Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Mental Health Medicines

Formulary

Edition 2.1

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All information is believed to be correct at the time of publication.

Mental Health Formulary

Contents: **Page Number**

1. Introduction

The Cheshire and Wirral Partnership NHS Foundation Trust (CWP) mental health formulary is a reference guide that highlights the formulary decisions approved by the CWP Medicines Management Group in conjunction with Primary Care. Medicine selection has been based on evidence of efficacy and adverse effects, and prudent considerations around cost. It is intended that the formulary promotes rational prescribing of cost effective medicines in recognition of limited resources. The clinical evidence reviewed in reaching these decisions is based on research studies published in reputable journals, national clinical guidelines and technology appraisals from NICE (National Institute for Health and Clinical Excellence) and SMC (Scottish Medicines Consortium), and professional body guidelines.

1.1 New medicine requests

The process for requesting a new medicine is documented in
MP6: Introduction of new medicines

1.2 Non-formulary medicines

CWP has a list of non-formulary medicines that includes those considered by MMG but not approved those with applications in progress and those with no current application – list available from the pharmacy team.

In cases where formulary choices may not be appropriate, a named patient request, by the patient's consultant, for a non-formulary medicine can be made to the Chief Pharmacist and Chairperson of Medicines Management Group for consideration. The request should be in letter format detailing:

- the non-formulary medicine being requested
- patient demographics
- diagnosis and previous/current medication
- response and symptom control to previous/current treatment
- adverse effects to previous/current medication
- relevant test results
- other mitigating circumstances

The letter should be faxed and/or sent to: -
Chief Pharmacist, Management Suite, Bowmere Hospital, Countess of Chester Health Park, Liverpool Rd, Chester CH2 1BQ.
Fax Number: 01244 397495.

Chairperson, Medicines Management Group, Bowmere Hospital, Countess of Chester Health Park, Liverpool Rd, Chester CH2 1BQ.
Fax Number: 01244 397430

A timely response to the named patient application will be made within 5 working days of receipt if sufficient details are provided in the letter.

Prescribing of non-formulary medicines will be monitored by the MMG and prescribers will have to justify their prescribing practice to the MMG, their line manager and where appropriate, the medical director, as it contravenes the remit of the MMG within the organisation. Formulary decisions made by MMG are final but an appeal process is in place to review decisions in light of new evidence, issuing of NICE guidance or change in funding implications.

1.2.1 Patients Admitted on Non-Formulary Medicines

When a patient is admitted to hospital on a non-formulary medicine, consideration should be given to changing to a formulary option, where this is practicable and not likely to be detrimental to the patient's care.

Where it is not practicable to change, the ward pharmacist should be contacted so that appropriate arrangements for continuing the treatment can be made.
When therapy with a non-formulary drug is continued on admission, medication brought into hospital by the patient may be used see **MP20: Policy for the reuse of patients own drugs** and the medicines chart will be appropriately annotated by the pharmacist as existing therapy (ET).

1.3 Physical health and antimicrobial formularies

Our mental health formulary choices cover the range of mental health conditions treated within CWP.

Physical health medicines should be prescribed in line with our local acute trusts and clinical commissioning group formularies – East and Central Cheshire, Western Cheshire and Wirral commissioning groups.

In-patient antimicrobial prescribing should be in line with our adopted formulary from Wirral Clinical Commissioning Group –available from the pharmacy team

Prescribing of antimicrobial medicines within Community Care Western Cheshire is directed by the antimicrobial formulary approved between Western Cheshire clinical commissioning group and CWP – available from pharmacy team

1.4 Information to patients

The www.choiceandmedication.org/cheshire-and-wirral website is the main reference source used by CWP for supporting patients/carers information on all mental health medicines.

2. Hypnotics & Anxiolytics

2.1 Hypnotics

CSM Advice:

- Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress

April 2004 - National Institute for Health and Clinical Excellence (NICE) published Insomnia – newer hypnotic drugs **NICE TA077**

NICE recommendations:

- When, after due consideration of the use of non-pharmacological measures (advising patients to have regular sleeping hours, avoid caffeine at bedtime), hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, it is recommended that hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications
- It is recommended that, because of the lack of compelling evidence to distinguish between zaleplon, zolpidem, zopiclone or the shorter-acting benzodiazepine hypnotics, the drug with the lowest purchase cost (taking into account daily required dose and product price per dose) should be prescribed
- It is recommended that switching from one of these hypnotics to another should only occur if a patient experiences adverse effects considered to be directly related to a specific agent
- Patients who have not responded to one of these hypnotic drugs should not be prescribed any of the others

CWP Medicines Management Group have produced a healthcare professional sleep hygiene leaflet – Contact the locality clinical pharmacist for information

CWP Sleep Guidance April 2014

First line
Zopiclone 7.5mg orally at bedtime; Patients aged 65 year and over 3.75mg at bedtime

Second line
Zolpidem 10mg orally at bedtime, Patients aged 65 year and over 5mg at bedtime
Zaleplon 10mg orally at bedtime, Patients aged 65 and over 5mg at bedtime

Note: All hypnotics have some addictive or abuse potential.
If drugs are necessary, restrict to "when required" use and as far as possible add "only after 11 pm" or similar appropriate time dependent on the patient.

