Medical use and combination drug therapy among US adult users of central nervous system stimulants: a cross-sectional analysis

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ABSTRACT

Objective Examine patterns of adult medical use of amphetamine and methylphenidate stimulant drugs, classified in the USA as Schedule II controlled substances with a high potential for psychological or physical dependence.

Design Cross-sectional study.

Setting and participants Prescription drug claims for US adults, age 19–64 years, included in a commercial insurance claims database with 9.1 million continuously enrolled adults from 1 October 2019, through 31 December 2020. Stimulant use was defined as adults filling one or more stimulant prescriptions during calendar 2020.

Outcome measures The primary outcome was an outpatient prescription claim, service date and days’ supply for central nervous system (CNS)-active drugs. Combination-2 was defined as 60 days or more of combination treatment with a Schedule II stimulant and one or more additional CNS-active drugs. Combination-3 therapy was defined as the addition of 2 or more additional CNS-active drugs. Using service date and days’ supply, we examined the number of stimulant and other CNS-active drugs for each of the 366 days of 2020.

Results Among 9 141 877 continuously enrolled adults, the study identified 276 223 individuals (3.0%) using Schedule II stimulants during 2020. They filled a median of 8 (IQR, 4–11) prescriptions for these stimulant drugs that provided 227 (IQR, 110–322) treatment days of exposure. Among this group, 125 781 (45.5%) combined use of one or more additional CNS active drugs for a median of 213 (IQR, 126–301) treatment days. Also, 66 996 (24.3%) stimulant users used two or more additional CNS-active drugs for a median of 182 (IQR, 108–276) days. Among stimulants users, 131 485 (47.6%) were exposed to an antidepressant, 85 166 (30.8%) filled prescriptions for anxiety/sedative/hypnotic medications and 54 035 (19.6%) received opioid prescriptions.

Conclusion A large proportion of adults using Schedule II stimulants are simultaneously exposed to one or more other CNS-active drugs, many with tolerance, withdrawal effects or potential for non-medical use. There are no approved indications and limited clinical trial testing of these multi-drug combinations, and discontinuation may be challenging.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study of adult use of amphetamine and methylphenidate stimulants uses a large commercial claims database with 20 million covered individuals designed for research use into US medical care issues.

⇒ The study population for the primary outcome was large (n=276 223) and contained extensive detail on each central nervous system-active prescription, including drug, drug class, strength and days’ supply, permitting evaluation of exposure for each day of 2020.

⇒ The commercially insured population assessed in this study may not represent all commercially insured adults and omits those insured in state Medicaid programmes, through other government programmes, the uninsured and adults over age 64 years.

⇒ Although the MarketScan data set includes up to four diagnosis codes for each outpatient and emergency department encounter, the diagnoses cannot be directly linked to specific prescription drug claims and were not evaluated.

INTRODUCTION

Amphetamines and the chemically related methylphenidate are central nervous system (CNS) stimulants in medical use for 85 years.1 Their complex mechanisms of action have not been completely elucidated in 137 years since they were first synthesised,2 but many stimulant effects are primarily the result of increased release of dopamine and norepinephrine. Their effects have led to multiple medical indications over the many decades, including nasal congestion, narcolepsy, appetite suppression, binge eating, depression, senile behaviour, lethargy and attention deficit hyperactivity disorder (ADHD). In the USA, risks of addiction and non-medical use have led to amphetamines and methylphenidate being classified (along with opioids and barbiturates) as Schedule II controlled substances.3
Over the years, many amphetamine and methylphenidate drug products have been created and marketed with various combinations, salts, esters and optical isomers. In July 2022, The US Food and Drug Administration (FDA) Orange Book listed 272 approved drug products with amphetamine ingredients and 303 approved products with methylphenidate. These product totals also reflect various strengths, dosage forms and formulations.

