The **Black Book** of Psychotropic Dosing and Monitoring 2018

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In an effort to allow for the widest distribution of these guidelines, the authors have modified the originally printed material to more closely conform to the limitations of product labeling. For many of the drugs discussed herein, initiation at lower doses may increase tolerability and efficacy.

The **Black Book** of Psychotropic Dosing and Monitoring 2018

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Introduction

Current Psychotropic Dosing and Monitoring Guidelines

By Alan F. Schatzberg, MD
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Psychopharmacology Bulletin is well into its sixth decade of publishing. During that time, psychopharmacology has advanced as a medical discipline by maximizing research into the biological causes of psychiatric disorders.

For many academics and clinicians, biological and psychopharmacological approaches have become the mainstay of psychiatry. The profound shift in the treatment of psychiatric disorders has been fueled by new developments that have come in several forms—from novel drugs to new indications for older agents. Advanced formulations of previously released drugs may now allow for more convenient dosing and administration.

Since the last update of *The Black Book* in 2007, new psychotropics have expanded existing classes of drugs, while others have challenged the well-worn nomenclature of psychiatric agents. For example, the first serotonin–norepinephrine reuptake inhibitor (SNRI), venlafaxine, was introduced in 1994. Since then, other SNRIs like **atomoxetine (Strattera)**—a norepinephrine-predominant SNRI used in the treatment of ADHD since 2002—and, two years later, **Duloxetine (Cymbalta)** were approved for the treatment of depression, neuropathic pain, major depressive disorder (MDD), generalized anxiety disorder (GAD), diabetic neuropathy, chronic musculoskeletal pain, including chronic osteoarthritis pain and chronic lower back pain. Four years later, the FDA approved **desvenlafaxine (Pristiq)**—the active metabolite of venlafaxine, followed

by **milnacipran (Savella, Toledomin, Ixel)** for the treatment of depression and fibromyalgia. **Levomilnacipran (Fetzima)**—the levorotating isomer of milnacipran—was approved by the FDA for treatment of MDD in July 2013.

Two neuroscience-based nomenclature serotonin multimodal (S-MM) agents have been approved for MDD: **vilazodone (Viibryd)** and **vortioxetine (Trintellix, formerly Brintellix)**. Vilazodone is a serotonin partial agonist reuptake inhibitor (SPARI) and a dual-acting 5HT1A partial agonist, used for MDD and off-label for anxiety and obsessive-compulsive disorder (OCD). Like vortioxetine, vilazodone has a beneficial profile as it applies to weight gain and sedation. Threatening side effects such as seizures, induction of mania, and activation of suicidal ideation, are rarely seen in either agent. Vortioxetine is used off-label for generalized anxiety disorder, cognitive symptoms associated with depression, and geriatric depression. Sexual dysfunction has been noted in some patients, but at significantly lower rates than for SSRI-class antidepressants. Vortioxetine's pro-cognitive side effects and use in the elderly are especially notable. Equally worthy of mention is **Flibanserin (Addyi)**, the first FDA-approved agent for generalized hypoactive sexual desire disorder (HSDD) in premenopausal women.

Second-generation antipsychotics (SGAs/atypicals), which include **clozapine (Clozaril)**, **olanzapine (Zyprexa)**, **risperidone (Risperdal)**, **quetiapine (Seroquel)**, **ziprasidone (Geodone)**, **aripiprazole (Abilify)**—and, more recently, **paliperidone (Invega)**, **iloperidone (Fanapt)**, **lurasidone (Latuda)**, and **asenapine (Saphris)** have now largely supplanted first-generation "typical" antipsychotics such as perphenazine and haloperidol. The SGAs may be more helpful than typical agents in treating the negative symptoms of schizophrenia, but not all clinical trials bear that out. Perhaps of the most importance, it is clear that virtually all of the SGAs are effective antimanic drugs and probably work faster than mood-stabilizing agents such as lithium.

The anticonvulsant class of agents have been a source of great study in the treatment of bipolar disorder since the anticonvulsant, **lamotrigine (Lamictal)**, became only the second drug approved for use in the maintenance and treatment in bipolar patients. Other anticonvulsant-class drugs are being studied. They include **gabapentin (Neurontin)**, **pregabalin (Lyrica)**, **topiramate (Topamax)**, **tiagabine (Gabitril)**, **ethosuximide (Zarontin)**, **zonisamide (Zonegran, Excegran)**, and **levetiracetam (Keppra)**.

For the purposes of the *2018 Black Book*, the advance toward effective and well-tolerated anxiolytics and hypnotics has been stymied for a variety of reasons. Although clinicians have a number of effective anti-anxiety agents to choose from, there are still significant limitations to the available agents. The benzodiazepines, while rapidly acting and effective, carry the risk of dependence and cognitive side effects. Antipsychotics have well-known limitations and are considered third-line agents. Many clinicians regard buspirone as a weak anxiolytic at best.

For the past 30 years, the efforts to develop better hypnotics have focused entirely on chemicals that bind to some form of benzodiazepine receptor. So far, this systematic approach has yielded a handful of agents—**zolpidem (Ambien)**, **zaleplon (Sonata)**, and **eszopiclone (Lunesta), and zopiclone (Imovane)**—that are active at benzoreceptors but are not chemically benzodiazepines. Though none of these agents is remarkably different from benzodiazepines, the non-benzo hypnotics have some advantages in that they are less likely to cause rebound insomnia or to exacerbate obstructive airway problems through muscle relaxation, and may show continued efficacy, when given nightly, for much longer.

Along with benzodiazepines, stimulants continue to pose unique problems for the clinician. The good news is that a number of new stimulant dosing options have become available over the last 10 years. Novartis, the manufacturer of **Ritalin** and **Ritalin SR**, has developed **Ritalin LA** (long acting), designed to release half of each dosage quickly and the other half slowly. Novartis has also obtained pure

d-methylphenidate (**Focalin**), which is twice as potent as racemic Ritalin.

To add options (and perhaps confusion) to the field, Celltech pharmaceuticals introduced a long-acting **methylphenidate (Metadate CD)**, which produces about eight hours of effect. A transdermal methylphenidate patch, Daytrana, has recently become available. **Lisdexamfetamine (Vyvanse)** represents another approach: once-a-day dosing. Lisdexamfetamine is essentially a pro-drug that is metabolized to dextroamphetamine. It has been studied in ADHD and shown to be effective at doses of 30–70 mg taken in the morning. (500) In 2009, **guanfacine (Intuniv, Tenex)**, in its extended-release formulation, became the second non-stimulant to be approved for the treatment of ADHD. Guanfacine, used historically as an antihypertensive, may signal an area of future research.

New to this edition is the inclusion of drugs used for substance use disorders. These agents are new and frequent subjects in the popular press, but they remain a frustrating lesson in incremental progress for experts in the field. The most positive research into opiate addictions is the continuing results of **buprenorphine (Suboxon, Probuphine implant)** therapy as an alternative to methadone treatment. Buprenorphine, **Butrans (transdermal patch)**, and **Suboxone (buprenorphine and naloxonel, a mixed agonist-antagonist)** have allowed for the possibility of an office-based treatment outside of highly regulated methadone clinics. Studies support that outpatient buprenorphine treatment is highly effective in reducing relapse and may be safer than methadone treatment (Bell et al. 2009; Parran et al. 2010). The drug given usually at dosages of 6–20 mg/day, with a target dosage of around 16 mg/day.

New medications for dementia and Alzheimer's disease (AZ) continue to confound researchers, despite vigorous efforts. Since the mid-1990s, the FDA has approved a number of cholinesterase inhibitors (CIs) to treat mild to moderate AZ have been approved by the FDA. Currently, the most commonly prescribed CI is **donepezil (Aricept)**, which has shown to have a modest effect in slowing the

progression of AZ. Two other CIs, **rivastigmine (Exelon)**, and **galantamine (Reminyl)**, have been equally unsuccessful in slowing the progression of AZ, but they do show an improvement in the quality of life in some patients. In 2003, **memantine (Namenda)** became the first drug to be approved for moderate to severe AZ. Memantine is a moderate N-methyl-D-aspartate (NMDA) antagonist that is thought to mitigate the toxic effects of increased calcium flow into neurons by blocking NMDA receptors. Memantine appears to improve cognition significantly more than placebo in patients with moderate or more severe dementia.

Additionally, patients who are already taking a CI, appear to improve with the addition of memantine (Reisberg et al. 2003, Tariot et al. 2004).

Two high-profile clinical trials into new AZ drugs manufactured by major pharmaceutical companies were discontinued recently. The most promising new AZ drug on the horizon is **Biogen's aducanumab**—an antiamyloid drug. Biogen's data from early Alzheimer's disease patients who have been taking the drug for two to three years is promising. Aducanumab is currently being evaluated in two global Phase III studies, ENGAGE and EMERGE, with the first data emerging sometime after 2020.