Nitrazepam has too long a half life to be recommended as a hypnotic**.**

Note: Temazepam is currently not a recommended choice. Contact locality clinical pharmacist for information and advice

Temazepam April 2014 (Final).pdf

2.2 Child and Adolescent Mental Health Services (CAMHS)

Melatonin is a pineal hormone that may affect sleep pattern. The licensed formulation Circadin® is available for off label use for treatment of children with neurological or neurodevelopmental disorders suffering from severe sleep disturbances under shared care agreement

Shared care guideline available from pharmacy team

Melatonin MR* 2mg orally once daily.
If no beneficial response within 7 to 14 days, increase in 2mg steps every 7 to 14 days. Usual dosage range is 2 to 6mg, maximum 10mg

2.2.1 Sleep onset insomnia and delayed sleep phase syndrome

Melatonin* (children 1 month to 18 years), orally, initially 2 to 3mg daily before bedtime increased if necessary after 1 to 2 weeks to 4 to 6mg daily before bedtime: max 10mg daily

The need to continue melatonin should be reviewed every 6 months by CAMHS consultant.

The use of melatonin (Circadin®) in other patient groups will be considered by the MMG on a non-formulary request application for an off-label indication.

* Unlicensed indication

2.3 Anxiolytics

CSM (Committee on Safety of Medicines) Advice:

- Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or causing the patient unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic, or psychotic illness
- The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate and unsuitable

First line:
Diazepam 2mg orally up to three times a day increased if necessary to 15 to 30mg daily in divided doses. Patients aged 65 years and over, use half adult dose
Or
Lorazepam 1 to 4mg orally in divided doses (maximum daily dose - 4mg). Patients aged 65 years and over use half adult dose

For equivalent doses of oral benzodiazepines contact your locality clinical pharmacist:

3. Drugs used in psychoses and related disorders

February 2014 - National Institute for Health and Care Excellence (NICE) Clinical Guideline (CG) 178 Schizophrenia was published **NICE CG178**

- Current evidence suggests all antipsychotics have equal efficacy (with the exception of clozapine)
- In CWP the choice of antipsychotics in psychosis is detailed in policy MP22. First line agents are listed in Appendix 1 of this policy.
- Aripiprazole (except CAMHS), quetiapine MR and risperidone long acting injection are non-formulary and are requested on a named patient basis only via the MMG chair and Chief Pharmacist.
  Note: Asenapine and paliperidone are also non-formulary within the Trust.
- Clozapine is reserved as a third line agent for treatment resistant schizophrenia as per NICE guidance. See the Trusts Medicines management policy on initiation, maintenance and monitoring patients on clozapine (**MP05**) and also community initiation of clozapine (**MP13**) for more information

For more information see **MP22: Policy for prescribing antipsychotic medications in psychotic conditions (excluding bipolar disorder)**

Appendix 1 within policy MP22 provides a comparison table of antipsychotic medication

Note: See the current issue of BNF for full dose range

Patients within CWP currently prescribed oral aripiprazole, oral quetiapine MR or risperidone LAI will continue with their current treatment until treatment is reviewed and switched, if appropriate.

For patients that prescribers are considering initiation with oral aripiprazole, oral quetiapine or risperidone long acting injection, a request letter must be sent to the Chief Pharmacist, and the Chair of Medicines Management Group (MMG). The letter should contain the following information;

- Full clinical history (including diagnosis)
- Response to previous medications and
- Rationale for request of named-patient medication.

A patient decision aid has been developed, see **Appendix 2 (of policy MP22)**, to promote discussions between patients and prescribers.
Note: From aripiprazole post-marketing surveillance information, weight gain, weight decreases have been reported but the incidences of these adverse reactions cannot be estimated from the available data.

3.1 Hyperprolactinaemia

Hyperprolactinaemia is an increase in prolactin plasma levels which occurs when dopamine inhibits prolactin release. All antipsychotics have the propensity to cause this, however some are reported to not increase prolactin levels above the normal range at standard doses. These antipsychotic medications are: aripiprazole, clozapine, olanzapine and quetiapine. The degree of prolactin elevation is likely to be

dose related. For more information on the management of hyperprolactinaemia see **(Appendix 5 in MP22)**
Note: if quetiapine or aripiprazole are considered as treatment options where there is a history of raised prolactin, the named-patient application process should be followed.

