Medication 101

ANTIDEPRESSANTS

MEDICATION (commercial)	Dosages (mg) Steps / Min eff. / Max			Pearls / highlights
SSRI				
Citalopram (Celexa)	5	20	40	
Escitalopram (Cipralex)	5-10	10	20	If private insurance, better than Citalopram
Sertraline (Zoloft)	25	50	200	Good for anxiety and broad range of dosage
Fluoxetine (Prozac)	10-20	20	80	Long half-life
Luvoxamine (Luvox)	50	100	300	
Paroxetine (Paxil)	20 (25 CR)	20	50 (65 CR)	Anticholinergic, sexual side effets
SNRI				
Venlafaxine (Effexor)	37,5	75	225	Energy, concentration. For hot flashes if hormotx contraindicated Significant discontinuation. Above 200 mg for NA effect.
Desvenlafaxine (Pristiq)	50	50	100	Easier dosage than Venlafaxine if private insurance
Duloxetine (Cymbalta)	30	60	60 BID	Approved for fibromyalgia. Now covered by RAMQ
Milnacipran (Ixel)	12,5	50 BID	100 BID	
Levomilnacipran (Fetzima)	20	40	120	
Noradrenaline and dopamine recapture inhibitor				
Buproprion (Wellbutrin)	150 100 (SR)	150	300	Energy, concentration. Well tolerated, good adjunct
a2-Adrenergic antagonist and 5-HT2 antagonist				
Mirtazapine (Remeron)	7,5	15	45	Good for sleep, appetite, elderly; good adjunct
Serotonin modulator				
Vortioxetine (Trintellix)	5	10	20	New action mode, well tolerated Now covered by RAMQ
SSRI with serotonin modulation				
Trazodone (Desyrel)	25	50	150	* * doses for hypnotic, not for mood ** advise patient to get out of bed slowly at night (orthostasis)
Vilazodone (Viibryd)	10	20	40	To take with food

Additional noteworthy info:

If no partial response after 2 weeks, change medication.

Keep the same dosage as long as there is still improvement. If improvement plateaus, R/A if increase is needed.

If your patient has private insurance but is not sure if the medication is covered, includean alternative if the first medication is not covered or too expensive.

When a patient clinical state worsen, reassess suicidality and psychosis.

Below 21 year old, advise that paradoxical suicidal ideations might occur and if it is the case, to discontinue right away the medication and contact MD (note, there is no increase risk of completed suicide) .

Always worth asking quickly if there is family history of bipolar disorder in the family. If so, provide brief psychoeducation about sign and symptoms of mania (decreased need for sleep, increase psychomotor activity or sociability, ideas going faster) and advise to seek quicker follow-up.

Serotonin syndrome is a medical emergency, by Hunter Criteria: serotonergic agent by patient plus ≥ 1:

- spontaneous clonus
- Inducible/ocular clonus + either agitation or diaphoresis
- tremor and hyperreflexia
- hypertonia, T > 38 C (100.4 F) + either ocular clonus or inducible clonus

MOOD STABILIZERS

MEDICATION (other names)	Dosages available	Usual dosages	Pearls / highlight
Lithium (Lithium Carbonate Carbolith, Eskalith)	Slow-release 300 mg Controlled release 450 mg Capsule 150, 300 and 600 mg Available in liquid form	CANMAT : blood levels 12h post dose Mania: 0.8–1.2 mEq/L Depression above 0.8-1.2 mEq/L Maintenance: 0,6-1 mEq ** mEq does not equal mmol depending of formulation **	NSAIDs contraindicated (Li toxicity, renal SE) Avoid dehydration (heat, sport, fever) Li toxicity can present with diarrhea (which will worsened toxicity by dehydration) Good adjunct in depression (uni and bipolar) Risk of cardiac malformation ** always tell patient to check with their pharmacist if they take natural products or over the counter medication**
Valproate (Depakene, Divalproate, Epival)	125, 250, 500 mg Available in liquid form	CANMAT: blood levels 12h post dose 350-700 mM/L (50- 100 ug/mL) (usually laboratory ranges are for epilepsy)	Contraindicated for any woman in childbearing age (teratogenic) Can be in loading dose in acute mania
Lamotrigine (Lamictal)	25, 50, 100 mg	100 mg BID	For bipolar depressive episode tx + prevention Need to be titrated slowly due to risk of Steven Johnson Syndrome
Topiramate (Topamax)	25, 100, 200 mg	200-300 mg	Risk of nephrolithiasis
Carbamazepine (Tegretol)	100, 200 mg	Blood sampled just prior the next dose Above 7 mg/L	Enzymatic inductor, usually avoided as will induce metabolism of any other medication

Reminder that nature does not follow textbooks! We treat people, not laboratory values.