The jury is still out on anorexiants as effective weight management tools. New agents such as **lorcaserin (Belviq, Belviq XR)** join newly approved dual compounds such as **naltrexone-bupropion (Contrave)** and **phentermine-topiramate (Qsymia)** in the quest to ally one of the holy grails of medicine, obesity.

The 2018 Black Book provides practical information regarding many different psychotropic drugs. We have included information derived from our reading of the psychiatric literature as well as from our own clinical practice. As with previous editions, the 2018 edition of this monograph is aimed at providing the clinician with an up-to-date set of tables and the framework for applying an ever-expanding list of psychotropic agents in clinical practice.

This work is written as a practical, usable, clinical guide. We have provided at the end of *The Black Book* a list of selected, relevant articles and books for readers who want to go beyond the material presented here.

— Editorial Director, *James M. La Rossa Jr., contributed to the 2018 update of* **The Black Book**

Dosage Ranges

Table 1: PSYCHOTROPIC DRUG DOSAGE RANGES

Generic	Brand Name	Dosage Range* (mg/day)
Alprazolam	Xanax Xanax XR	1–4
Amantadine	Symmetrel	100–300
Amisulpride	Soilan	400–1200
Amitriptyline	Elavil	50–300
Amoxapine	Asendin	200–600
Amphetamine-D	Dexedrine	5–40
Amphetamine/ dextroamphetamine	Adderall Adderall Xr	5–40
Aripiprazole	Abilify	2–30
Armodafinil	Nuvigil	150–250
Asenapine	Saphris	10–20
Atomexetine	Strattera	40–100[b]
Benztropin	Cogentin	0.5–6
Biperiden	Akineton	2–24
Blonanserin	Lonasen	8–16
Brexpiprazole	Rexulti	2–4
Buprenorphine	Suboxon (w/Naloxone) Probuphine Implant	8–32
Bupropion	Wellbutrin Wellbutrin SR Wellbutrin XL	200–450
Buspirone	BuSpar	20–60
Carbamazepine	Tegretol Tefgretol XR Carbatrol	400–1,600
Cariprazine	Vraylar	1.5–6
Chlordiazepoxide	Librium Limibitrol Librax	15–40
Chlorpromazine	Thorazine	200–800
Citalopram	Celexa	20–40
Clomipramine	Anafranil	100–250
Clonazepam	Klonopin	0.5–4
Clonidine	Catapres Kapvay Duraclon (Injectable)	0.1–0.4
Clorazepate	Azene Tranxene	15–60
Clozapine	Clozaril Leponex Versacloz (oral suspension) Fazaclo ODT (oral tablets)	25–700
Desipramine	Norpramin	100–300
Desvenlafaxine	Prestiq	50–100
Dextromethorphan	Nuedexta	10–20
Diazepam	Valium	4–40
Diphenhydramine	Benadryl Sominex injection:	50 10–50
D-methamphetamine	Desoxyn	20–25
Disulfiram	Antabuse	250–500

Generic	Brand Name	Dosage Range* (mg/day)
Donepezil	Aricept	5–10
Doxepin	Sinequan Silenor	75–150
Droperidol	Inapsine	2.5–15
Duloxetine	Cymbalta	60–120
Escitalopram	Lexapro	10–40
Estazolam	ProSom	1–4
Eszopiclone	Lunesta	1–3
Ethosuximide	Zarontin	15–40
Flibanserin	Addyi	100
Fluoxetine	Prozac Sarafem	20–80
Flupenthixol	Depixol	3–6
Fluphenazine	Prolixin	1–40
Fluphenazine decanoate	Prolixin Decanaote	1–20
Flurazepam	Dalmane	15–30
Fluvoxamine	Luvox Luvox CR	100–300
Gabapentin	Neurontin Gralise (XR) Horizant (XR)	900–3,600
Galantamine	Reminyl Razadyne	16–24
Guanfacine XR	Intuniv Tenex	1–4
Haloperidol	Haldol	1–40
Haloperidol decanoate	Haldol Decanaote	50–100 mg/mL
Hydroxyzine	Atarax Marax Vistaril	50–100
Iloperidone	Fanapt	12–32
Imipramine	Tofranil	150–300
Imipramine Pamoate	Tofranil-PM	150–300
Isocarboxazid	Marplan	40–60
Lamotrigine	Lamictal Lamictal ODT Lamictal XR	100–400
Levetiracetam	Keppra Keppra XR	1000–3000
Levomilnacipran	Fetzima	40–120
Lisdexamfetamine	Vyvanse	30–70
Lithium carbonate	Eskalith Eskalith CR Lithobid (slow release)	600–1,800
Lofepramine	Deprimyl Gamanil	140–210
Lorazepam	Ativan	1–6
Loxapine	Loxitane, Adasuve	20–250
Lurasidone	Latuda	20–80
Maprotiline	Ludiomil	75–225
Memantine	Namenda Namenda XR	5–28

Table 1: PSYCHOTROPIC DRUG DOSAGE RANGES *(CONT'D)*

Generic	Brand Name	Dosage Range* (mg/day)
Mesoridazine	Serentil Lidanil	100–400
Methylphenidate (D, L)	Concerta Ritalin, Ritalin-SR Ritalin LA, Metadate ER Metadate CD Methylin (chewable) Methylin ER Daytrana (Trans. Patch) Focalin Focalin XR	18–72 10–60 20–60 5–30 10–40
Mianserin	Lerivon	30–90
Milnacipran	Savella Ixel Toledomin	100–200
Mirtazapine	Remeron	15–45
Moclobemide	Aurorix Arima Manerix	300–600
Modafinil	Provigil Alertec Modiodal	50–800
Molindone	Moban	40–225
Naltrexone	Revia	50–150
	Vivitrol (injection)	380 mg/4 wks
Naltrexone-Buproprion	Contrave	16/180 bid
Nefazodone	Dutonin	300–600
Nortriptyline	Pamelor	50–300
Olanzapine	Zyprexa	5–20
	Symbyax (olanzapine-fluoxetine)	6–12/25–50
Oxazepam	Serax	15–120
Oxcarbazepine	Trileptal Oxtellar XR	600–2400
Paliperidone	Invega	6–12
Paliperidone palmitate	Invega Sustenna	
Paroxetine Paxil CR	Paxil	20–50
Perphenazine	Trilafon	12–64
Phenelzine	Nardil	45–90
Pimavanserin	Nuplazid	34
Pimozide	Orap	1–10
Pregabalin	Lyrica	150–600
Procyclidine	Kemadrin	5–20
Propranolol	Inderal InnoPran XL	40–400
Protriptyline	Triptil Vivactil	15–60
Quazepam	Doral	7.5–30
Quetiapine	Seroquel Seroquel XR	50–800

Generic	Brand Name	Dosage Range* (mg/day)
Ramelteon	Rozerem	8
Reboxetine	Norebox Erdonax	2–10
Risperidone	Risperdal Risperdal M-Tab Risperdal Consta	2–16
Rivastigmine	Exelon	6–12
Selegiline	Eldepryl Emsam (patch)	20–60
Sertindole	Serdolect	12–24
Sertraline	Zoloft	50–200
Sodium Oxybate	Xyrem	6–9 g/night
Sulpiride	Dolmatil	150–2400
Suvorexant	Belsomra	10–20
Tasimelteon	Hetilioz	20
Temazepam	Restoril	15–30
Thioridazine	Mellaril	200–800
Thiothixene	Navane	5–60
Tiagabine	Gabitril	4–56
Tianeptine	Coaxil Stablon Tatinol	37.5
Topiramate	Topamax Qudexy XR Trokendi XR	200–400
Tranylcypromine	Parnate	30–60
Trazodone	Desyrel	150–600
Trazadone XR	Oleptro	150–375
Triazolam	Halcion	0.125–0.5
Trifluoperazine	Stelazine	2–6
Trihexyphenidyl	Artane	2–30
Trimipramine Maleate	Surmontil	50–300
Valproic Acid/750–4,200 Valproate sodium Divalproex sodium	Depakene Depacon Depakote	500–1500
Venlafaxine	Effexor, Effexor XR	75–375
Varenicline	Chantix	0.5–4
Vilazodone	Viibryd	40
Vortioxetine	Trintellix	10–20
Zaleplon	Sonata	10–20
Ziprasidone	Geodon	40–200
Zolpidem	Ambien Ambien-CR	5–10
Zonisamide	Zonegran Excegran	100–600
Zopiclone	Imovane	7.5
Zotepine	Lodopin Zoleptil	75–300
Zuclopenthixol	Clopixol	20–60