3.2 High dose antipsychotics

HDAT (High Dose Antipsychotic Therapy) The Consensus statement on high-dose antipsychotic medication (Royal College of Psychiatry Council Report CR138, May 2006) defines high-dose antipsychotic use as: A total daily dose of a single antipsychotic which exceeds the upper limit stated in the Summary of Product Characteristics (SPC) or British National Formulary (BNF) and a total daily dose of two or more antipsychotics which exceeds the Summary of Product Characteristics or BNF maximum using the percentage method.
Note: Doses higher than those stated in the BNF are unlicensed.
For further information see **MP18: High Dose Antipsychotic Therapy (HDAT) Guideline**

All patients on high-dose antipsychotic treatment must be monitored as per guidance within the policy.

3.3 Pregnancy

When prescribing for patients who are pregnant or planning a pregnancy please refer to **MP3: Guidance on the Recommended Psychotropic Agents for use in Pregnancy and Lactation.** If you require more information, contact your locality pharmacist for advice on prescribing in pregnancy and lactation.

3.4 Antipsychotics in young people

The NICE Technology Appraisal 213 **(TA213)** issued guidance around the prescribing of aripiprazole for young people aged 15 to 17. Aripiprazole is therefore considered an option for the treatment of schizophrenia in people aged 15 to 17 years who are intolerant of risperidone, or for whom risperidone is contraindicated, or whose schizophrenia has not been adequately controlled with risperidone.

3.5 Rapid Tranquilisation (also called urgent sedation)

This is the use of medication to calm/lightly sedate the patient and reduce the risk to self and/or others. The aim is to achieve an optimal reduction in agitation and aggression thereby allowing a thorough psychiatric evaluation to take place whilst allowing comprehension and response to spoken messages throughout. For information on rapid tranquilisation including treatment algorithms, see Trust **MP10: Rapid Tranquilisation policy**

4. Antipsychotic medication for bipolar disorder

Treatment for Bipolar affective disorder should be in line with the NICE Clinical Guideline 38. (**NICE CG38**)

- In CWP the choices of antipsychotics in bipolar disorder are detailed in policy MP24. First line agents are listed in Appendix 1 of this policy.

The treatment of bipolar disorder is based primarily on psychotropic medication to reduce the severity of symptoms, stabilise mood and prevent relapse. Antipsychotic medications may have a role in such treatment. Individual variation in response to medication will often determine the choice of drug, as will the side effects and potential harms associated with each drug (Appendix 2 in MP 24).

NOTE: Risperidone long-acting injection (LAI) is not licensed for use in bipolar disorder and so is not within the scope of this guideline. Asenapine was licensed for bipolar mania in 2012 but should not be initiated as it is non-formulary within the Trust.

The antipsychotics licensed for the treatment of bipolar mania in the UK are risperidone, olanzapine, quetiapine, aripiprazole and asenapine.
When treating acute mania with antipsychotics in adults the preferred choices within CWP are **oral olanzapine, quetiapine immediate release (IR) or oral risperidone** and the following should be taken into account:

- Individual risk factors for side effects;
- The need to titrate treatment at the lower end of the therapeutic dose range recommended in the summary of product characteristics and titrate according to response;
- That if an antipsychotic alone proves inadequate augmenting it with valproate or lithium should be considered.

Aripiprazole is licensed for treatment of mania in adolescents aged 13-18 years and is recommended by NICE TA292 as an option for treating moderate to severe manic episodes in adolescents with bipolar I disorder. It should be considered as a treatment option alongside oral olanzapine, oral risperidone and quetiapine IR taking the factors listed above into account.

5. Antimanic drugs

Treatment for Bipolar affective disorder should be in line with the NICE Clinical Guideline 38.
Treating bipolar disorder with drugs – NICE CG38

The key points regarding medicine choices are detailed below.
● **Lithium carbonate** (prescribe by brand – Priadel®), **olanzapine** or **valproate** should be considered for long-term treatment of bipolar disorder.
The choice of medication should depend on:

- response to previous treatments
- the relative risk, and known precipitants, of manic versus depressive relapse
- physical risk factors, particularly renal disease, obesity and diabetes
- the patient's preference and history of adherence
- gender (valproate should not be prescribed for women of child-bearing potential)
- a brief assessment of cognitive state (such as the Mini-Mental State Examination) if appropriate, for example, for older people.

● **Valproate** (semisodium valproate/sodium valproate/valproic acid) should **NOT** be prescribed routinely for women of child-bearing potential. If no effective alternative to valproate can be identified, adequate contraception should be used, and the risks of taking valproate during pregnancy should be explained. This advice should be recorded in the patients' notes.

See also CWP Lithium policy MP4 for information on initiation, plasma monitoring and maintenance treatment.

