ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES

GUIDELINES FOR PSYCHOTROPIC MEDICATION PRACTICES

I. CASE DOCUMENTATION

A. The Physician Initial Note must contain the following:

1. Date of patient contact (month, day, year)
2. Reason for referral
3. Recent course of illness
4. Mental Status Exam
5. Clinical impressions
6. Five Axis DSM diagnosis (current edition)
7. Treatment plan specifying target symptoms and behaviors
8. Documentation of completed or non-completed Medication Consent Form
9. Prior medication trials and duration
10. Past and current drug, ETOH and smoking use
11. Allergy assessment
12. Current medication and dose
13. Patient medical history including concurrent disease states
14. Family history
15. Physician signature (with degree)
16. Clinical risk assessment for patients who are pregnant or breast-feeding

B. The Physician Progress Note, on each medication visit, must contain the following:

1. Date (month, day, year)
2. Location where service provided
3. Type and duration of service
4. Description of service related to diagnosis, symptoms, established goals, and expressed in terms of changes in the individual's functioning. If there is little progress, a clear explanation of the limited progress must be included.
5. Complete list of currently prescribed medications including strength, route and directions for administration.
6. Description of response to/outcome of medication therapy
7. Assessment of lab data if applicable
8. Assessment of medication compliance
9. Description of adverse drug experiences or documentation if none present
10. Clinical risk assessment for patients who are pregnant or breast-feeding
11. Physician signature (with degree)

C. The Discharge Summary is complete

II. PRESCRIPTION AND MONITORING PRACTICES

A. Informed Consent form completed and current

B. Medication Orders

1. Each medication order includes the date, drug name, route, strength, and directions for administration
2. Each order is signed or co-signed by the attending psychiatrist
3. The Medication Order Sheet "Pink Sheet" is current,

complete and updated whenever a medication change is made. Log must match the current MD progress note
4. The IM Medication Administration Record (MAR) is completed and accurate

C. The psychiatrists must see each patient in a face to face evaluation at least once every three months

III. ANTIPSYCHOTIC MEDICATIONS

A. Usual indications[11]
1. Schizophrenia
2. Delusional disorders
3. Schizo-affective disorders
4. Schizophreniform disorder, brief reactive psychosis, or psychotic disorder NOS
5. Bipolar disorder
6. Major depressive episode with psychotic features
7. Borderline personality disorder
8. Other appropriate indications as documented

B. Antipsychotic dosage range *within* the approved dosing guidelines for Alameda County BHCS or, if antipsychotic dosage range *outside* the dosing guidelines, chart documentation supports dosage. Please note:
- *quetiapine (Seroquel)* doses should be *at least* 300mg within 1 months of initiation. (No use for sleep or anxiety disorders)[11]
- *aripiprazole (Abilify)* initiated at doses of 2-15mg, and should be maintained at that dose range for at least 2 weeks before any dosage adjustments. (Aripiprazole should be dosed only once daily)
- *ziprasidone (Geodon)* should be titrated to 120-160mg within the first month of treatment.

C. Dosing
1. No "as needed" dosing (prn) of antipsychotic agents without documented rationale
2. Clozapine Monitoring Committee Guidelines are being followed for all patients taking clozapine

D. If an additional antipsychotic medication is simultaneously prescribed, the rationale is documented. (Documentation as outlined in the "Practice Guideline: Polypharmacy", Attachment #1).

E. Adjunctive Monitors[11,13]
1. Baseline assessment of movement disorders documented
2. If possible symptoms of T.D. are noted, AIMS examination done initially and at least every 6 months
3. Weight: Measured at baseline, at every visit for 9 months, then every 3 months thereafter
4. Glucose: Measured at baseline, at 6 months, then annually
   - If glucose level is outside the normal range, at least on of the following must be documented:
     - A change of medication or dose
     - Discussion of physical health lifestyle improvements
     - A primary care referral or conversation with the physician
5. Cholesterol/triglycerides: Measured at baseline, at 6 months, then annually

- If the lipid levels are outside the normal range, at least one of the following must be documented:
    - A change of medication or dose
    - Discussion of physical health lifestyle improvements
    - A primary care referral or conversation with the physician

6. Prolactin (for clients on risperidone or any conventional agent) if possible symptoms of hyperprolactinemia (amenorrhea, gynecomastia, galactorrhea etc.) are noted: measured at baseline, at 6 months, then annually
7. Electrocardiogram (for clients on thioridazine or ziprasidone): Obtain baseline ECG only in clients at risk* for QT_c prolongation. Periodic monitoring would be dependent on changes in electrolyte status (hypokalemia or hypomagnesemia) as a result of diuretic therapy, diarrhea, etc.

These drugs are contraindicated in clients with a known history of QT prolongation (including congenital long QT syndrome), with recent acute myocardial infarction, with uncompensated heart failure, or with a history/family history of syncope or sudden cardiac death. These agents should not be used with any drug that prolongs the QT interval, and should be discontinued in patients who are found to have a QT_c interval over 500 milliseconds.