Antidepressants

Table 2: MOOD DISORDERS—ANTIDEPRESSANTS: NAMES, FORMULATIONS, STRENGTHS, AND DOSAGES

Generic Name	Brand[a] Name	Formulations[b] and Strengths	Usual Therapeutic Dosage (mg/day)[c]
A: SSRIs			
citalopram	Celexa	Tablets: 10, 20, 40 mg Oral solution: 10 mg/5 mL (240-mL bottle)	20–40
escitalopram	Lexapro	Tablets: 5, 10, 20 mg Oral solution: 5 mg/5 mL (240-mL bottle)	
fluoxetine	Prozac	Capsules: 10, 20, 40 mg Capsule (weekly): 90 mg Oral solution: 20 mg/5 mL (120-mL bottle) Tablets: 10, 20 mg	20–60
fluvoxamine	Luvox Luvox CR	Tablets: 25, 50, 100 mg Tablets: 100, 150 mg	100–200
paroxetine	Paxil	Tablets: 10, 20,30, 40 mg Oral suspension: 10 mg/5 mL (250-mL bottle)	20–50
	Paxil-CR (controlled-release)	Tablets: 12.5, 25, 37.5 mg	
sertraline	Zoloft	Tablets: 25, 50, 100 mg Oral concentrate: 20 mg/mL (60-mL bottle)	50–200
5-HT$_2$ antagonists			
nefazodone	Generic only	Tablets: 50, 100, 150, 200, 250 mg	300–500
trazodone	Generic only	Tablets: 50, 100, 150,[d] 300[d] mg	150–300
	Oleptro (extended release)	Tablets (scored): 150, 300 mg	150–375
Other			
bupropion	Wellbutrin and generic	Tablets; 75, 100 mg	200–450
	Wellbutrin SR (sustained-release)	Tablets: 100, 150, 200 mg	
	Wellbutrin XL (extended-release)	Tablets: 150, 300 mg	
mirtazapine	Remeron	Tablets: 7.5, 15, 30, 45 mg Soltabs: 15, 30, 45 mg	15–45
vortioxetine	Brintellix	Tablets: 5, 10, 20 mg	10–20
vilazodone	Viibryd	Tablets: 10, 20, 40 mg	40

Generic Name	Brand[a] Name	Formulations[b] and Strengths	Usual Therapeutic Dosage (mg/day)[c]
B: SNRIs			
venlafaxine	Effexor Effexor-XR (sustained-release) and generic	Tablets: 25, 37.5, 50, 75, 100 mg Capsules: 37.5, 75, 150 mg	75–375
desvenlafaxine	Prestiq	Tablets (extended release): 50, 100 mg	50–100
duloxetine	Cymbalta	Capsules: 20, 30, 60 mg	60–120
levomilnacipran	Fetzima	Capsules: 20, 40, 80, 120 mg	40–120
milnacipran[e]	Savella	Tablets: 12.5,25, 50, 100 mg	100–200
C: Tricyclics			
amitriptyline	Elavil	Tablets: 10, 25, 50, 75, 100, 150 mg	150–300
clomipramine	Anafranil	Capsules: 25, 50, 75 mg	100–250
desipramine	Norpramin	Tablets: 10, 25, 50, 75, 100, 150 mg	150–300
doxepin	Sinequan	Capsules: 10, 25, 50, 75, 100, 150 mg Oral solution: 10 mg/mL (120-mL bottle)	150–300
imipramine	Tofranil	Tablets: 10, 25, 50 mg	150–300
imipramine pamoate	Tofranil-PM[f]	Capsules: 75, 100, 125, 150 mg	150–300
nortriptyline	Aventyl, Pamelor	Capsules: 10, 25, 50, 75 mg Oral solution: 10 mg/5 mL (480-mL bottle)	50–150
protriptyline	Vivactil	Tablets: 5, 10 mg	15–60
trimipramine maleate	Surmontil	Capsules: 25, 50, 100 mg	150–300
D: Tetracyclics			
amoxapine	Asendin	Tablets: 25, 50, 100, 150 mg	150–400
maprotiline	Ludiomil	Tablets: 25, 50, 75 mg	150–225

Generic Name	Brand Name	Tablets and Capsules	Oral Concentrate	Usual Therapeutic Dosage (mg/day)[b]
E: MAOIS				
phenelzine	Nardil	Tablet: 15 mg	None	45–90
selegiline	Eldepryl	Capsule: 5 mg	None	20–50
	Carbex	Tablet: 5 mg		
	Zelapar	Orally disintegrating tablet: 1.25 mg		

Table 2: MOOD DISORDERS—ANTIDEPRESSANTS: NAMES, FORMULATIONS, STRENGTHS, AND DOSAGES *(CONT'D)*

Generic Name	Brand Name	Tablets and Capsules	Oral Concen-trate	Usual Therapeutic Dosage (mg/day)[b]
	Emsam	Patch: 6 mg/24 hr, 9 mg/24 hr, 12 mg/24 hr		
tranylcypromine	Parnate	Tablet: 10 mg	None	30–60
isocarboxazid	Marplan	Tablet: 10 mg	None	30–60

Note: 5-HT_2 = serotonin$_2$ receptor.
[a]All the tricyclic and tetracyclic antidepressants shown are available generically. Most of the brand name drugs listed have been discontinued.
[b]Not available in an injectable form.
[c]Dosage ranges are approximate. Many patients will respond at relatively low dosages (even dosages below those in ranges given above); others may require higher dosages.
[d]Trazodone also available in 150- and 300-mg divided-dose formulations.
[e]Approved for fibromyalgia; doses given are those recommended for that use.
[f]Sustained release.

Table 3: PHARMACOKINETICS OF SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)

SSRI	Half-Life (hours)	Metabolite and Its Half-Life	Peak Plasma Level (hours)	% Protein Bound
fluoxetine	24–72	norfluoxetine, 7–14 days	6–8	94
sertraline	25	*N*-desmethylsertraline, 2–3 days	6–8	95
paroxetine	<20	NA	2–8	99
fluvoxamine	15	NA	2–8	77
citalopram	35	NA	4–6	91
escitalopram	32	*S*-demethylcitalopram	5	56

Note: NA = not applicable.

Table 4: ADJUNCTIVE AGENTS FOR SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)–INDUCED SEXUAL DYSFUNCTION

Adjunctive Agent	Dosage	Studies
buspirone	20–60 mg/day	Landén et al. 1999; Norden 1994
bupropion	75–150 mg/day	Ashton and Rosen 1998; Labbate and Pollack 1994; DeBattista et al. 2005
sildenafil	50–100 mg prn	Ashton and Bennett 1999; Gupta et al. 1999; Nurnberg et al. 1999a, 1999b, 2008; Fava et al. 2006a
tadalafil	10–20 mg	Segraves et al. 2007
vardenafil	10–20 mg	Rosen et al. 2006
Ginkgo biloba	60–240 mg/day	Wheatley 2004
amantadine	100–300 mg/day	Balon 1996; Shrivastava et al. 1995
cyproheptadine	4–12 mg prn	Aizenberg et al. 1995; Keller Ashton et al. 1997
yohimbine	5.4 mg tid	Jacobsen 1992; Price and Grunhaus 1990

Table 5: INHIBITION OF CYTOCHROME P450 ENZYMES BY ANTIDEPRESSANTS

Enzyme	Drugs Metabolized	Antidepressant Inhibitors
2D6	TCAs (hydroxylation) bupropion venlafaxine thioridazine 1C antiarrhythmics β-blockers paroxetine risperidone codeine haloperidol clozapine benztropine perphenazine	fluoxetine (norfluoxetine) sertraline (desmethylsertraline) paroxetine fluvoxamine and citalopram (weakest)
1A2	caffeine theophylline phenacetin TCAs (demethylation) clozapine diazepam	fluvoxamine
3A3/4	alprazolam triazolam TCAs (demethylation) terfenadine astemizole carbamazepine erythromycin dexamethasone citalopram escitalopram cyclosporine	fluoxetine sertraline fluvoxamine nefazodone
2C19	TCAs (demethylation) warfarin tolbutamide phenytoin diazepam	fluoxetine fluvoxamine sertraline

Note: TCA = tricyclic antidepressant.

Table 6: NOREPINEPHRINE (NE) AND SEROTONIN (5-HT) REUPTAKE–BLOCKING EFFECTS OF THE NON-MAOI ANTIDEPRESSANTS

Antidepressant	NE	5-HT
amitriptyline	+	++
amoxapine	++	+
bupropion	+/–	0
citalopram/escitalopram	0	+++
clomipramine	++	+++
desipramine	+++	+
doxepin	+	+
fluoxetine	0	+++

Table 6: NOREPINEPHRINE (NE) AND SEROTONIN (5-HT) REUPTAKE–BLOCKING EFFECTS OF THE NON-MAOI ANTIDEPRESSANTS *(CONT'D)*

Antidepressant	NE	5-HT
fluvoxamine	0	+++
imipramine	+	++
levomilnacipran	++	
maprotiline	++	0
mirtazapine	+	–
nefazodone	0/+	+
nortriptyline	++	+
paroxetine	+[a]	+++
protriptyline	+++	+
sertraline	0	+++
trazodone	0	+
trimipramine	0	0
venlafaxine	+	++

Note: Data are approximations of relative activity from in vivo, in vitro, and clinical studies. Data on clomipramine include results on desmethylclomipramine on both active metabolites with pronounced effects on horadrenergic systems. In certain in vivo models, the tricyclic antidepressants (other than clomipramine) and trazodone have been reported not to block 5-HT uptake. MAOI = monoamine oxidase inhibitor. Strength of effect represented on a scale from 0 (no effect) to +++ (marked effect). +/– indicates marginal effect.
[a]Effect at high doses.