● If the patient has frequent relapses, or symptoms continue to cause functional impairment, switching to an alternative monotherapy or adding a second prophylactic agent (lithium, olanzapine or valproate) should be considered.

Possible combinations are lithium with valproate, lithium with olanzapine, and valproate with olanzapine.

● If a trial of a combination of prophylactic agents proves ineffective prescribing lamotrigine (especially if the patient has bipolar II disorder) or carbamazepine may be an option.

If a patient is taking an antidepressant at the onset of an acute manic episode, the antidepressant should be stopped.

NOTE:
Lithium should be prescribed by brand due to differences in bioavailability. If a patient is to be initiated on lithium within CWP, the Priadel® brand should be prescribed.
If a patient is admitted on another brand of lithium, then that same brand should be prescribed to maintain treatment

Valproate semisodium (Depakote®) and sodium valproate dose for dose are NOT bioequivalent.
It is generally accepted that a 750mg dose of Depakote® is equivalent to 800mg of sodium valproate

6. Antidepressant drugs

6.1 Antidepressant selection

A medicines management treatment pathway has been developed between CWP and primary care for the management of moderate to severe depression. This Pathway is based on the recommendations by NICE Guideline 90, amended October 2009. It should not be considered in isolation but as part of the care pathway for managing depression.

For more information see **MP12: Antidepressant treatment pathway for adults over 18 with moderate to severe depression**

All antidepressants should be initiated in their generic form as they are seen to be equally effective as other antidepressants. The order of use should be as detailed below referring to the above policy and the current BNF for detail on each medicine.

NOTE: Previously successful drugs should be considered first

First line
Fluoxetine 20mg, orally, once daily
Or
Citalopram 20mg, orally, once daily (**note: contraindicated in patients on medication that can prolong QT interval e.g. antipsychotics, methadone**)
Or
Sertraline 50mg, orally, once daily (especially for patients who have had a previous myocardial infarction and epilepsy)

Second line (use if first line is ineffective after 3 to 4 weeks or not tolerated)
Escitalopram 10mg, orally, once daily (**note: contraindicated in patients on medication that can prolong QT interval e.g. antipsychotics, methadone)**
Or
Mirtazapine 15 to 30mg, orally, daily. Can be increased to 45mg daily if necessary
Note: 15mg dose has anxiolytic action. Increase dose to 30mg after 5 to 7 days for antidepressant action
Or
Paroxetine 20mg, orally, once daily
Or
Venlafaxine MR 75mg tablets, once daily increasing dose as appropriate
Or
Lofepramine 70mg, orally, once daily for one week then increased to 140 mg daily
Or
Other tricyclics i.e. amitriptyline, clomipramine, imipramine, nortriptyline should be used in doses higher than 125mg **(Avoid using dosulepin –associated with relatively high risk of fatality in overdose)**
Or
Duloxetine 60mg, once daily (for patients not suitable for venlafaxine or with medical comorbidity

Note: Hyponatraemia may occur with all antidepressants especially SSRIs and tricyclics and is particularly common in patients aged 65 and over.

6.2 Continuation and maintenance antidepressant treatment

Continue treatment for:

- A minimum of 6 months after remission, 24 months in the elderly.
- Longer than 6 months (24 in the elderly) in patients with residual depressive symptoms and other factors increasing risk of relapse.
- At least 2 years (and consider maintenance) for people who have had two or more depressive episodes in the recent past and who have experienced significant functional impairment during the episodes
- Consider maintenance for patients who have had more than 5 depressive episodes or who have persistent risk factors for relapse/recurrence.
- Continue the same dose as used during the acute phase.

6.3 Discontinuing antidepressant therapy

Discontinuation or withdrawal syndrome has been associated with the abrupt discontinuation of all doses of antidepressants and with drugs that have a shorter half-life. Symptoms usually appear within a few days of stopping the antidepressant.

Most reactions are mild and rarely last more than two weeks. Withdrawal symptoms include dizziness, anxiety and agitation, abdominal spasms, low mood and mood swings. Fluoxetine has a lower prevalence of withdrawal symptoms due to its long half life.

6.4 Switching antidepressants

- Abrupt withdrawal of the original antidepressant should be avoided.
- Cross tapering is preferred, where the dose of the original antidepressant is slowly reduced while the dose of the new antidepressant is slowly increased. The speed is judged by monitoring patient tolerability. When switching, consider a different SSRI or better tolerated new generation antidepressant before switching to an antidepressant of different pharmacological class that may be less well tolerated.

Contact locality clinical pharmacist for advice on cross titration and switching regimes

6.5 Combination therapy

Potential dangers of simultaneously administering two antidepressants include pharmacodynamic interactions (serotonin syndrome, hypotension, drowsiness) and pharmacokinetic interactions (e.g. elevation of tricyclic plasma levels by some SSRIs). Consideration must be given to the pharmacological action of each antidepressant when adding a second agent. There is little rationale for using two SSRI's together.

