and voriconazole*

**USE IN SPECIFIC POPULATIONS**

**Pregnancy**

**Pregnancy Exposure Registry**

Report pregnancies to the National Pregnancy Registry for Psychiatric Medications at 1-888-967-2385, and at the website [www.momensmentalhealth.org/registry](http://www.momensmentalhealth.org/registry).

**Risk Summary**

Based on findings from animal reproduction studies, vloxezone may cause maternal harm and harm to the developing embryofetus during pregnancy. Discontinue Ceplene® when pregnancy is recognized unless the benefits of therapy outweigh the potential risk to the mother. Available data from case series with vloxezone use in pregnant women are insufficient to determine if a drug-associated risk of major birth defects, miscarriages or adverse maternal outcomes.

In animal reproduction studies, oral administration of vloxezone to pregnant rats and rabbits during the period of organogenesis did not cause significant maternal toxicity but caused fetal toxicity and delayed fetal development in the rat at doses up to 2 times the maximum recommended human dose (MRHD) of 400 mg/day, based on mg/m². In the rabbit, vloxezone caused maternal toxicity without significant fetal toxicity at doses ≥ 7 times the MRHD based on mg/m². The no-observed-adverse-effect levels (NOAELs) for fetal toxicity are approximately equal to or less than the MRHD, based on mg/m² in the rat and rabbit, respectively. Oral administration of vloxezone to pregnant rats and mice during pregnancy and lactation caused maternal toxicity and death at doses approximately 2 and 1 times the MRHD, based on mg/m², respectively (see Data). At these maternal toxicity doses, vloxezone caused offspring toxicity. The NOAEL for maternal and developmental toxicity is approximately equal to or less than the MRHD, based on mg/m².

**Data**

**Animal Data**

Vloxezone was administered orally to pregnant rats during the period of organogenesis at doses of 13, 33, and 82 mg/kg/day, which are less than, equal to, and 2 times the MRHD of 400 mg/day, based on mg/m², respectively. Vloxezone did not cause maternal toxicity at doses up to 82 mg/kg/day. Vloxezone at 82 mg/kg/day increased early and late resorptions, delayed fetal development, and possibly caused low incidences of fetal malformations or anomalies (cardiac holes, missing cranial vaults, and morphological changes associated with hypoplastic tubules in the kidney). The NOAEL for fetal toxicity is approximately equal to or less than the MRHD, based on mg/m², respectively (see Data).

Vloxezone was administered orally to pregnant rabbits during the period of organogenesis at doses of 43, 97, and 130 mg/kg/day, which are approximately 4, 7, and 11 times the MRHD of 400 mg/day, based on mg/m², respectively. Vloxezone decreased maternal body weight, weight gain, or food consumption at doses ≥ 87 mg/kg/day but did not cause fetal toxicity at doses up to 130 mg/kg/day. The NOAELs for maternal and fetal toxicity is 43 and 130 mg/kg/day, respectively, which are approximately 4 and 11 times the MRHD, based on mg/m².

Vloxezone was administered orally to pregnant rats during the period of organogenesis at doses of 43, 97, and 130 mg/kg/day, which are approximately 4, 7, and 11 times the MRHD of 400 mg/day, based on mg/m², respectively. Vloxezone decreased maternal body weight, weight gain, or food consumption at doses ≥ 87 mg/kg/day, and caused fetal toxicity at doses of 97 mg/kg/day and greater (based on mg/m²). The NOAEL for maternal toxicity is 43 mg/kg/day and 87 mg/kg/day at which is approximately 2 and 5 times the MRHD, respectively. Vloxezone caused maternal toxicity, decreased body weight, weight gain, and food consumption at doses ≥ 87 mg/kg/day and maternal deaths near term at 217 mg/kg/day. At these maternal toxicity doses, vloxezone caused decreased body weight, increased maternal deaths, and maternal deaths near term at 217 mg/kg/day. At these maternal deaths and decreased body weight in the offspring. The NOAEL for both maternal and developmental toxicity is 33 mg/kg/day, which is less than the MRHD, based on mg/m².

**Lactation**

**Risk Summary**

There are no data on the presence of vloxezone in human milk, the effects on the breastfed infant, or the effects on milk production. Vloxezone is likely present in rat milk. When a drug is present in animal milk, it is likely that the drug will be present in human milk.