Table 7: RELATIVE RECEPTOR-BLOCKING EFFECTS OF ANTIDEPRESSANTS

Antidepressant	ACh	α_1	H_1	5-HT_1	5-HT_2
amitriptyline	+++	+++	++	+/–	+/–
amoxapine	+	++	+	+/–	+++
bupropion	0	0	0	0	0
citalopram/escitalopram	0	0	0	0	0
clomipramine	+	++	+	0	+
desipramine	+	+	+	0	+/–
doxepin	++	+++	+++	+/–	+/–
fluoxetine	0	0	0	0	+/–
fluvoxamine	0	0	0	0	0
imipramine	++	+	+	0	+/–
maprotiline	+	+	++	0	+/–
mirtazapine	0	0	+++	+	+
nefazodone	0	+	0	+	++
nortriptyline	+	+	+	+/–	+
paroxetine	+	0	0	0	0
protriptyline	+++	+	+	0	+
sertraline	0	0	0	0	0
trazodone	0	++	+/–	+	++
trimipramine	++	++	+++	0	+/–
venlafaxine	0	0	0	0	0

Note: Data are approximations of relative activity from in vivo, in vitro, and clinical studies. ACh = muscarinic acetylcholine receptor; α_1 = α_1-adrenergic receptor, H_1 = $histamine_1$ receptor; 5-HT_1 = $serotonin_1$ receptor; 5-HT_2 = $serotonin_2$ receptor. Strength of effect represented on scale from 0 (no effect) to +++ (marked effect). +/– indicates marginal effect.

Table 8: TRICYCLIC ANTIDEPRESSANTS (TCAs): OVERVIEW

Efficacy	Second- or third-line agents for MDD (FDA approved for all) Panic disorder OCD (FDA approved for clomipramine) Pain syndromes Migraine prophylaxis Enuresis (FDA approved for imipramine)
Side effects	Dry mouth, constipation, urinary retention, blurred vision, confusion Weight gain Sedation Sexual dysfunction Orthostasis Tachycardia Cardiac conduction abnormalities
Dosage and administration	Individualize with low hs dosing (25–50 mg) for imipramine and amitriptyline. Increase by 25–50 mg every 3–7 days to target dosage of 150–300 mg/day. (Nortriptyline should be started at 10–25 mg and increased, as needed, to a maximum dosage of 150 mg/day.) Monitor levels and ECGs after dose stabilized.
Safety in overdose	Lethal in overdose (induces arrhythmias). Lavage and monitor on a cardiac bed for QRS widening.
Discontinuation	Flulike and GI symptoms from cholinergic rebound. Reduce by 25–50 mg every 3 days.
Drug interactions	CNS depressants: ↑ sedation, ataxia Anticoagulants: ↑ warfarin levels Antipsychotics: ↑ TCA and antipsychotic levels Cimetidine: ↑ TCA levels Clonidine: hypertensive crisis (avoid) L-Dopa: TCAs ↓ absorption MAOIs: serotonin syndrome (avoid clomipramine; imipramine and amitriptyline may be used with close monitoring) Stimulants: ↑ TCA levels Oral contraceptives: ↑ TCA levels Quinidine: ↑ arrhythmias (avoid) SSRIs: ↑ TCA levels Sympathomimetics: ↑ arrhythmias, hypertension, tachycardia

Note: CNS = central nervous system; ECG = electrocardiogram; FDA = U.S. Food and Drug Administration; GI = gastrointestinal; MAOI = monoamine oxidase inhibitor; MDD = major depressive disorder; OCD =obsessive-compulsive disorder; SSRI = selective serotonin reuptake inhibitor.

Table 9: MONOAMINE OXIDASE INHIBITORS (MAOIs): OVERVIEW

Efficacy	Third-line agents for MDD (FDA approved for resistant depression) Social anxiety Panic disorder Second-line agents for Parkinson's disease (selegiline has FDA approval)
Side effects	Weight gain Orthostasis Sexual dysfunction Dry mouth Insomnia/somnolence Headache
Safety in overdose	Can be lethal in overdose. Hypertensive crisis, stroke, and myocardial infarction have been reported. Manage with lavage, emesis induction, and close management of blood pressure and airway.
Dosage and administration	Phenelzine: start at 15 mg bid or tid and increase by 15 mg per week to target dosage of 60–90 mg/day.
	Tranylcypromine: start at 10 mg bid or tid and increase by 10 mg per week to target dosage of 40–60 mg/day.
	Isocarboxazid: start at 10 mg bid and increase dosage, if the drug is tolerated, by 10 mg every 2–4 days to 40 mg/day by end of first week. Maximum recommended dosage is 60 mg/day, administered in divided doses.
	Selegiline transdermal system (Emsam): start with 6-mg patch daily for 4 weeks and then increase to 9-mg patch for 2 weeks, and then 12-mg patch as needed. No dietary restrictions at 6 mg/day.
Discontinuation	Flulike symptoms, hallucinations, hypomania, and dysphoria reported with sudden discontinuation. Taper dose by 25% per week.
Drug interactions	Foods containing high levels of tyramine (contraindicated) (see Table 3–14): hypertensive crisis β-Blockers: ↑ hypotension, bradycardia Oral hypoglycemics: ↑ hypoglycemic effects Bupropion (contraindicated): hypertensive crisis, seizure Carbamazepine (contraindicated): hypertensive crisis Meperidine (contraindicated): serotonin syndrome Nefazodone: possible serotonin syndrome Sympathomimetics: hypertensive crisis SSRIs (contraindicated): serotonin syndrome TCAs: clomipramine contraindicated Mirtazapine (contraindicated): hypertensive crisis SNRIs (contraindicated): serotonin syndrome

Note: FDA = U.S. Food and Drug Administration; MDD = major depressive disorder; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant.

Table 10: FOODS TO BE AVOIDED WITH MONOAMINE OXIDASE INHIBITORS (MAOIs)

Foods definitely to be avoided:
- Beer, red wine
- Aged cheeses (cottage and cream cheese are allowed)
- Dry sausage
- Fava or Italian green beans
- Brewer's yeast
- Smoked fish
- Liver (beef or chicken)

Foods that may cause problems in large amounts but are otherwise less problematic:
- Alcohol
- Ripe avocado
- Yogurt
- Bananas (ripe)
- Soy sauce

Foods that were thought to be problems but are probably not problematic in usual quantities:
- Chocolate
- Figs
- Meat tenderizers
- Caffeine-containing beverages
- Raisins

Source: Based on McCabe and Tsuang 1982.

Table 11: ANTIDEPRESSANT OVERDOSES AND THEIR MANAGEMENT

Drug	Toxic Dose	Toxicity Manifestations	Management
TCAs	>1,500 mg (imipramine and most TCAs)	Anticholinergic symptoms, arrhythmia, hypotension, delirium, seizures	Gastric lavage, fluid support, cardiac monitoring
MAOIs	≥2 mg/kg	CNS excitation, hypo- or hypertension, delirium, fever, arrhythmia, seizures, rhabdomyolysis	Gastric lavage, fluids, cardiac monitoring, antihypertensives, body cooling, benzodiazepines for CNS symptoms, maintenance of MAOI diet
Bupropion	>2 g	CNS excitation, seizures	Gastric lavage, benzodiazepines, anticonvulsants
SSRIs	Unknown	CNS excitation, somnolence, GI irritation	Gastric lavage, supportive care
SNRIs (venlafaxine, duloxetine)	Unknown	Cardiotoxicity, hypertension, seizures, serotonin effects	Gastric lavage, supportive care

Note: CNS = central nervous system; G1 = gastrointestinal; MAOI = monoamine oxidase inhibitor; SNR1 = serotonin-norepinephrine reuptake inhibitor, SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant.

Table 12: POTENTIAL AUGMENTING AGENTS FOR ANTIDEPRESSANTS

Antidepressant	Augmenting Agent
Tricyclics/tetracyclics	lithium
	thyroid supplements
	amphetamines
	SSRIs
	monoamine precursors
	MAOIs
SSRIs	lithium
	thyroid supplements
	TCAs
	trazodone
	buspirone
	pindolol
	modafinil
	stimulants
	atomoxetine/reboxetine
	SGAs
	folate
	pramipexole/ropinirole
	mirtazapine
	bupropion
	lamotrigine
	D-cycloserine
MAOIs	lithium
	SGAs
	thyroid supplements
	TCAs

Note: SGA = second-generation antipsychotic; SSRI = selective serotonin reuptake inhibitor; MAOI = monoamine oxidase inhibitor; TCA = tricyclic antidepressant.