Useful combinations are:

Mirtazapine plus SSRI

Mirtazapine plus venlafaxine

7. Antimuscarinic drugs

Antimuscarinic drugs reduce the symptoms of Parkinsonism induced by antipsychotic drugs, but there is no justification for giving them routinely in the absence of parkinsonian side-effects. **Tardive dyskinesia (abnormal involuntary movements that may be irreversible) is not improved by antimuscarinic drugs and may be made worse.**

Note: These medications have the potential for abuse

7.1 Extrapyramidal side effects:

7.1.1 Parkinsonism induced by antipsychotics:

First line
Procyclidine 2.5mg orally three times a day, increased gradually in steps of 2.5 to 5mg daily every 2 to 3 days if necessary. Maximum of 30mg daily.
Use the lower end of dosage range in those aged 65 and over.
Note: Last dose not recommended after 6pm

Second line
Trihexyphenidyl (benzhexol) 1mg orally daily increased by 2mg every 3 to 5 days according to response; usual maintenance dose 5 to 15mg daily in 3 to 4 divided doses. Max 20mg daily
Use the lower end of dosage range in those aged 65 and over
Or
Orphenadrine 50mg orally three times a day, increased in steps of 50mg every 2 to 3 days according to response; Max 400mg daily
Use the lower end of dosage range in those aged 65 and over

7.1.2 Dystonic reactions –oculogyric crisis, torticollis
Procyclidine intramuscularly 5 to 10mg usually effective in 5 to 10 minutes

7.1.3 Akathisia and tardive dyskinesia – contact locality clinical pharmacist for advice

7.2 Hypersalivation

Hyoscine hydrobromide 300micrograms* (Kwells®) up to three times a day
Or
Hyoscine hydrobromide TTS 1mg* (Scopoderm TTS®) apply one patch, to hairless area behind ear, every 72 hours

Counselling – apply replacement patch behind other ear. Wash hands after handling patch and wash application site after removing and use one patch at a time.

Contact locality clinical pharmacist for advice if first line treatment is ineffective or not tolerated.

*unlicensed indication

8. Drugs for Attention Deficit Hyperactivity Disorder

In 2008, NICE published guidance on Attention Deficit Hyperactivity Disorder (ADHD), Clinical Guideline 72 (**CG72**)

While the NICE guideline advises against the diagnosis and initiation of drug treatment at a primary care level it does support GPs prescribing and monitoring of drug treatment via a shared care agreement. Joint shared care agreements for methylphenidate and atomoxetine for ADHD in Children and Adolescents aged 6-18 years has been put in to place to support the NICE guidance and should be used in conjunction with CG72.

Shared care guidelines available for NHS Wirral – contact the pharmacy team
Shared care guidelines available for Western Cheshire – contact the pharmacy team
Shared care guidelines for East and Central Cheshire agreement currently under development

First line
Methylphenidate (**CD2**- (Controlled Drug Schedule 2)) **- Dose and administration**

Immediate release tablets
Child 6 to18 years initially 5 mg 1 to 2 times daily, increased if necessary at weekly intervals by 5 to 10 mg daily; usual max. 60 mg daily in 2 to 3 divided doses but may be increased to 2.1 mg/kg daily (max. 90 mg daily) split in to 2 to 3 divided doses under the direction of a specialist.

Evening dose If effect wears off in evening (with rebound hyperactivity) a dose at bedtime may be appropriate (establish need with trial bedtime dose)

Modified release tablets
Concerta XL® Child 6 to 18 years initially 18 mg once daily (in the morning), increased if necessary at weekly intervals by 18 mg according to response; licensed maximum of 54 mg once daily, but may be increased to 2.1 mg/kg daily (maximum dose 108 mg daily) under the direction of a specialist.

Modified release capsules
Equasym XL® Child 6 to18 years initially 10 mg once daily in the morning before breakfast, increased gradually at weekly intervals if necessary; licensed maximum. 60 mg daily, but may be increased to 2.1 mg/kg daily (max. 90 mg daily) under the direction of a specialist.

Medikinet XL® Child 6 to 18 years 10 mg once daily in the morning with breakfast, adjusted at weekly intervals according to response; licensed max. 60 mg daily, but may be increased to 2.1 mg/kg daily (maximum. 90 mg daily) under the direction of a specialist.

Contents of Equasym XL® and Medikinet XL® capsules can be sprinkled on a tablespoon of applesauce, then swallowed immediately without chewing.

Please note due to the different release characteristics of the modified release preparations it is essential that brand prescribing takes place. Immediate release preparations should be prescribed generically as methylphenidate.