The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for Ceplene® and any potential adverse effects on the breastfed child from Ceplene® or from the underlying maternal condition.

**Pediatric Use**

The safety and effectiveness of Ceplene® in pediatric patients ages 6 to 17 years of age with ADHD have been established based on randomized, placebo-controlled studies in pediatric patients.

The safety and effectiveness of Ceplene® have not been established in pediatric patients younger than 6 years old.

Patients treated with Ceplene® should be monitored for suicidal thoughts and behavior, and for changes in weight.

**Juvenile Animal Toxicity Data**

Vloxezone was administered orally to juvenile rats from postnatal day (PND) 23 through PND 70 at doses of 43, 130, and 217 mg/kg/day, which are approximately 1.2, and 3 times the MRHD of 400 mg/day, based on mg/m² in children, respectively. Vloxezone decreased body weight, weight gain, and food consumption in both sexes at 217 mg/kg/day. Sexual maturation, reproductive capacity, and learning and memory were not affected. The NOAEL for juvenile toxicity is 130 mg/kg/day, which is approximately 2 times the MRHD, based on mg/m² in children.

**Geriatric Use**

Clinical trials of Ceplene® in the treatment of ADHD did not include sufficient numbers of patients aged 65 and older to determine whether they respond differently from younger patients.

**Renal Impairment**

**Dosage Reduction**

Dosage reduction is recommended in patients with severe (eGFR < 30 mL/min/1.73 m²) [MDRD] renal impairment.

No dosage adjustment of Ceplene® is recommended in patients with mild to moderate (eGFR 30 to 60 mL/min/1.73 m²) [MDRD] renal impairment.

The exposure of vloxezone increases in patients with renal impairment.

**Hepatic Impairment**

The effect of hepatic impairment on the pharmacokinetics of vloxezone is unknown. Ceplene® is not recommended in patients with hepatic impairment.

**OVERDOSAGE**

**Human Experience**

The pre-marketed clinical trials with Ceplene® do not provide information regarding symptoms of overdose.

Literature reports from post-marketing experience with immediate-release vloxezone include cases of overdose from 1000 mg to 6500 mg (2.5 to 16.25 times the maximum recommended daily dose). The most reported symptom was dizziness. Impaired consciousness, diminished reflexes, and increased heart rates have also been reported.

**Treatment and Management**

There is no specific antidote for Ceplene® overdose. Administer symptomatic and supportive treatment as appropriate. In case of overdose, consult a Certified Poison Control Center (1-800-222-1222 or www.poisong.org).

**NON-CLINICAL TOXICOLGY**

**Carcinogenesis, Mutagenesis, and Impairment of Fertility Carcinogenesis**

Vloxezone did not increase the incidence of tumors in rats treated for 2 years at oral doses of 22, 43, and 82 mg/kg/day. The high dose of 57 mg/kg/day is approximately equal to the MRHD of 400 mg/day, based on mg/m² in children.

Vloxezone did not increase the incidence of tumors in Tg(24Rl) mice treated for 26 weeks at oral doses of 43, 13, and 43 mg/kg/day.

**Mutagenesis**

Vloxezone was not genotoxic in a battery of genotoxicity tests. It was not mutagenic in the in vitro bacterial reverse mutation (Ames) assay or clastogenic in the in vitro mammalian chromosomal aberration assay or in the in vivo rat bone marrow micronucleus assay.

**Impairment of Fertility**

Vloxezone was only administered to male and female rats prior to and throughout mating and continued until completion of the second litter at doses of 13, 33, and 82 mg/kg/day, which are less than, equal to, and 2 times the MRHD, based on mg/m², respectively. Vloxezone did not affect male or female fertility parameters in the rat. The NOAEL for male and female fertility is 82 mg/kg/day, which is approximately 2 times the MRHD, based on mg/m².

**Animal Toxicology and/or Pharmacology**

In animal studies, Ceplene® treatment caused dose-dependent concomitant increases at oral doses of ≥ 130, ≥ 173, and ≥ 39 mg/kg/day in the rat, mouse, and dog, respectively, which are approximately equal to or slightly higher than the MRHD of 400 mg/day, based on mg/m² in children.

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APSARD would not be successful without the hard work of our board members. We are grateful for their time, dedication and passion for better the field of ADHD and related disorders.