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Table 13: COMMON ANTIDEPRESSANT DOSAGES IN CHILDREN

Drug	Dosage Range	Serum Level (ng/mL)
imipramine	1–5 mg/kg/day	150–250
desipramine	1–5 mg/kg/day	150–250
nortriptyline	0.5–2 mg/kg/day	75–150
phenelzine	0.25–1 mg/kg/day	NA
fluoxetine	5–30 mg/day	NA
bupropion	1–7 mg/kg/day	NA
citalopram	10–20 mg/day	NA

Note: NA = not applicable.

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Mood Stabilizers

Table 14: MOOD STABILIZERS: NAMES, FORMULATIONS, AND STRENGTHS

Generic Name	Brand Name
lithium carbonate[a]	Eskalith* Lithobid (slow release) Eskalith-CR* (controlled release)
lithium citrate	Generic[c]
carbamazepine[a]	Tegretol Tegretol-XR (sustained release) Carbatrol (sustained release)
valproic acid[a]	Depakene
valproate sodium	Depacon
divalproex sodium[a]	Depakote Depakote ER (sustained release)
lamotrigine[a]	Lamictal[e] Lamictal ODT[e] Lamictal XR[e] (extended release) and generic
gabapentin[a,f]	Neurontin Gralise (extended release)
gabapentin enacarbi[f]	Horizant (extended release)
oxcarbazepine[a,f]	Trileptal Oxtellar XR (extended release)
topiramate[a,f]	Topamax Qudexy XR Trokendi XR
tiagabine[a,f]	Gabitril

[a]Available in generic form.
[b]Scored tablets.
[c]Cibalith-S: brand discontinued.
[d]Equivalent to 300 mg lithium carbonate.
[e]Patient titration kits available.
[f]Not FDA approved for mood stabilization or for other psychiatric uses.
*Brand taken off the market; available in generic.

Formulations and Strengths
Capsule: 150, 300, 600 mg Tablet: 300 mg Tablet: 450 mg[b]
Syrup: 8 mEq/5 mL[d] (480-mL bottle)
Tablets: 200 mg Chewable tablet: 100, 200 mg Suspension: 100 mg/5 mL (450-mL bottle) Tablets: 100, 200, 400 mg Capsules: 100, 200, 300 mg
Capsule: 250 mg Syrup: 250 mg/5 mL (480-mL bottle)
Injection: 100 mg/mL (5-mL vial)
Enteric-coated tablets: 125, 250, 500 mg Capsule, sprinkle: 125 mg Tablets: 250, 500 mg
Chewable tablets: 2, 5, 25 mg Tablets: 25, 100, 150, 200, 250 mg Orally disintegrating tablets: 25, 50, 100, 200 mg Tablets: 25, 50, 100, 150, 200, 250, 300 mg
Capsules: 100, 300, 400 mg Tablets: 100, 300, 400, 600, 800 mg Oral solution: 250 mg/5 mL Tablets: 300, 600 mg
Tablets: 300, 600 mg
Tablets: 150, 300, 600 mg Suspension: 300 mg/5 mL Tablets: 150, 300, 600 mg
Tablets: 25, 50, 100, 200 mg Capsules, sprinkle: 15, 25 mg Capsules, sprinkle: 25, 50, 100, 150, 200 mg Capsules: 25, 50, 100, 200 mg
Tablets: 2, 4, 12, 16 mg

Table 15: NEW ANTICONVULSANTS

	Pregabalin (Lyrica)	Oxcarbazepine (Trileptal)	Gabapentin (Neurontin)
Serum plasma level, ng/mL	NA	NA	NA
Adult dosage, mg/day	150–600 300–450 given in divided doses (for fibro-myalgia) 150–300 given in divided doses (for neuropathic pain)	600–2,400	900–2,400 (for seizure maintenance treatment)
Protein binding	–	40% bound	Minimally bound (<3%)
Half-life, hours	–	2–9	5–7
Metabolic pathway	–	Hepatic CYP 3A enzyme	Drug not appreciably metabolized hepatically
Routes of elimination	–	Renal (95%); fecal (5%)	Renal
Common drug interactions	No significant drug interactions are known; antacids decrease absorption and bioavailability of pregabalin	Induces metabolism of CYP 3A3/4–dependent drugs (weaker than carba-mazepine); decreases levels of pheno-barbital, phenytoin, sex steroids, haloperidol, valproic acid, calcium channel blockers, and others (see Table 5–4)	No significant drug inter-actions are known; antacids decrease bio-availability of gabapentin by 20%; cimetidine decreases renal clearance by 13%
Common adverse effects	Somnolence, dizziness, ataxia, fatigue	Dizziness, drowsiness, ataxia, weight gain	Somnolence, dizziness, fatigue, ataxia
Indication (FDA approved)	Partial seizures Postherpetic neuralgia Fibromyalgia Neuropathic pain associated with diabetic neuropathy	Partial complex seizures	Partial seizures Postherpetic neuralgia

Note: CYP = cytochrome PH50; FDA = U.S. Food and Drug Administration; NA = not applicable.
Source. Adapted for the most part from 2002 black book.

Lamotrigine (Lamictal)	Topiramate (Topamax)	Tiagabine (Gabitril)
NA	NA	1–234
300–500 (for seizure maintenance treatment) 200 (for bipolar disorder monotherapy) 100 (concurrently with valproate for bipolar disorder) 400 (concurrently with carbamazepine or other enzyme-inducing drugs [and not taking valproate] for bipolar disorder)	200–400 (for seizure maintenance treatment) 100 given in two divided doses (for migraine prophylaxis)	4–32
55% bound	20% bound	96% bound
25–32	20–30	7–9
Glucuronidation/ conjugation	20% metabolized hepatically	Oxidation/ glucuron-idation
Renal	Renal	Urinary (25%); fecal (63%)
Valproate doubles serum levels; carbamazepine decreases serum levels by 50%; phenytoin decreases serum levels by 50%	Phenobarbital decreases serum levels by 40%; carbamazepine decreases topi-ramate levels by 50%–60%; valproate decreases topiramate levels by 15%; phenytoin decreases topiramate levels by 48%	Carbamaze-pine decreases tiagabine levels; phenytoin decreases tiagabine levels; tiagabine decreases valproate levels
Rash: 1 of 10 (serious rashes, such as Stevens-Johnson syndrome: 1 of 1,000), dizziness, ataxia, nausea, vomiting	Psychomotor slowing, decreased concentration, somnolence, fatigue, anorexia, kidney stone formation	Dizziness, depression, asthenia, nervousness, tremors, somnolence, cognitive deficits
Partial seizures Maintenance treatment of bipolar I disorder	Epilepsy Prophylaxis of migraine headaches	Epilepsy

Table 16: TOXICOLOGY OF MOOD STABILIZERS

System	Drug		
	Lithium	**Valproate**	**CBZ**
CNS	Tremor Ataxia Cognitive slowing	Sedation Tremor Ataxia	Sedation Dizziness Ataxia
GI	Dyspepsia Weight gain Diarrhea	Dyspepsia LFT increases Weight gain Hepatic failure (rare) Pancreatitis	Dyspepsia LFT increases
Dermato-logical	Rash Hair loss Acne	Rash Hair loss	Rash
Renal/ Urogenital	NDI Nephropathy	Minimal	SIADH
Cardiac	T wave changes Sinoatrial block	Minimal	Arrhythmia
Hemato-logical	Leukocytosis	Thrombo-cytopenia Coagulation defect	Thrombo-cytopenia Aplastic anemia (rare)
Endocrine	Hypothyroidism	Minimal	Lower levels of T_3,T_4

Note: 8P = blood pressure; CBZ = carbamazepine; CNS = central nervous system;
GI = gastrointestinal; LFT = liver function test; NDI = nephrogenic diabetes insipidus;
SIADH = syndrome of inappropriate antidiuretic hormone;
T_3 = triiodothyronine; T_4 = thyroxine.
[a]Secondary to hyperchloremia.

Table 17: ANTICONVULSANT DOSAGES IN BIPOLAR ILLNESS

Medication	Usual Dosage Range	Serum Level (µg/mL)
valproate	15–60 mg/kg/day	50–125
carbamazepine	200–1,600 mg/day	6–10
lamotrigine	50–200 mg/day	NA
gabapentin	900–3,600 mg/day	NA
oxcarbazepine	600–2,400 mg/day	NA

Note: NA = not applicable.