Second line

1) **Atomoxetine - Dose and administration – initiated under direction of specialist only**

   - Considered an option if methylphenidate is not tolerated due to adverse effects relating to its stimulant properties.
   - Considered an option if 24 hour treatment of ADHD symptoms is needed.

Child 6 to 18 years:
body-weight under 70 kg: initially 500 micrograms/kg daily for 7 days then increased according to response to usual maintenance dose 1.2 mg/kg daily; but may be increased to 1.8 mg/kg (max. 120 mg) daily under the direction of a specialist.

body-weight over 70 kg: initially 40 mg daily for 7 days then increased according to response to usual maintenance dose 80 mg daily, but may be increased to max. 120 mg daily under the direction of a specialist
Total daily dose may be given *either* as a single dose in the morning *or* in 2 divided doses with last dose no later than early evening

2) **Lisdexamfetamine Dimesylate (Elvanse®)** (**CD2**)

Elvanse® is indicated in the treatment of ADHD as a second-line drug in CAMHS.

The situations in which Elvanse® might be considered are:
a. Previous treatment with Methylphenidate has been clinically inadequate despite therapeutic doses having been utilised. Elvanse® can be considered as long as there are no contraindications for the further use of stimulants.

b. If a young person is unable to swallow Methylphenidate in its various forms. The fact that Elvanse® can be dissolved in water may mean that it is indicated for patients who have sensory sensitivities to the tablets or capsules of Methylphenidate.

c. In situations where a duration of action longer than 12 hours, but less than 24 hours, is needed then Elvanse® may be preferable. The form of Methylphenidate with the longest duration of action is currently Concerta® (up to 12 hours).

d. If treatment with Atomoxetine has been ineffective and there are no contraindications for using stimulants.

See Elvanse® Summary of Product Characteristics (SPC) for full product information -https://www.medicines.org.uk/emc/medicine/27442

Pathway for the prescribing of Lisdexamfetamine Dimesylate (Elvanse®)

CWP Elvanse pathway 2014.pdf

9. Drugs used in substance dependence

9.1 Alcohol dependence

For more information see Alcohol withdrawal management in the in-patient setting **Trust policy MP23. In the community setting, consult (DA3) - The alcohol detoxification policy for complex patients**

Hospital detoxification can be undertaken effectively and safely using a reducing regime of chlordiazepoxide dependent on age and SADQ score (Severity of Alcohol Dependence Questionnaire)

Where there is known hepatic insufficiency, oxazepam is considered the drug of choice for alcohol detoxification

Contact your locality clinical pharmacist for a bespoke oxazepam detoxification regime chart.

9.1.2 Vitamin supplementation

Oral thiamine is poorly absorbed in alcohol dependent patients. All in-patients treated for alcohol withdrawal should receive Pabrinex IMHP® (high potency vitamins B and C) by intramuscular injection one pair of ampoules daily, for five days

Potentially serious allergic adverse reactions to injectable thiamine may occur although this is very rare (1 in 5 million for the intramuscular route) and should not preclude use. Facilities for treating anaphylactic reactions (including resuscitation facilities) should be available when parenteral thiamine is administered

Parenteral treatment should be followed by treatment with oral vitamin preparations if Wernicke's encephalopathy is to be prevented. Prescribe:

- Vitamin B Compound Strong TWO tablets three times daily and
- Thiamine 100mg ONE tablet TWO times daily

For a minimum of 2 weeks. After this period review supplementation requirements.

Contact your locality clinical pharmacist for further advice if required.

9.1.3 Withdrawal seizures

In patients experiencing withdrawal seizures rectally administered:

Diazepam 500 micrograms per kg up to a maximum of 30mg should be used (elderly 250 micrograms per kg up to a maximum of 15mg).

The intravenous route should NOT be used because of the risk of respiratory depression.

The emergency team or ambulance should be called according to local procedure.

The dose of rectal diazepam can be repeated **after 15 minutes** if necessary. No further doses should then be administered within the next 12 hours without obtaining specialist advice. Where rectal diazepam has been used any further reduction of oral benzodiazepine should be delayed for 24 to 48 hours in order to reduce the risk of further seizures.

9.1.4 Prophylaxis treatment of reflux oesophagitis

Lansoprazole 15 to 30mg capsule, orally, once daily (15mg in moderate to severe liver disease) for 7 days
Or
Omeprazole 20mg capsule, orally, once daily (10mg in moderate to severe liver disease) for 7 days

Patients with **moderate or severe liver disease** should be kept under regular supervision.

9.1.5 Nausea and vomiting

Buccal prochlorperazine 3mg 1 to 2 tablets twice daily (buccal).