Medical use of the CNS stimulants amphetamine and methylphenidate has been reported to be increasing among adults in observational studies. Using the US Medical Expenditure Survey Panel, a representative sample of all US households, we previously reported a 79% increase from 2013 to 2018 in the number of adults self-reporting prescriptions for these Schedule II stimulants. A Centers for Disease Control study using the National Prescription Audit reported increased dispensing rates from 2014 to 2019 ‘driven by notable increases in adults over age 20’. A 2022 study in the electronic health records of 70 million patients in 52 healthcare organisations reported stimulant prescriptions increased by 250% from 2006 to 2016, with these substances increasingly dispensed to older individuals.

Amphetamines are also frequently reported in overdose toxicity, recreational or other non-medical use. In a Kentucky state report of fatal drug overdose toxicity in 2021, amphetamine products were ranked fourth among substances found in postmortem toxicology testing, behind fentanyl, 4-ANPP (fentanyl precursor) and illicit methamphetamine. In the Kentucky reports, amphetamine as a listed substance in overdose death toxicology increased from 20.2% of cases in 2017 to 42.0% in 2021. The 2020 National Survey of Drug Use and Health estimated that 1.5% (SE 0.12%) of adults 26 or older (3.2 million) reported misuse of medical stimulants, including both Schedule II and non-scheduled stimulant drugs.

In this study, we used a large commercial claims database with 20 million covered individuals to investigate the extent of medical use of these high-risk stimulants among adults and analyse combination therapy with other psychiatric drugs.

**METHODS**

**Data source**

The data for this study were extracted from the MarketScan 2019 and 2020 Commercial Claims and Encounters Databases. The study population was defined as adults aged 19–64 years who were continuously enrolled in an included commercial benefit plan from 1 October 2019 through 31 December 2020. Also required was a valid enrolment ID and a non-missing gender as reflected in the Annual Enrolment Summary and the Enrolment Detail tables.

**Identification of valid cases**

From the study population, we identified valid cases as any continuously enrolled adult filling at least one prescription for a Schedule II stimulant drug during calendar 2020 as reflected in the Outpatient Pharmaceutical Claims table. For inclusion, the claims record had to include a valid National Drug Code, a service date in 2020, and a non-missing value for the days’ supply. Valid claim records indicated a therapeutic class of stimulants (71) and a Drug Enforcement Administration (DEA) class 2. Cocaine is an FDA-approved Schedule II stimulant but not indicated for outpatient treatment, and no cases appeared in the claims data.

**Assessment of drug exposure**

We defined exposure as starting on the prescription service date and extending without interruption through the days’ supply. To include exposure that occurred in 2020 but began with a prescription filled in 2019, we included any prescription claim filled in 2019 that included days’ supply extending into 2020. Days’ exposure was censored on 31 December 2020, even if the days’ supply extended into 2021. For the stimulant medications, we counted as 1 day of exposure even if more than one stimulant prescription was in effect on that day.

Drug class and other drug-specific details were extracted from the Micromedex RED BOOK, which we linked to the Commercial Claims database through National Drug Codes. CNS-active drug classes were defined as antidepressants, anxiolytics/sedatives/hypnotics, antipsychotics, opioids, anti-convulsants and other CNS-active drugs. Opioids that were not Schedule II were classified separately. We excluded non-steroidal anti-inflammatory drugs and non-opioid pain medications that are active within and outside of the CNS but are listed in the RED BOOK grouping of CNS-active drug products. Exposure to included CNS-active drugs was assessed in the same procedure as for the Schedule II stimulants except that we counted all CNS-active prescriptions that were in effect on any study day.

**Stimulant exposure**

We evaluated patterns of stimulant use with day-by-day exposure during calendar 2020. Treatment days were the sum of every day in 2020 with one or more stimulant prescriptions in effect, including prescriptions that were initiated in 2019 but still had days of supply extending into 2020. Prescription starts in 2020 were defined as any prescription claim filled in 2019 that included days’ supply extending into 2020, and a non-missing value for the days’ supply. To include exposure that occurred in 2020 but began with a prescription filled in 2019, we included any prescription claim filled in 2019 that included days’ supply extending into 2020. Days’ exposure was censored on 31 December 2020, even if the days’ supply extended into 2021. For the stimulant medications, we counted as 1 day of exposure even if more than one stimulant prescription was in effect on that day.