Gabapentin	Lamotrigine	Topiramate	Tiagabine
Somnolence Dizziness Ataxia	Dizziness Ataxia Somnolence	Dizziness Ataxia Speech problems Cognitive slowing	Dizziness Somnolence Difficulty concentrating
Dyspepsia (rare)	Nausea Vomiting	Nausea Dyspepsia Abdominal pain	Nausea Abdominal pain
Pruritus (rare)	Rash Acne	Rash (rare) Pruritis (rare)	Rash (rare) Alopecia
None	Vaginitis Urinary tract infection	Dysmenor-rhea Metabolic acidosis[a]	None
None	Palpitations (rare) Hypotension (rare)	BP changes (rare)	Hypertension Palpitations
Leukopenia (rare)	None	Leukopenia	None
None	Hypothyroidism (rare)	Weight decrease	Goiter (rare)

Table 18: DRUG INTERACTIONS OF ANTICONVULSANT MOOD STABILIZERS

Anticon-vulsant	Drugs That May ↑ Anticonvulsant Levels	Drugs That May ↓ Anticonvulsant Levels	Drugs Whose Blood Levels ↓ With Concurrent Anticonvulsant Use
Valproate	Aspirin Cimetidine Clarithromycin Erythromycin Fluvoxamine Fluoxetine Ibuprofen Phenothiazines Topiramate Troleandomycin	Carbamazepine Ethosuximide Oxcarbazepine Phenobarbital Phenytoin Primidone Rifampin	Zonisamide Clinically significant metabolic induction by other drugs with valproate not reported

Table 18: DRUG INTERACTIONS OF ANTICONVULSANT MOOD STABILIZERS *(CONT'D)*

Anticon-vulsant	Drugs That May ↑ Anticonvulsant Levels	Drugs That May ↓ Anticonvulsant Levels	Drugs Whose Blood Levels ↓ With Concurrent Anticonvulsant Use
Carbamazepine	Cimetidine	Felbamate	Atypical antipsychotics
	Ciprofloxacin	Phenobarbital	Benzodiazepines
	Clarithromycin	Rifampin	Doxycycline
	Diltiazem		Ethosuximide
	Doxycycline		Fentanyl
	Erythromycin		Glucocorticoids
	Fluconazole		Methadone
	Fluoxetine		Neuroleptics
	Fluvoxamine		Oral contraceptives
	Grapefruit juice		Phenytoin
	Isoniazid		Protease inhibitors
	Itraconazole		TCAs (?)
	Ketoconazole		Theophylline
Carbamazepine	Nefazodone		
	Norfloxacin		
	Prednisolone		
	Propoxyphene		
	Protease inhibitors (e.g., Ritonavir, Indinavir)		
	TCAs		
	Troleandomycin		
	Valproate		
	Verapamil		
	Warfarin		
Lamotrigine	Valproate	Carbamazepine	Valproate
		Ethosuximide	
		oral Contraceptives	
		Oxcarbazepine	
		Phenobarbital	
		Phenytoin	
		Primidone	
Oxcarbazepine			Ethinyl estradiol levonorgestrel
Topiramate			Oral contraceptives

Note: TCAs = tricyclic antidepressants; ↑ = increase; ↓ = decrease.

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Table 19: COMMON MOOD STABILIZER DOSAGES IN CHILDREN

Drug	Dosage Range	Serum Level
lithium	300–2,400 mg/day	0.5–1.2 mEq/L
valproate	15–60 mg/kg/day	50–100 μg/mL
carbamazepine	10–50 mg/kg/day	8–12 μg/mL
oxcarbazepine	5–30 mg/kg/day (150–1,200 mg/day)	NA
lamotrigine	0.15–5.0 mg/kg/day (25–200 mg/day)	NA

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Antipsychotics

Table 20: ANTIPSYCHOTIC DRUGS: NAMES, FORMULATIONS, AND STRENGTHS

Generic Name	Brand Name
Aripiprazole	Abilify Abilify disc melt Abilify maintena
Asenapine	Saphris
Chlorpromazine	Thorazine[a]
Clozapine	Clozaril[a,b] FazaClo
Droperidol	Inapsine[a]
Fluphenazine	Prolixin[a]
Fluphenazine decanoate	Prolixin decanoate[a]
Haloperidol	Haldol[a]
Haloperidol decanoate	Haldol decanoate[a]
Iloperidone	Fanapt
Loxapine	Loxitane[a] Adasuve
Lurasidone	Latuda
Olanzapine	Zyprexa[a] Zydis[a] Zyprexa intramuscular
Paliperidone	Invega
Paliperidone palmitate	Invega Sustenna
Perphenazine	Trilafon[a]
Pimozide	Orap
Quetiapine	Seroquel[a] Seroquel XR
Risperidone	Risperdal[a] Risperdal M-TAB[a] Risperdal Consta
Thioridazine	Mellaril[a]
Thiothixene	Navane[a]
Trifluoperazine	Stelazine[a]
Ziprasidone	Geodon[a]

[a]Available in generic form.
[b]Use of clozapine must be registered with the manufacturer's monitoring national registry (see subsection "Clozapine" in this chapter).

Formulations and Strengths
Tablets: 2, 5, 10, 15, 20, 30 mg Orally disintegrating tablets: 10, 15 mg Oral solution: 1 mg/mL (150 mL) Injection: 9.75 mg/1.3 mL Intramuscular injection: 300, 400 mg
Tablets (sublingual): 5, 10 mg
Tablets: 10, 25, 50, 100, 200 mg Injection: 25 mg/mL (1-mL and 2-mL ampules)
Tablets: 25, 50, 100, 200 mg Oral suspension: 50 mg/mL Orally disintegrating tablets: 12.5, 25, 50, 100, 150, 200 mg
Injection: 2.5 mg/mL (1- and 2-mL ampules and vials)
Tablets: 1, 2.5, 5, 10 mg Concentrate: 5 mg/mL (120-mL bottle) Elixir: 2.5 mg/5 mL (60-mL and 473-mL bottles) Injection: 2.5 mg/mL (10-mL multidose vial)
Injection: 25 mg/mL (5-mL multidose vial)
Tablets: 0.5, 1, 2, 5, 10, 20 mg Concentrate: 2 mg/mL Injection: 5 mg/mL (1-mL ampule and single-dose vial; 10-mL multidose vial)
Injection: 50 mg/mL (1-mL ampule and 5-mL multidose vial), 100 mg/mL (5-mL multidose vial)
Tablets: 1, 2, 4, 6, 8, 10, 12 mg
Capsules: 5, 10, 25, 50 mg Inhalation powder: 10-mg unit in single-use inhaler; must be administered by health care professional
Tablets: 20, 40, 60, 80, 120 mg
Tablets: 2.5, 5, 7.5, 10, 15, 20 mg Orally disintegrating tablets: 5, 10, 15, 20 mg Injection: 10-mg vial (before reconstitution)
Tablets (extended release): 1.5, 3, 6, 9 mg
Injection: 39, 78, 117, 156, 234 mg
Tablets: 2, 4, 8, 16 mg
Tablets: 1, 2 mg
Tablets: 25, 50, 100, 200, 300, 400 mg Tablets (extended release): 50, 150, 200, 300, 400 mg
Tablets: 0.25, 0.5, 1, 2, 3, 4 mg Oral solution: 1 mg/mL (30-mL bottle) Orally disintegrating tablets: 0.5, 1, 2, 3, 4 mg Long-acting injectable: 12.5, 25, 37.5, 50 mg
Tablets: 10, 25, 50, 100 mg Concentrate: 30 mg/mL (120-mL bottle)
Capsules: 1, 2, 5, 10 mg
Tablets: 1, 2, 5, 10 mg
Tablets: 20, 40, 60, 80 mg Injection: 20-mg vial (before reconstitution)

Table 21: ANTIPSYCHOTIC DRUG POTENCY

Generic Name	Brand Name	Chlorpromazine Equivalence
aripiprazole	Abilify	10 mg
chlorpromazine	Thorazine	100 mg
clozapine	Clozaril	50 mg
fluphenazine hydrochloride	Prolixin	2 mg
fluphenazine decanoate	Prolixin Decanoate	0.25 cc/month
haloperidol	Haldol	2 mg
loxapine	Loxitane	10 mg
molindone	Moban	10 mg
olanzapine	Zyprexa	~5 mg
perphenazine	Trilafon	10 mg
prochlorperazine	Compazine	15 mg
quetiapine	Seroquel	63 mg
risperidone	Risperdal	0.5 mg
thioridazine	Mellaril	100 mg
thiothixene	Navane	4 mg
trifluoperazine	Stelazine	5 mg