9.2 Nicotine replacement therapy

As of February 2014 CWP NHS Foundation Trust went smoke free. This means that no-one is permitted to smoke under any circumstances whilst on Trust property
See CWP strategy about smoke free NHS (CP28)

MP14: Nicotine Replacement Therapy (NRT)

NICE recommends varenicline within its licensed indications as an option for smokers who have expressed a desire to quit smoking (TA123). From the Champix® Summary of Product Characteristics on the Electronic Medicines Compendium "The safety and efficacy of CHAMPIX® in patients with serious psychiatric illness such as schizophrenia, bipolar disorder and major depressive disorder has not been established". Due to the above information, we do not currently consider this medication to be appropriate for prescribing in the acute care setting of a Mental Health Trust. Across the CWP footprint, there are guidelines for prescribing Varenicline in the Primary care environment.

9.3 Opioid substitution

For more comprehensive information please see DA4 Buprenorphine and Buprenorphine Naloxone combination Suboxone prescribing guidance

And

MP8 Policy for in-patient and out of hours management of adult drug misusers

NICE recommend the use of buprenorphine as part of the treatment of opiate dependence provided it is more beneficial to the patient than oral methadone would be, this includes patient preference**.** Consequently, patients should only be prescribed buprenorphine if it is felt that this offers clear advantages to methadone. If both drugs are equally suitable, methadone should be prescribed as first choice – thus based on NICE Technical Appraisal Guidance 114 **(TA114),** allied with costs the choice of medication is:

- 1st line – Methadone;
- 2nd line – Buprenorphine (generic) supervised / unsupervised;
- 3rd line – Buprenorphine / Naloxone combination (Suboxone), if supervised facilities are not available.

Other Drug and Alcohol services medicines policies within CWP include:

DA1 – Guidance for the care of pregnant women who have an alcohol misuse problem.
DA2 – Guidance on the management of Benzodiazepine dependence and withdrawal
DA3 – Guidance for community alcohol detoxification in patients with complex needs

9.4 Core Community Drugs Team Formulary List.

As part of the rational prescribing of medication, the Monitoring Prescribing in Community Drugs Teams sub-group of the MMG have agreed a formulary list of medicines depicting their place across the health economy.

9.4.1 Routine CDT Formulary

Methadone Oral Solution/mixture (1mg/1mL)
Methadone Mixture 1mg/1mL S/F
Buprenorphine (400micrograms; 2mg and 8mg) tablets
Suboxone (3rd line)
Diazepam (2mg tabs only)
Thiamine tablets
Vitamin B Co Strong tablets
Pabrinex IM injection
Chlordiazepoxide
Oxazepam (Alcohol detoxification with hepatic insufficiency)
Metoclopramide tablets
Temazepam
Lorazepam
Rectal diazepam
Naltrexone 50mg tablets (licensed generic should be prescribed for alcohol detoxification)

9.4.2 Preparations less routinely prescribed

Methadone Tablets (5mg) – (Off-label use)
Methadone Ampoules (Various strengths 10mg (10mg/mL); 20mg (10mg/mL); 35mg (35mg/3.5mL); 50mg (50mg/1mL and 50mg/5mL)
Water for injections
Dexamfetamine (Restricted use)
Diazepam 5/10mg tablets – With explanation to GP
Lofexidine

9.4.3 Medication that may be appropriate to prescribe on an ad hoc basis

Penicillin V (500mg) - Indications clearly marked
Flucloxacillin (500mg) - Indications clearly marked
Hyoscine butylbromide tablets
Prochlorperazine buccal tablets
Quinine sulphate tablets
Lansoprazole /Omeprazole (depending on local health economy)
Carbamazepine
Loperamide
Trimipramine
Propranolol
Domperidone

9.4.4 Medication currently prescribed which could be transferred over to primary care

Mirtazapine (15mg; 30mg and 45mg)
Fluoxetine 20mg
Citalopram
Sertraline
Clomipramine
Venlafaxine (IR and MR) **Tablets only**
Antipsychotics (typical and atypical)
Zopiclone (within NICE guidance)
Tramadol (for analgesia – Note: From **June 2014 now a Controlled Drug)**
Amitriptyline
Nitrazepam
Morphine sulphate preparations (tablet, capsules MR, immediate release, liquid for pain management)
Codeine (for analgesia)
Dihydrocodeine (for analgesia)

4.9.5 Restricted (Non /Formulary) – patients to be reviewed/MMG approval

MXL (Named patient list only - restricted)
MST continuous ((Named patient list only - restricted)
Diamorphine HCL (Reefers, tablets ampoules, powders) (NF- restricted)
Diconal
Oxycodone
Pregabalin
Zomorph (Modified release morphine sulphate – Named patient list only - restricted)
Morphine sulphate immediate release tablets/liquid for dependence

10. Drugs for dementia

The National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 42 **(CG42*)*** Dementia has been amended to incorporate the updated NICE technology appraisal of drugs for Alzheimer's disease, published in March 2011(TA217**)**