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**Combination treatment assessment**

The Combination-2 outcome variable was defined as 60 days or more of exposure to both stimulants and one or more additional CNS-active drugs. The robustness of this definition was evaluated through calculating the

number of treatment days in 2020 in which the Combination-2 definition applied. Combination-3 was defined similarly, except it required two or more additional CNS-active drugs’ exposure for 60 days or longer. We also evaluated specific drug combinations of stimulants and other classes of CNS-active drugs but included any use of the other classes during 2020.

Statistical analysis
We calculated full population descriptive statistics for the MarketScan dataset without the need to estimate sampling variation, confidence intervals or other measures of statistical uncertainty. We used SAS V.9.4 (SAS Institute) for Linux and conducted the analysis from January to August 2022.

Public and patient involvement
None.

RESULTS
The study population was 9 141 877 US commercially insured adults age 19–64 years with continuous coverage for outpatient drug claims from 1 October 2019 through 21 December 2020. Figure 1 shows the selection of the study population among the MarketScan commercially insured adult population with coverage for all or part of 2020. Among this group, 276 223 adults (3.0%) filled at least one prescription claim for a Schedule II stimulant. Demographic characteristics of the stimulant vs non-stimulant adult population are shown in table 1. The population skewed towards the younger age groups with a prevalence of 4.6% in the age 19–34 years group.

<table>
<thead>
<tr>
<th>Schedule II stimulant</th>
<th>Not exposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured adults, no (%)</td>
<td>276 223 (3.0)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>119 271 (2.7)</td>
</tr>
<tr>
<td>Female</td>
<td>156 952 (3.3)</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
</tr>
<tr>
<td>19–34</td>
<td>128 257 (4.6)</td>
</tr>
<tr>
<td>35–44</td>
<td>66 387 (3.4)</td>
</tr>
<tr>
<td>45–54</td>
<td>51 658 (2.4)</td>
</tr>
<tr>
<td>55–64</td>
<td>29 921 (1.4)</td>
</tr>
<tr>
<td>Prescription claims, median (IQR)</td>
<td></td>
</tr>
<tr>
<td>Total prescriptions</td>
<td>21 (12–36)</td>
</tr>
<tr>
<td>CNS prescriptions</td>
<td>12 (7–21)</td>
</tr>
</tbody>
</table>

Source: MarketScan Research Databases, 2019–2020, commercially insured adults, age 19–64 years. Schedule II stimulants include amphetamine and methylphenidate drug products.

CNS, central nervous system.
Combined use of stimulants with other CNS-active drugs was more common among females, 82 556 (52.6%) compared with males, 43 225 (36.2%). As shown in figure 2, combined use increased by age group, with 34.7% of those age 19–34 years rising to 63.2% among those age 55–64 years.

**Specific drug combinations**

Among the adults, 47.6% were also taking antidepressants for one or more days during the study year, 30.8% were taking an anxiolytic/sedative/hypnotic and 15.5% were also exposed to Schedule II opioids. The utilisation of non-stimulant CNS-active drugs is shown by drug class in table 5. The top 20 specific non-stimulant drugs are shown in online supplemental table 1 and reinforce the by-class analysis showing antidepressants and anxiolytics/sedatives/hypnotic drugs as the most frequently administered combinations.

**DISCUSSION**

Using a large commercial claims database, we found a 3% prevalence of adults age 19–64 years who were exposed to Schedule II stimulants for a median of 227 days (IQR, 110–322) during 2020. Among these 276 223 individuals, 45.5% had 60 days or more of stimulant use combined with one or more additional CNS-active drugs, including 24.3% taking two or more additional CNS-active drugs. Approximately one-half (47.6%) of stimulant users were also taking an antidepressant during the year, while nearly one-third (30.8%) were also taking anxiolytics/sedatives/hypnotics. The stimulant-exposed patient population utilised a median of 15 (IQR, 9–26) prescriptions for drugs active in the CNS.