Table 22: TYPICAL (D_2 ANTAGONIST) ANTIPSYCHOTICS: OVERVIEW

Efficacy	Schizophrenia (positive symptoms) (FDA-approved indication) Tourette's disorder (pimozide; FDA-approved indication) Mania (FDA-approved indication for chlorpromazine only) Psychotic depression (with antidepressant) Drug-induced psychosis Agitation,[a] nausea, hiccups (not FDA approved for these purposes; off-label)
Side effects	EPS (more common in high-potency drugs) NMS (rare) Dry mouth, constipation, urinary retention, sedation, weight gain (more common in low-potency drugs) Skin and eye complications QT interval prolongation (thioridazine)
Dosage and administration	Individualize dosing. 50–150 mg chlorpromazine equivalents (see Table 4–2) to start, with maximum total daily dose of 300–600 mg chlorpromazine equivalents (e.g., 6–12 mg haloperidol).
Safety in overdose	CNS depression, hypotension, ECG changes, EPS. Manage with vital sign support, gastric lavage. Do not induce emesis secondary to aspiration risk.
Drug interactions	CNS depressants: ↑ sedation Antacids: ↓ antipsychotic absorption Carbamazepine: ↓ antipsychotic levels SSRIs: ↑ antipsychotic levels Nicotine: ↓ antipsychotic levels

Table 22: TYPICAL (D_2 ANTAGONIST) ANTIPSYCHOTICS: OVERVIEW *(CONT'D)*

	Meperidine: ↑ sedation, hypotension β-Blockers: ↑ hypotension; may ↑ antipsychotic and β -blocker levels TCAs: may ↑ antipsychotic and TCA levels Valproic acid: chlorpromazine may ↑ valproic acid levels

Note: CNS = central nervous system; ECG = electrocardiogram; EPS = extrapyramidal symptoms; FDA = U.S. Food and Drug Administration; NMS = neuroleptic malignant syndrome; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant. [a]Agitation associated with psychosis: FDA-approved indication for intramuscular olanzapine only.

Table 23: SECOND-GENERATION (DOPAMINE-SEROTONIN ANTAGONIST) ANTIPSYCHOTICS: OVERVIEW

Efficacy	Schizophrenia (FDA approved for all) Treatment-resistant schizophrenia (clozapine) Mania (FDA approved for aripiprazole, asenapine, olanzapine, quetiapine, risperidone, and ziprasidone) Bipolar depression (FDA approved for lurasidone, quetiapine, and Symbyax [olanzapine-fluoxetine]) Depression/anxiety/agitation (efficacy established but not FDA approved for these purposes)
Side effects	Weight gain Gastrointestinal effects Insulin resistance Sedation Akathisia Orthostatic hypotension Bradykinesia Tachycardia Dizziness ↑ Triglycerides (except ziprasidone) EPS, NMS (rare) Agranulocytosis (clozapine) (rare) Seizures (clozapine)
Safety in overdose	Seizures with clozapine in overdose. Respiratory depression in combination with other CNS depressants. QT interval changes. Lavage and vital sign support.
Dosage and administration	Clozapine: 12.5–25 mg; then increase dosage 25–50 mg per week, as needed and tolerated, to 300–600 mg/day Risperidone: 0.5–1 mg bid to 3 mg bid by end of first week, as tolerated Olanzapine: 2.5–5 mg hs; increase by 5 mg every week to 20 mg hs Quetiapine: 25 mg bid; increase total daily dose by 50 mg, as needed and tolerated, to 300–600 mg/day Ziprasidone: 20 mg qd or bid; increase by 20–40 mg per week, to a maximum dosage of 80 mg bid Aripiprazole: 15 mg qd; increase up to 30 mg/day after 1 week Lurasidone: 20–40 mg/day; increase by 20–40 mg/day up to 120–160 mg/day

Table 23: SECOND-GENERATION (DOPAMINE-SEROTONIN ANTAGONIST) ANTIPSYCHOTICS: OVERVIEW *(CONT'D)*

	Asenapine: 5–10 mg bid sublingually and then increase by 5 mg/day to a maximum of 10 mg bid Iloperidone: 1 mg po bid day one, 2 mg bid day two, and then increase by 2 mg/day to a target dosage of 6–12 mg/day
Full benefits in 4 weeks to 6 months	
Discontinuation	Mild cholinergic rebound, faster relapse. Taper as slowly as titrated up.
Drug interactions	Fluvoxamine (1A2 inhibitor): ↑ second-generation antipsychotic levels EtOH: ↑ sedation and orthostasis Antihypertensives: may ↑ orthostasis Carbamazepine: ↓ serum levels of olanzapine; ↓ clozapine levels; ↑ hematological adverse events with clozapine CNS depressants: ↑ sedation Ciprofloxacin (Cipro) (potent 1A2 inhibitor): ↑ second-generation antipsychotic levels

Note: CNS = central nervous system; EPS = extrapyramidal symptoms; EtOH = ethanol; FDA = U.S. Food and Drug Administration; NMS = neuroleptic malignant syndrome.

Table 24: ANTIPSYCHOTIC DOSAGES IN CHILDREN

Drug	Common Pediatric Therapeutic Dosage
Chlorpromazine	0.25 mg/kg tid
Trifluoperazine	0.5–10 mg bid
Haloperidol	0.15–0.5 mg/kg/day (in divided doses [bid])
Aripiprazole	2–10 mg/day
Olanzapine	2.5–5 mg qhs
Quetiapine	25–300 mg/day
Risperidone	1–2 mg/day

Table 26: INTERACTIONS OF COMMONLY USED PSYCHOACTIVE DRUGS WITH CARDIOVASCULAR MEDICATIONS

Drug	TCA	SSRI
calcium channel blockers	Increase hypotension	NA
thiazide diuretics	May increase hypotension	NA
(β-blockers	May increase hypotension	May increase (β-blockers
reserpine, guanethidine	Antagonize antihypertensive agents	NA
clonidine, prazosin	Increase hypotension	NA
1A antiarrhythmics	Prolong cardiac conduction	NA
1C antiarrhythmics	Prolong cardiac conduction	Increase 1C levels
digitalis	Increases digoxin and TCA levels	May increase digoxin levels

Note: NA = applicable; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant.

Table 25: ANTIPARKINSONIAN DRUGS: NAMES, FORMULATIONS, STRENGTHS, AND DOSAGE RANGES

Generic Name	Brand Name	Formulations and Strengths	Usual Dosage Range (mg/day)
Primarily anticholinergic benztropine	Cogentin[a]	Tablets: 0.5, 1, 2 mg Injection: 1 mg/mL (2-mL ampule)	2–6
Biperiden	Akineton	Tablet (HCl): 2 mg	2–8
Diphenhydramine	Benadryl[b]	Tablet: 25 mg Capsules: 25, 50 mg Elixir and syrup: 12.5 mg/5 mL (120-mL and 480-mL bottles) Injection: 50 mg/mL (1-mL single-dose vial; 10-mL multidose vial; 1-mL prefilled syringe)	50–300
Trihexyphenidyl	Artane[b]	Tablets: 2, 5 mg Elixir: 2 mg/5 mL (480-mL bottle)	4–15
Dopaminergic amantadine	Symmetrel[b]	Tablet and capsule: 100 mg Syrup: 50 mg/5 mL (480-mL bottle)	100–300

[a]Tablets only available in generic form.
[b]Available in generic form.

Antipsychotic	Lithium	Carbamazepine
Increase hypotension	Raise or lower lithium levels, bradycardia	Increase carbamazepine levels
Increase hypotension	Increase lithium levels	NA
Increase antipsychotic levels	NA	Decrease (β-blocker levels
Increase hypotension	NA	Unknown
Increase hypotension	NA	Unknown
Prolong cardiac conduction	Prolong sinus recovery time	May decrease antiarrhythmic levels
May prolong cardiac conduction	Prolong sinus recovery time	May decrease antiarrhythmic levels
May increase digoxin levels	Prolongs sinus recovery time	Unknown

Anxiolytics/Hypnotics

Table 27: BENZODIAZEPINES: NAMES, FORMULATIONS, STRENGTHS, AND ANXIOLYTIC DOSAGE RANGE

Generic Name	Brand Name[a]	Formulations and Strengths	Anxiolytic Dosage Range (mg/day)[b]
2-Keto			
chlordiazepoxide	Librium	Capsules: 5, 10, 25 mg	15–40
clorazepate	Tranxene	Tablets: 3.75, 7.5, 15 mg	15–40
diazepam	Valium	Tablets: 2, 5, 10 mg Oral solution: 1 mg/mL Concentrate solution: 5 mg/5 mL (30-mL) Injection: 5 mg/mL, 10 mg/2 mL intramuscular device injection Rectal gel: 2.5, 10, 20 mg	5–40
clonazepam	Klonopin	Tablets: 0.5, 1, 2 mg Oral disintegrating tablets: 0.125, 0.25, 0.5, 1, 2 mg	
3-Hydroxy			
lorazepam	Ativan	Tablets: 0.5, 1, 2 mg Oral concentrate: 2 mg/mL (30-mL) Injection: 2 mg/mL, 4 mg/mL (both in 1-mL prefilled syringe and single-dose vial and 10-mL multidose vial)	1–6 1–2
oxazepam	Serax	Capsules: 10, 15, 30 mg	15–120
Triazolo			
alprazolam	Xanax	Tablets: 0.25, 0.5, 1, 2 mg Oral disintegrating tablets: 0.25, 0.5, 1, 2 mg Oral concentrate: 1 mg/mL	1–4
alprazolam XR	Xanax XR	Tablets: 0.5, 1, 2, 3 mg	

[a]The benzodiazepines shown are available in generic form.
[b]Approximate dosage ranges. Some patients will require higher dosages; others may respond to dosages below the range.