To our departing board members, thank you for your commitment to APSARD, we look forward to growing your legacy.

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Not a member? Join APSARD Today!

APSARD is thrilled to introduce Special Interest Groups (SIGs) as a new member benefit! Special Interest Groups help establish better relationships, enable networking, and information exchange. Through the leadership of our dedicated SIG Co-Chairs, members with shared interests will have the opportunity to meet and discuss ideas, trends, issues, and thoughts. We hope that all of our members will find at least one of our inaugural SIGs to participate in!

You can learn more about each SIG Group on our website HERE. Our inaugural SIGs are:

- College Students & ADHD
- ADHD & Substance Use Disorders
- Pediatrics-Psychiatry Interface
- Women & Girls with ADHD
- Technology & ADHD

For additional information please email the Executive Office at info@apsard.org
We are grateful for the generous support of our sponsors and exhibitors! Their support has made a quick transition to a virtual conference possible.

Visit the exhibitors in the virtual conference hall by clicking the "Exhibit Hall" icon on the left hand navigation bar.
Discover a novel approach to pediatric ADHD symptom coverage

Join us for a discussion on this novel, once-daily prodrug that helps provide ADHD symptom coverage throughout the day

Innovation in ADHD Symptom Coverage
Saturday, January 15, 2022 | 2:45 PM-3:45 PM EST

Andrew J. Cutler, MD  
Chief Medical Officer  
Neuroscience Education Institute  
Clinical Associate Professor of Psychiatry  
SUNY Upstate Medical University  
Syracuse, New York

Theresa Cerulli, MD  
Clinical Instructor  
Beth Israel Deaconess Medical Center  
Medical Director  
Cerulli and Associates  
Boston, Massachusetts

Visit the Corium booth to learn more

ADHD, attention deficit hyperactivity disorder.
Congrats!

2022 TRIS RESEARCH AWARD WINNERS

You can view the Tris Research Award winners’ posters in the e-poster gallery. Be sure and leave notes of congratulations in the discussion forum.

Comparative Analysis of the Efficacy of Two Kappa Opioid Receptor Antagonists in a Preclinical Model of Autism Spectrum Disorder
Deidre McCarthy

ADHD-Related Sex Difference in Delay Discounting and Cognitive Control in Childhood Predict Adolescent Substance Use and Self-Harm
Keri Rosch

Risk-Taking and Depression-Like Behaviors Following Repetitive Mold Traumatic Brain Injury in an ADHD Model
Pradeep Bhide
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AGENDA
12:00 PM - 12:05 PM
Welcome Remarks
– Greg Mattingly, MD, Chair (Washington University)

12:05 PM - 12:25 PM
Adult ADHD: Are We Missing It in Practice?
– Maggie Sibley, PHD (University of Washington)

12:25 PM - 12:45 PM
Mechanism of Action of Treatments for Adult ADHD
– Vladimir Maletic, MD (University of South Carolina)

12:45 PM - 1:05 PM
Innovations in Management of Adult ADHD
– Greg Mattingly, MD (Washington University)

1:05 PM - 1:25 PM
Question and Answer Session

1:25 PM - 1:30 PM
Closing Remarks
– Greg Mattingly, MD, Chair (Washington University)

For more information on this session, please visit: apsard.societyconference.com

This symposium is supported by an independent educational grant from Supernus Pharmaceuticals.
Join our special guest speaker at APSARD 2022 for a discussion on

**All-Day ADHD Management Without the Need for an Immediate-Release Component or Augmentation**

Andrew J. Cutler, MD
Neuroscience Education Institute
SUNY Upstate Medical University

**SATURDAY, JANUARY 16**
**2:30 PM - 3:30 PM EASTERN**

Sponsored by Ironshore Pharmaceuticals Inc., makers of

![Jornay PM Logo](image)

**INDICATION**
JORNAY PM is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 6 years and older.

**IMPORTANT SAFETY INFORMATION**

**WARNING: ABUSE AND DEPENDENCE**
CNS stimulants, including JORNAY PM, other methylphenidate-containing products, and amphetamines, have a high potential for abuse and dependence. Assess the risk of abuse prior to prescribing and monitor for signs of abuse and dependence while on therapy.

Please click here for **Full Prescribing Information, including Boxed Warning.**