Medication 101

ANTIPSYCHOTICS

MEDICATION (commercial)	Usual dosages	Pearls / highlight
Partial dopamine agonist (third generation)		
Aripiprazole (Abilify)	Adjunct MDE: 2-15 mg Antipsychotic 10-20 mg Available LAI (Maintena)	Less weight gain Akathisia can occur
Rexulti (Brexipirazole)	1-3 mg	Less weight gain
Serotonin-dopamine antagonist (atypical or second generation antipsychotic SGA)		
Quetiapine (Seroquel)	Sedation: 25-50 mg Mood: 150-300 mg Bipolar: 300-600 mg Psychosis: aim 600 mg	IR and XR have the same effect, only sedation peak and duration are different (quicker and shorter with IR)
Olanzapine (Zyprexa)	Sedation: 2-5 mg 5-20 mg	Sedative Weight gain Smoking increase metabolism (CYP1A2)
Risperidone (Risperdal)	Emotion regulation: 1-3 mg Mood: 1-3 mg Antipsychotic: 1-6 mg Available in LAI (paliperidone; Sustenna and Trinza)	Very tolerated and high potency Available in liquid and M-tab (SL) "Most typical of atypicals": + EPS, less metabolic SE
Lurasidone (Latuda)	Bipolar: 20 – 80 mg Psychosis: 40-160 mg	Weight neutral To take with food (350 cal)
Iloperidone (Fanapt)	1 mg BID, gradually to 12 mg BID	Weight neutral
Ziprasidone (Geodon)	Depression: 20-80 mg BID Bipolar: 80-160 mg (divided) Psychosis: 40-200 mg	
Asenapine (Saphris)	5-10 mg BID	Sublingual, do not eat nor drink 10 min after SL
Clozapine (Clozaril) Clozapine and Clozaril are not monitored by the same company, nor fully equivalent, therefore cannot be substituted.	Minimum effective dose 25 mg increase every 72 h ** Need titration from 25 mg if stopped for more than 72 hours (otherwise can be life-threatening)	Smoking increase metabolism (CYP1A2) Regular bloodwork needed Frequent side effects: orthostatic hypotension, sialorrhea (treat with atropine drops SL), sedation. Rare but significant side effects: neutropenia, myocarditis, paralytic ileus, seizure. Can also cause nocturnal urinary incontinence.
Dopamine agonists (typical or first generation antipsychotic FGA)		
Haloperidol (Haldol)	2,5-5 mg	
Loxapine (Loxapac, Xylac)	25-50 mg	Sedative properties

Additional information

In hospital setting, if prescribing an antipsychotic, add:
If acute dystonia: Cogentin 2 mg IM stat and advise MD.

Suggest patient to have Diphenydramine (Benadryl) at home in case dystonia occurs, to take and then to seek medical consultation.

Neuroleptic malignant syndrome (NMS) is medical emergency:
Altered mental status
Hyperthermia
Autonomic lability
Increased tonus, rigidity
Hyperreflexia
Tremors
Diaphoresis
Increased CK

Options for akathisia:
Decrease dosage of antipsychotic
Change antipsychotic
Propanolol
Benzodiazepine

Options for EPS:
Decrease dosage of antipsychotic
Change antipsychotic
Anticholinergic medication
Antihistaminic medication

Young man, antipsychotic naïve at higher risk for acute dystonia,
elderly woman for tardive dyskinesia

OTHERS

MEDICATION (other names)	Mechanism	Available dosages (max)	Pearls / highlight
Pregabalin	Glutamate voltage-calcium channel blocker	25, 50, 75, 100, 150, 225, 300 mg (600 mg/day, in BID-TID)	Helpful with neuropathic pain In anxiety guidelines Steps of 12,5 mg for elderly
Revia	Mu opiod receptors antagonist	25 mg (50)	Not contraindicated when still using alcohol (in fact, to take if not abstient) Increase total abstinence, but also reduce frequency and severity of binges. Sinclair Method to consider (50 mg one hour prior consumption)

BENZODIAZEPINES

MEDICATION (commercial)	Minimum dose (NOT equivalents)
Short half-life	
Alprazolam (Xanax)	0,25
Oxazepam (Serax)	7,5
Triazolam (Halcion)	0,25
Intermediate	
Lorazepam (Ativan)	0,5
Temazepam (Restoril)	0,25
Long half-life	
Chlordiazepoxide (Librium)	10-25
Diazepam (Valium)	5-10
Clonazepam (Klonopin, Rivotril)	0,25-0,5 (0,125)

Practical clinical approach to tapering benzodiazepine

Provide psychoeducation regarding the long-term risks of benzodiazepine (cognitive side-effect, fall, fractures, etc). If there is clear need for underlying condition treatment (i.e. anxiety disorder or mood disorder), initiate treatment for the condition. Verbalize explicitly that prescribing is a medical act to avoid personalizing the issue.

Use a benzodiazepine converter online (equivalency tables are expert-opinion; there is no evidence-based conversion available) to convert benzodiazepine to long acting benzodiazepine (Clonazepam would be a good choice). Then transition to the Clonazepam dosage (total daily can be divided up to QID if needed). Then decrease by 0,125 – 0,25 mg steps every four weeks (or slower if needed). Explain to the patient that if something stressful arise, you can discuss postponing the decrease but you will not increase it back.

Consider non-benzodiazepine PRNs (in doubt, seek advice from the consulting psychiatric of your area).