Table 28: BENZODIAZEPINES (E.G., DIAZEPAM, CLONAZEPAM, ALPRAZOLAM): OVERVIEW

Efficacy	Generalized anxiety (FDA approved) Panic disorder (FDA approved for alprazolam, clonazepam) Insomnia (FDA approved) Seizure disorder (FDA approved for clonazepam) Muscle relaxation Anesthesia Alcohol withdrawal

Table 28: BENZODIAZEPINES (E.G., DIAZEPAM, CLONAZEPAM, ALPRAZOLAM): OVERVIEW *(CONT'D)*

Side effects	Sedation Lethargy Dependence/Withdrawal
Safety in overdose	Safe in overdose up to 30 times the normal daily dose. Usual symptoms of overdose include sedation, drowsiness, ataxia, and slurred speech. May result in respiratory depression in combination with other CNS depressants. Management includes gastric lavage, forced emesis, and assisted ventilation.
Dosage and administration	Varies by benzodiazepine and indication; see Table 6–1.
Discontinuation	Taper by no more than 25% of total dose per week after long-term administration. Withdrawal includes insomnia, agitation, anxiety, and, rarely, seizures.
Drug interactions	Additive CNS depression with ethanol, barbiturates, and other CNS depressants Drugs that ↑ triazolo-benzodiazepine levels include; cytochrome P450 3A4 inhibitors, ketoconazole, fluconazole, nefazodone Drugs that ↓ triazolo-benzodiazepine levels include: carbamazepine

Note: CNS = central nervous system; FDA = U.S. Food and Drug Administration.

Table 29: BENZODIAZEPINES: ABSORPTION AND PHARMACOKINETICS

Generic Name	Oral Absorption	Major Active Components	Approximate Half-life (hours)[a]
2-Keto			
chlordiazepoxide	Intermediate	chlordiazepoxide desmethylchlordiazepoxide demoxepam desmethyldiazepam	20 30 Unknown 60
clorazepate	Fast	desmethyldiazepam	60
diazepam	Fast	diazepam desmethyldiazepam methyloxazepam	40 60 10
halazepam	Intermediate	desmethyldiazepam	60
prazepam	Slow	desmethyldiazepam	60
3-Hydroxy			
lorazepam	Intermediate	lorazepam	14
oxazepam	Slow to intermediate	oxazepam	9
Triazolo			
Alprazolam alprazolam XR	Intermediate	alprazolam	14

[a]Based on ranges of half-lives reported in young, psychiatrically and physically healthy volunteers.

Table 30: BENZODIAZEPINE HYPNOTICS

Generic Name	Brand Name	Formulation and Strengths	Dosage (mg/day)
flurazepam[a]	Dalmane	Capsules: 15, 30 mg	15–30
temazepam[a]	Restoril	Capsules: 7.5, 15, 22.5, 30 mg	15–30
quazepam	Doral	Tablets: 15 mg	7.5–15
triazolam[a]	Halcion	Tablets: 0.125, 0.25 mg	0.125–0.5
estazolam[a]	ProSom	Tablets: 1, 2 mg	1–4

[a]Available in generic form.

Table 31: OTHER NIGHTTIME HYPNOTIC AGENTS

Generic Name	Brand Name	Formulations and Strengths	Dosage (mg/day)[a]
zolpidem	Ambien[b] Ambien-CR Edular Zolpimist	Tablets: 5, 10 mg Tablets (extended release): 6.25, 12.5 mg Sublingual: 5, 10 mg Oral spray solution: 5 mg/spray (60 mL)	5–10
zaleplon	Sonata[b]	Capsules: 5,10 mg	5–10
eszopiclone	Lunesta[b]	Tablets: 1, 2, 3 mg	1–3
ramelteon	Rozerem	Tablet: 8 mg	8

[a]Adult dosages. Patients may require slightly higher dosages of choloral hydrate or ethchlorvynol. For child dosages, consult the latest edition of *Goodman & Gilman's*.
[b]Lower doses may be indicated when combined with potent cytochrome P450 3A4 inhibitors (e.g., fluoxetine).

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Absorption	Major Active Metabolites	Approximate Half-life (hrs)
Intermediate	hydroxyethylflurazepam desalkylflurazepam	1 100
Intermediate	None	8
Intermediate	oxoquazepam desalkyloxoquazepam	39 73
Intermediate	—	3
Intermediate	—	16

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Anorexiants/Psychostimulants and Alzheimer's Agents

Table 32: ANOREXIANTS

Agent	Dosage Range (mg/day)	Indication
Lorcaserin (Belviq, Belviq XR)	20–40	Obesity
Naltrexone-Bupropion (Contrave)	16/180 bid	Obesity
Phendimetrazine (various)	70–105	Obesity
Phentermine-topiramate (Qsymia)	3.75/23–15/92	Obesity
Zonisamide (Zonegran, Excegran)	100–600	Obesity

Table 33: STIMULANTS: NAMES, FORMULATIONS, AND STRENGTHS

Generic Name	Brand Name
D-amphetamine[a]	Dexedrine Spansule (sustained release)
	Immediate release
amphetamine/dextroamphetamine[a,b]	Adderall
	Adderall XR
D-methamphetamine[a]	Desoxyn
Methylphenidate[a]	Ritalin
	Methylin
	Methylin ER
	Ritalin SR
	Ritalin LA
	Metadate ER
	Metadate CD
	Concerta
	Daytrana
dexmethylphenidate[a,b]	Focalin
	Focalin XR
lisdexamfetamine	Vyvanse
modafinil[a]	Provigil
armodafinil	Nuvigil
guanfacine extended release	Intuniv

[a]Available in generic form.
[b]Available in generic except the extended-release form.
[c]Delivery rate of 1.1, 1.6, 2.2, and 3.3 mg/hour for the 10-, 15-, 20-, and 30-mg patches, respectively. In vivo delivery rate is based on a wear period of 9 hours of pediatric patients ages 6–12 years.

Formulations and Strengths
Capsules: 5, 10, 15 mg
2.5, 7.5, 15, 20, 30 mg
Tablets: 5, 7.5, 10, 12.5, 15,20, 30 mg Capsules: 5, 10, 15, 20, 25, 30 mg
Tablet: 5 mg
Tablets: 5, 10, 20 mg
Tablets, chewable: 2.5, 5, 10 mg Oral solution: 5 mg/5 mL, 10 mg/5 mL (500 mL)
Tablets: 10, 20 mg
Tablet: 20 mg
Capsules: 10, 20, 30, 40 mg
Tablets: 20 mg
Capsules: 10, 20, 30, 40, 50, 60 mg
Tablets: 18, 27, 36, 54 mg
Transdermal patch: 10, 15, 20, 30 mg/ 9 hours[c]
Tablets: 2.5, 5, 10 mg Capsules: 5, 10, 15, 20, 25, 30, 35, 40 mg
Capsules: 20, 30, 40, 50, 60, 70 mg
Tablets: 100, 200 mg
Tablets: 50, 150, 250 mg
Tablets: 1, 2, 3, 4 mg

Table 34: DRUGS FOR ALZHEIMER'S DISEASE (CHOLINESTERASE INHIBITORS & MEMANTINE)

Drug	Dosage	Peak Plasma
Donepezil (Aricept)	5–10 mg/day	3–4 hours
Galantamine (Reminyl)	16–32 mg/day	1 hour
Memantine (Namenda, Namenda XR)	5–28 mg/day	3–7 hours
Rivastigmine (Exelon)	6–12 mg/day	1.4–2.6 hours
Tacrine (Cognex)	40–160 mg/day	1–2 hours

CYP = cytochrome P450.

Table 35: ADVERSE EFFECTS OF CHOLINESTERASE INHIBITORS

Symptom	Donepezil	Galantamine
GI		
Nausea,	+	++++
Vomiting		
Weight loss	+	+
LFTs rise	–	–
CNS		
Insomnia	+/–	+
Fatigue	+/–	+
Depression	+/–	+
Miscellaneous		
Syncope	+/–	+
Increased urination	+/–	+
Rhinitis	+/–	+

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Elimination Half-life	Steady State	Protein Binding	Metabolism
70 hours	15 days	96%	2D6, 3A3/4
7 hours	–	18%	2D6, 3A4
60–80 hours	12 weeks	45%	Not CYP dependent
1.5–3 hours	24–48 days	40%	Not CYP dependent
2–4 hours	24–36 hours	55%	1A2

Rivastigmine	Tacrine
++	+++
++ (dose dependent)	+
–	+++
+/–	+
+/–	+/–
+/–	+/–
+	+/–
+/–	+/–
–	–

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