IV. MOOD STABILIZERS

A. Usual indication
1. Bipolar disorder mixed, manic or depressed
2. Schizoaffective disorder
3. Bipolar disorder NOS
4. Cyclothymia
5. Borderline personality disorder
6. Refractory depression
7. Other appropriate indications as documented

B. Mood stabilizer dosage range *within* the approved dosing guidelines for Alameda County BHCS, or if dosage range *outside* the dosing guidelines, chart documentation supports dosage

C. No "as needed" dosing (prn) of mood stabilizers

D. If more than one mood stabilizer is simultaneously prescribed, the rationale is documented. (Documentation as outlined in the "Practice Guideline: Polypharmacy", Attachment #1).

E. Serum Levels
1. Serum level assessed both *prior to* and *after* a dosage adjustment as indicated, except for patients taking divalproex sodium (valproic acid), when levels at these times may be ordered solely based on clinical judgment of need
2. Serum level of the mood stabilizer, when measured, is within the therapeutic range:
    - Lithium 0.6 – 1.2 mEq/L
    - Valproic Acid 50 – 125 mcg/ml
    - Carbamazepine 4 – 12 mcg/ml
3. If serum level outside therapeutic range, chart documentation supports dosage
4. Once stabilized, serum levels of carbamazepine and valproic acid drawn at least every 6 months; for lithium, every 12 months

F. Adjunctive Monitors
   1. Prior to initiation: assessment of renal, hepatic, hematological, thyroid function, and electrolytes, as well as pregnancy status
   2. Maintenance assessment:
      - Lithium: renal and thyroid function tested yearly
      - Valproic acid: hematological and hepatic functions tested twice yearly
      - Carbamazepine: hematological and hepatic function tested quarterly

V. ANTIDEPRESSANTS

A. Usual indication
   1. Major Depression
   2. Dysthymia
   3. Bipolar disorder, depressed
   4. Schizoaffective disorder, depressed
   5. Anxiety disorders (Panic, OCD, GAD, PTSD)
   6. ADHD
   7. Other appropriate indications as documented

B. Antidepressant dosage range is *within* the approved dosing guidelines for Alameda County BHCS or if dosage range *outside* the dosing guidelines, chart documentation supports dosage

C. No "as needed" dosing (prn) of antidepressant agents, without documented rationale.

D. If an additional antidepressant medication is simultaneously prescribed, the rationale is documented. (Documentation as outlined in the "Practice Guideline: Polypharmacy", Attachment #1).

E. Laboratory studies
   1. Baseline and maintenance laboratory assessments as indicated for tricyclic agents
   2. Baseline liver function tests upon initiation of nefazodone
   3. Maintenance liver function tests every six months during continuation of nefazodone (in addition to monitoring for clinical signs and symptoms of hepatic dysfunction in medical progress notes)

F. Pediatric Antidepressant Use
   1. Recommended follow-up as clinically indicated.
   2. In addition to securing informed consent:
      - Documentation within the patient's chart indicates that discussions with the patient/caregiver took place regarding the potential risk of clinical worsening upon initiation or change in dose of medication, including "activation" and suicidal ideation.

VI. ANXIOLYTICS

A. Indication
   1. Anxiety disorders (Panic, OCD, GAD, PTSD)
   2. Acute psychomotor agitation
   3. Alcohol or sedative withdrawal
   4. Anxiety associated with other mental disorders
   5. Akathesia or tardive dyskinesia

6. Bipolar disorder (clonazepam or lorazepam recommended)
7. Other appropriate indications as documented

B. Dosage Range
Anxiolytic dosage range is *within* the approved dosing guidelines for Alameda County BHCS or if dosage range *outside* the dosing guidelines, chart documentation supports dosage

C. No more than one antianxiety agent at one time, unless from different pharmacological class, except during the transition from one agent to another.

D. No use of benzodiazepines in patient with history of, or concurrent abuse of drug and alcohol , or history of addiction to antianxiety agents, unless supported by chart documentation.

VII. HYPNOTICS

A. Indication
1. Insomnia

B. Dosage Range
Hypnotic dosage range is *within* the approved dosing guidelines for Alameda County BHCS or if dosage range *outside* the dosing guidelines, chart documentation supports dosage

C. No more than one hypnotic agent prescribed at one time

D. No use of benzodiazepines in a patient with history of, or concurrent abuse of drug and alcohol, or history of addiction to antianxiety agents, unless supported by chart documentation.

E. No use of chloral hydrate in patients with marked hepatic or renal impairment

VIII. ADHD MEDICATIONS

A. Indication
1. ADHD
2. Refractory Depression (psychostimulants only)
3. Other appropriate indications as documented

B. Dosage Range
Medication dosage range is *within* the approved dosing guidelines for Alameda County BHCS or if dosage range is *outside* the dosing guidelines, chart documentation supports dosage

C. Adjunctive Monitors for psychostimulants
1. Height and weight every 6 months (in children and adolescents)
2. Pulse every 3 months, and blood pressure every 6 months (in patients >12 yrs old)

D. Adjunctive Documentation for *Adult* ADHD
1. For an adult patient seen by a BHCS psychiatrist the treatment of ADHD must only be for ADHD as a secondary diagnosis. The patient must also be concurrently undergoing treatment by the psychiatrist for a primary psychiatric diagnosis.