For Trust dementia pathway contact pharmacy team

10.1 Treating Behavioural and Psychological Symptoms in dementia (BPSD)

The challenging behaviour pathway is contained within the Dementia pathway above. It consists of a flowchart and provides advice on assessing and treating challenging behaviours in dementia (also known as Behavioural and Psychological Symptoms in Dementia - BPSD) which incorporates guidance on use and review of antipsychotic medications

General Principles:
Most BPSD are time-limited, so long term treatment is not always necessary.
Review treatment every 3 months as per the Royal College of Psychiatry Guidance.
Alzheimer's Society provides support to carers **www.alzheimers.org.uk**
If using drugs, then need to be aware that most are used "off-licence" please refer to **MP9: Policy for the initiation and maintenance of prescribing medicines for off label indications licensed medicines for unlicensed indication.** Off-label use should be documented including discussion of risks e.g. the increased risk of stroke with antipsychotics and benefits with patient &/or carers.

Risperidone is licensed for up to 6 weeks for aggression in Alzheimer's disease.
Note: This does not indicate that it is safer than other antipsychotics

If using medicines, then use the "Three Ts" approach

- Target Individual Symptoms
- Titrate dosage slowly. Start low, go slow. Increase (or decrease) dose every week or month by a small amount.
- Time-limited treatment

10.2 Specific Medicine Treatment Issues

- Typical antipsychotic medications are known to accelerate the cognitive decline and have an increased risk of long-term movement disorders in patients with dementia

- The balance of risks and benefits should be considered before prescribing antipsychotic drugs for older patients. In older patients with dementia, antipsychotic drugs are associated with a small increase in mortality and an increased risk of stroke or Transient Ischaemic Attacks (TIA)

- Tricyclic antidepressants (TCAs) may precipitate delirium in patients with dementia and should be avoided. Selective Serotonin Reuptake Inhibitors (SSRIs) are therefore the preferred choice in this patient group.

10.3 Treatment of Alzheimer's disease

NICE guidance **TA217** from 2011 updates and **replaces NICE technology appraisal guidance 111** issued in November 2006 (amended September 2007, August 2009).

Donepezil, galantamine and rivastigmine are now recommended as options for managing mild as well as moderate Alzheimer's disease, and memantine is now recommended as an option for managing moderate Alzheimer's disease for people who cannot take AChEi (Acetylcholinesterase inhibitors) , and as an option for managing severe Alzheimer's disease

Note: If prescribing an AChEi, should normally be start with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started).

10.3.1 Mild to moderate

First line

Donepezil, orally, 5mg once daily at bedtime, increased if necessary after one month to max. 10mg daily

**Orodispersible tablets should be reserved for those with swallowing difficulties or concordance with ordinary tablets. In all cases the generic orodispersible tablet should be prescribed unless there is a documented reason in the clinical notes for the branded product to be prescribed and supplied.*

Second line

Rivastigmine capsules

- Orally, 1.5mg twice daily, increased in steps of 1.5mg twice daily at intervals of at least 2 weeks according to response and tolerance; usual range 3 to 6mg twice daily; max 6mg twice daily.
- Patch, apply 4.6mg/24 hours patch to clean, dry, non-hairy, non-irritated skin on back, upper arm, or chest. Remove after 24 hours and put new patch in a different area. If well tolerated increase to 9.5mg/24 hours after at least 4 weeks. *Rivastigmine patch is restricted to those unable to tolerate oral medication or those with swallowing difficulties*.

Third line

Galantamine tablets, orally, 4mg twice daily for 4 weeks; maintenance 8 to 12mg twice daily.

This is available as a twice daily tablet and a MR once daily capsule. *The MR capsule should be reserved for those with difficulty taking the medicine twice daily.*

- **If donepezil is not prescribed the rationale for prescribing one of the alternative acetylcholinesterase inhibitors must be documented and details shared with the GP.**

10.3.2 Moderate to severe

Memantine, orally, 5mg once daily, increased in steps of 5mg at weekly intervals to maximum dose of 20mg daily

It is indicated in people who are unable to take acetylcholinesterase inhibitors because they are not tolerated or have been ineffective and for patients with severe disease.

Note: Combination treatment with memantine and an acetylcholinesterase inhibitor is not recommended

10.4 People with other dementias

- The use of anti-dementia drugs in conditions other than Alzheimer's disease is not recommended for cognitive symptoms by NICE, although they may be considered people with DLB (Dementia of Lewy Body type) who have non-cognitive symptoms causing significant distress or leading to behaviour that challenges **(CG42)** – Note this is off-label use of a licensed medication
- Dementia associated with Parkinson's Disease (see NICE guidance for Parkinson's Disease) **(CG35)**

Note: **Rivastigmine** is licensed for symptomatic treatment of mild to moderately severe dementia in patients with idiopathic Parkinson's disease