Utilisation of these Schedule II stimulants may have been restrained by the US DEA and state-level restrictions on the drugs with high potential for physiological or psychological dependence. This includes licensing of providers, a ban on refills without a direct or telemedicine encounter,
monitoring of provider prescribing and controls to prevent diversion from dispensing pharmacies. These findings add new public health concerns to those raised by our previous study reporting a 79% increase in stimulant use in adults over a 5-year period. This more detailed profile of how these stimulants are being utilised reveals several new patterns. First, once treatment started, most patients become long-term users—75% of patients continued throughout the 1-year period. This underscores the possible risks of non-medical use and dependence that have warranted the classification of these drugs as having a high potential for psychological or physical dependence and their prominent appearance in toxicology drug rankings of fatal overdose cases. Second, these data reveal an additional medical use for amphetamine and methylphenidate products beyond their primary approved use as monotherapy for adult ADHD. Nearly half the exposed population was being prescribed

### Table 4 Combination therapy in 2020 among Schedule II stimulant users

<table>
<thead>
<tr>
<th></th>
<th>Combination-2*</th>
<th>Combination-3†</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>All users</td>
<td>125 781 (45.5)</td>
<td>150 442 (54.5)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>43 225 (36.2)</td>
<td>76 046 (63.8)</td>
</tr>
<tr>
<td>Female</td>
<td>82 556 (52.6)</td>
<td>74 396 (47.4)</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19–34</td>
<td>44 549 (34.7)</td>
<td>83 708 (65.3)</td>
</tr>
<tr>
<td>35–44</td>
<td>32 608 (49.1)</td>
<td>33 779 (50.9)</td>
</tr>
<tr>
<td>45–54</td>
<td>29 708 (57.5)</td>
<td>21 950 (42.5)</td>
</tr>
<tr>
<td>55–64</td>
<td>18 916 (63.2)</td>
<td>11 005 (36.8)</td>
</tr>
<tr>
<td>Exposure pattern, median (IQR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stimulant treatment days</td>
<td>271 (179–335)</td>
<td>173 (60–300)</td>
</tr>
<tr>
<td>Combination therapy days</td>
<td>213 (126–301)</td>
<td>0 (0–5)</td>
</tr>
<tr>
<td>Non-stimulant CNS prescriptions</td>
<td>11 (6–20)</td>
<td>0 (0–1)</td>
</tr>
</tbody>
</table>

Source: MarketScan Research Databases, 2019–2020, commercially insured adults, age 19–64 years. Schedule II stimulants include amphetamine and methylphenidate drug products.
* ≥60 days’ use of stimulant+at least one other CNS-active drug.
† ≥60 days’ use of stimulant+at least two other CNS-active drugs.
CNS, central nervous system.
these drugs in combination therapy with one or more other psychiatric drugs, including 24.3% in combination therapy with two or more additional psychiatric drugs. Third, these combination therapy results identify patients who may be getting stimulants or other psychiatric drugs as part of a prescribing cascade. For example, 9.5% of the population getting a potent stimulant of the CNS were also taking alprazolam, an anxiolytic/sedative/hypnotic drug. These data do not indicate which intervention may have come first—a stimulant added to compensate for excess sedation from the benzodiazepine or the alprazolam added to calm excessive CNS stimulation and/or insomnia from the stimulants or other drugs. Since, in addition, alprazolam itself has a boxed warning for ‘abuse, misuse, and addiction,’ as well as dependence, and withdrawal reactions, 14 this complicates any discontinuation of either or both drugs. In addition, 15.5% of stimulant patients were also taking DEA Schedule II opioids.

### Limitations

While this study relies on a population of 9.1 million adults, this commercially insured population may not represent all commercially insured adults, and it omits those insured in state Medicaid programmes, through other government programmes, the uninsured and adults over age 64 years. This study also assumed that the entire days’ supply was taken as prescribed. However, the median of 227 days of treatment and timely renewals suggests that for these stimulants, non-adherence was relatively uncommon. Although the MarketScan data set includes up to four diagnosis codes for each outpatient and emergency department encounter, the diagnoses cannot be directly linked to specific prescription drug claims and were not evaluated. Since many providers will not accept a drug claim for a Schedule II stimulant without an on-label diagnosis of ADHD, we suspected that large numbers of this diagnosis were present.

### Conclusion

This real-world-evidence profile of amphetamine and methylphenidate use in a large adult population reveals new patterns of utilisation beyond the approved use as monotherapy for adult ADHD. Nearly half were prescribed one or more additional psychiatric drugs. Little scientific evidence is available to assess the risks and benefits of combination therapy with multiple psychiatric drugs. In addition, many combination therapy drugs had their own elevated risks of psychological or physical dependence or non-medical use. Discontinuation of two or more drugs with different withdrawal effects may be challenging.

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### Contributions

All the coauthors contributed to the study concept and design and to critical revision of the manuscript for important intellectual content. All coauthors have approved the final manuscript. TJM drafted the manuscript and is the guarantor. PWW and TJM provided the statistical analysis. The corresponding author attests that all listed authors meet the authorship criteria and that no others meeting the criteria have been omitted.

### Funding

The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

### Competing interests

GCA is past chair and a current member of FDA’s Peripheral and Central Nervous System Advisory Committee; is a co-founding principal and equity holder in Monument Analytics, a healthcare consultancy whose clients include the life sciences industry as well as plaintiffs in opioid litigation, for whom he has served as a paid expert witness; and is a past member of OptumRx’s National P&T Committee. These arrangements have been reviewed and approved by Johns Hopkins University in accordance with its conflict of interest policies. The other authors declare no competing interests.

### Patient and public involvement

Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

### Patent consent for publication

Not applicable.

### Ethics approval

Not applicable.

### Provenance and peer review

Not commissioned; externally peer reviewed.

### Data availability statement

No data are available. Data for this study were extracted from the MarketScan 2019 and 2020 Commercial Claims and Encounters Databases which were accessed under license and not publicly available.

### Supplemental material

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**Table 5** Other CNS-active drugs by drug class among those exposed to Schedule II stimulants in 2020

<table>
<thead>
<tr>
<th>Drug class†</th>
<th>Prescriptions</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (%)</td>
<td>No (%)</td>
</tr>
<tr>
<td>Anticonvulsant</td>
<td>225 592 (10.3)</td>
<td>38 112 (13.8)</td>
</tr>
<tr>
<td>Antidepressant</td>
<td>987 582 (45.1)</td>
<td>131 485 (47.6)</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>143 611 (6.6)</td>
<td>22 650 (8.2)</td>
</tr>
<tr>
<td>Anxiolytic/sedative/hypnotic</td>
<td>540 619 (24.7)</td>
<td>85 166 (30.8)</td>
</tr>
<tr>
<td>CNS other</td>
<td>75 613 (3.5)</td>
<td>14 558 (5.3)</td>
</tr>
<tr>
<td>Opioids other</td>
<td>48 257 (2.2)</td>
<td>11 322 (4.1)</td>
</tr>
<tr>
<td>Opioids Schedule II</td>
<td>149 368 (6.8)</td>
<td>42 713 (15.5)</td>
</tr>
<tr>
<td>Stimulant other</td>
<td>19 705 (0.9)</td>
<td>4 368 (1.6)</td>
</tr>
</tbody>
</table>

Source: MarketScan Research Databases, 2019–2020, commercially insured adults, age 19–64 years. Schedule II stimulants include amphetamine and methylphenidate drug products.

*Per cent totals by person do not add to 100 due to patients taking multiple medications.

†Drug classes defined in Micromedex RED BOOK for 2020. CNS, central nervous system.
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**REFERENCES**