2. The Connors' Adult ADHD Rating Scale (CAARS) Self Reporting & Screening Version must be scored at both assessment and again after 30 days of medication treatment. The scores must be documented within the BHCS patient chart.

E. No use of stimulants in a patient with history of, or concurrent abuse of drug and alcohol, or history of addiction to stimulants, unless supported by chart documentation.

IX. ANTIPARKINSONIANS

A. Indication
1. Alleviation of extrapyramidal side effects (EPS) induced by antipsychotic drugs
2. Prophylaxis of EPS induced by antipsychotic medications

B. Dosage Range
Antiparkinsonian dosage range is *within* the approved dosing guidelines for Alameda County BHCS or if dosage range *outside* the dosing guidelines, chart documentation supports dosage

C. Documentation
1. If antiparkinsonian medication is used with any atypical antipsychotic (clozapine, risperidone, olanzapine etc.) justification of specific need must be documented.

D. No more than one antiparkinsonian agent prescribed at one time, unless documentation supports use.

X. *MISCELLANEOUS*

A. Gabapentin: The literature has demonstrated **no** efficacy of this agent in mood stabilization. Specific rationale for use should be clearly written into the progress notes and medication treatment plans.

B. Topiramate: At present, there is no evidence-based literature to support its use as a mood stabilizer. Specific rationale for use should be clearly written into the progress notes and medication treatment plans.

C. Atomoxetine: In order for the pharmacy to dispense atomoxetine, the four scores (A through D) of the Connors' Adult ADHD Rating Scale (CAARS) Self Reporting & Screening Version must be written on the backside of the prescription at initiation and again after 30 days of medication treatment.

D. Controlled Substances: No use of any controlled substance in a patient with a history of substance abuse, unless supported by appropriate chart documentation.

6/97, rev. 7/99, 02/02, 08/02, 10/03, 1/05, 7/09, 11/11, 9/15

References

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7. Davis JM, Chen N. Dose response and dose equivalence of antipsychotics. J Clin Psychopharm. 24(2) 2004, 192-208.

8. Harvey PD, Green MF, Keefe RS et al. Cognitive functioning in schizophrenia: a consensus statement on its role in the definition and evaluation of effective treatments for the illness. J Clin Psych 65(3) 2004, 361-372

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10. Marder SR, Essock SM, Miller AL et al. The Physical Health Monitoring of Patients with Schizophrenia Am J Psych 161 (8) 2004, 1334-1349.

11. Schneeweiss S, Avorn J. Antipsychotic agents and sudden cardiac death-how should we manage the risk? NEJM 2009;360:294-295.

12. Ray WA, et al. Atypical antipsychotic drugs and the risk of sudden cardiac death. NEJM 2009; 360: 225-35.

13. ADA,APA,AACE. Consensus development conference on antipsychotic drugs and obesity and diabletes. Diabetes Care 2004; 27(2): 596-601.

(Attachment #1)

Alameda County Behavioral Health Care Services
Practice Guideline: Polypharmacy

Definition

Alameda County BHCS defines polypharmacy as:

- The use of more than one psychotropic medication within the same class at the same time, other than for cross-tapering purposes.

The "class" of psychotropic medications is considered as all antidepressants, all antipsychotics, all mood stabilizers, and anxiolytics/sleepers.

The prescribing clinician must clearly document:

1. The rationale justifying the use of the particular combination of medications based upon the identified symptoms of the disorder(s) and
2. Any additional likely/potential side effects to be experienced based on the particular medication combination.

Documentation of Target Symptoms

For each medication prescribed, the prescribing clinician must provide written documentation of the specific target symptoms for the use of the medication.

Some examples:

- Citalopram is being prescribed for treatment of Major Depressive Disorder. Target symptoms include: marked depressed mood, frequent suicidal ideation, and marked loss of energy.
- Ziprasidone is being prescribed for treatment of Schizophrenia, Paranoid Type. Target symptoms include: derogatory auditory hallucinations, delusions of having an electronic device in the brain, and tangential thought processes.

Rationale for Combination Use

Specific Rationales for the combined use of regularly prescribed psychotropic medications must clearly describe the reasons why the particular combination of medications is being prescribed. Rationales for polypharmacy and medication changes may include **lack of full response** (need to augment), **patient preference, intolerable side effects of one of the medications, diagnosis changes, evidence-based practice, adverse effect, prior response**, etc.

Some examples:

- Auditory hallucinations have not fully responded to risperidone alone. Haloperidol is added to target residual AH.
- Add venlafaxine to sertraline due to incomplete resolution of depressive symptoms.

References

1. Developed by The Arizona Department of Health Services Division of Behavioral Health Services. Practice Protocol; Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation.