Cheshire and Wirral Partnership NHS
NHS Foundation Trust

# Mental Health Medicines Formulary

# 2017-2018

**Edition 3**

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**Please note: the contents of this document are accurate at the time of writing only.**

## 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 Care 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 psychotropic medicines and non-formulary named-patient applications

### 1.2 Non-formulary medicines

CWP has a list of non-formulary medicines (see appendix 1). In cases where formulary choices may not be appropriate, a named patient request (NPR), by the patient's consultant, for a non-formulary medicine can be made to the Deputy Chief Pharmacist and Chairperson of Medicines Management Group for consideration. For details of what should be included in the application please see:


Named patient request form - May 2

http://nww.cwp.nhs.uk/TeamCentre/Pharmacy/PublishedDocuments/Named%20patient%20request%20form%20-%20May%202018.pdf

### 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 locality clinical pharmacist should be contacted so that appropriate arrangements for continuing the treatment can be made and the reason should be documented on carenotes. When therapy with a non-formulary drug is continued on admission, medication brought into hospital by the patient may be used and the medicines chart will be appropriately annotated by the pharmacist as existing therapy (ET). Please see details in see MP20: Policy for reuse of patients own drugs

### 1.3 Antibiotics

Please see current antibiotic formulary:


Management of Infection Guidelines f

http://nww.cwp.nhs.uk/TeamCentre/Pharmacy/PublishedDocuments/CWP%20Antibiotic%20Formulary%202017%20-%2018.pdf

### 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.

### 1.5 Pregnancy

The management of mental health problems during pregnancy and the postnatal period differs from at other times because of the nature of this life stage and the potential impact of any difficulties and treatments on the woman and the baby. There are risks associated with taking psychotropic medication in pregnancy and during breastfeeding and risks of stopping medication taken for an existing mental health problem. There is also an increased risk of postpartum psychosis. No psychotropic medication has a UK marketing authorisation specifically for women who are pregnant or breastfeeding. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The woman (or those with authority to give consent on her behalf) should provide informed consent, which should be documented. See NICE guidance **NGC192: antenatal and postnatal mental health clinical management and service guidance**.

**Please note: Prescribing of valproate to a woman of childbearing age requires a Name Patient Request to MMG**

## 2. Hypnotics & Anxiolytics

### 2.1 Hypnotics

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

**NICE recommendations:**

- When, after due consideration of the use of non-pharmacological measures, 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

Please see choice and medication for Handy Fact Sheet on Insomnia and sleep hygiene choiceandmedication sleep hygiene fact sheet

**First line**

**Zopiclone** - 7.5mg orally at bedtime (patients aged 65 years and over- 3.75mg at bedtime)

**Second line**

**Zolpidem** - 10mg orally at bedtime (patients aged 65 years and over- 5mg at bedtime)
**Zaleplon** 10mg orally at bedtime (patients aged 65 years 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 11pm" or similar appropriate time dependent on the patient.**

**Melatonin MR (adults)**

Please see link to melatonin pathway for in-patients (in line with licensed indications, i.e. in adults over the age of 55)


Melatonin Pathway.pdf

http://nww.cwp.nhs.uk/TeamCentre/Pharmacy/PublishedDocuments/Melatonin%20Pathway%20May%202018.pdf

For individual community patients, an NPR (named patient request) must be submitted

**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

**Melatonin MR*** (prescribe as Circadin® brand) - 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/24 hours
* Unlicensed indication

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

**2.3 Anxiolytics**

- 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. In patients aged 65 years and over, use half adult dose

Or

**Lorazepam** 1 to 4mg orally in divided doses (maximum daily dose = 4mg). In patients aged 65 years and over, use half adult dose

For equivalent doses of oral benzodiazepines, contact your locality clinical pharmacist.

## 3. Antipsychotics

Treatment for psychosis and schizophrenia should be in line with NICE CG 178 Psychosis and schizophrenia in adults: prevention and management **(NCG178/psychosis-and-schizophrenia).** As stated in this guidance, choice of antipsychotic medication should be made by the patient and healthcare professional together, taking into account the views of the carer if the patient agrees. Provide information and discuss the likely benefits and possible side effects of each drug, including:

- metabolic (including weight gain and diabetes)
- extrapyramidal (including akathisia, dyskinesia and dystonia)
- cardiovascular (including prolonging the QT interval)
- hormonal (including increasing plasma prolactin)
- other (including unpleasant subjective experiences)

Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication).
Current evidence suggests all antipsychotics have equal efficacy (with the exception of clozapine)
For more information see MP22: Policy for prescribing antipsychotic medications in psychotic conditions (excluding bipolar disorder)

Treatment for Bipolar disorder should be in line with the NICE Clinical Guideline 185 Bipolar disorder: assessment and management **(NGC 185/bipolar disorder).** NICE recommends that the antipsychotics of choice in the treatment of mania in bipolar disorder are risperidone, olanzapine, quetiapine and haloperidol. In CWP the choices of antipsychotics in bipolar disorder are detailed in policy MP24 Policy for prescribing medication in Bipolar Disorder. Asenapine was licensed for bipolar mania in 2012 but should not be initiated without MMG approval as it is non-formulary within the Trust. Aripiprazole is licensed for treatment of mania in adolescents aged 13-18 years and is recommended by **NICE TA292** (Aripiprazole for treating moderate to severe manic episodes in adolescents with bipolar I disorder) as an option for treating moderate to severe manic episodes in adolescents with bipolar I disorder for up to 12 weeks.

**Antipsychotics/ licensed indication**

| Antipsychotic | Licensed indication(s) |
|---|---|
| Amisulpride | Acute and chronic schizophrenic disorders |
| Aripiprazole | • Schizophrenia in adults and in adolescents aged 15 years and older.<br>• Treatment of moderate to severe manic episodes in Bipolar I Disorder and for the prevention of a new manic episode in adults who experienced predominantly manic episodes and whose manic episodes responded to aripiprazole treatment<br>• Treatment up to 12 weeks of moderate to severe manic episodes in Bipolar I Disorder in adolescents aged 13 years and older |
| Chlorpromazine | • Schizophrenia and other psychoses, mania, short term adjunctive management of severe anxiety, psychomotor agitation, excitement and violent or dangerously impulsive behaviour<br>• Childhood schizophrenia and autism |
| Clozapine | • Treatment-resistant schizophrenia (treatment resistance is defined as a lack of satisfactory clinical improvement despite the use of adequate doses of at least two different antipsychotic agents, including an atypical antipsychotic |

| | |
|---|---|
| | agent, prescribed for adequate duration)<br>• Psychosis during the course of Parkinson's disease |
| Flupentixol | Schizophrenia and other psychoses, particularly with apathy and withdrawal but not mania or psychomotor hyperactivity |
| Flupentixol decanoate | Maintenance treatment in schizophrenia and other psychoses |
| Haloperidol | • Treatment of schizophrenia and schizoaffective disorder.<br>• Acute treatment of delirium when non-pharmacological treatments have failed.<br>• Treatment of moderate to severe manic episodes associated with bipolar I disorder.<br>• Treatment of acute psychomotor agitation associated with psychotic disorder or manic episodes of bipolar I disorder.<br>• Treatment of persistent aggression and psychotic symptoms in patients with moderate to severe Alzheimer's dementia and vascular dementia when non-pharmacological treatments have failed and when there is a risk of harm to self or others.<br>• Treatment of tic disorders, including Tourette's syndrome, in patients with severe impairment after educational, psychological and other pharmacological treatments have failed. |
| **Antipsychotic** | **Licensed indication(s)** |
| Haloperidol | • Schizophrenia in adolescents aged 13 to 17 years when other pharmacological treatments have failed or are not tolerated.<br>• Persistent, severe aggression in children and adolescents aged 6 to 17 years with autism or pervasive developmental disorders, when other treatments have failed or are not tolerated.<br>• Tic disorders, including Tourette's syndrome, in children and adolescents aged 10 to 17 years with severe impairment after educational, psychological and other pharmacological treatments have failed. |
| Haloperidol decanoate | Maintenance treatment of schizophrenia/schizoaffective disorder |
| Lurasidone | Schizophrenia |
| Olanzapine | Schizophrenia, monotherapy and combination therapy for mania, preventing recurrence in bipolar disorder |
| Olanzapine embonate | Maintenance in schizophrenia in patients tolerant to oral olanzapine |
| Paliperidone | Schizophrenia, psychotic or manic symptoms of schizoaffective disorder |
| Paliperidone palmitate | Maintenance in schizophrenia in patients previously responsive to paliperidone or risperidone |
| Quetiapine | Schizophrenia, prevention/ treatment of mania and depression in bipolar disorder, adjunctive treatment of major depression |
| Risperidone | • Schizophrenia<br>• Moderate to severe manic episodes associated with bipolar |

| | |
|---|---|
| | disorders<br>• Short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological<br>• Short-term symptomatic treatment (up to 6 weeks) of persistent aggression in conduct disorder in children from the age of 5 years and adolescents with subaverage intellectual functioning or mental retardation diagnosed according to DSM-IV criteria, in whom the severity of aggressive or other disruptive behaviours require pharmacologic treatment. |
| Risperidone consta | Maintenance treatment of schizophrenia in patients currently stabilised with oral antipsychotics. |
| Sulpiride | Schizophrenia |
| Trifluoperazine | Schizophrenia and other psychoses, short term adjunctive management of psychomotor agitation, excitement and violent or dangerously impulsive behaviour, short term adjunctive management of severe anxiety |
| Zuclopenthixol | Schizophrenia and other psychoses |
| Zuclopenthixol acetate | Short term management of acute psychosis, short term management of mania, short term management of exacerbation of chronic psychosis |
| Zuclopenthixol decanoate | Maintenance in schizophrenia and paranoid psychoses |

See appendix 1 for list of antipsychotics that need a Named Patient Request to MMG

### 3.1 High dose antipsychotics (HDAT)

HDAT should only be initiated under Consultant supervision. Doses higher than those stated in the BNF are unlicensed. All patients on HDAT must be monitored as per trust guidelines: High Dose Antipsychotic Therapy Guidelines. These guidelines include the 'Ready Reckoner' to calculate whether an antipsychotic medication or a combination of antipsychotics constitutes HDAT.
An electronic HDAT Alert and checklist as part of an assist pathway has been implemented on carenotes for use across all teams.

### 3.2 Antipsychotics in young people

The NICE Technology Appraisal 213 **NICE 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.

### 3.3 Rapid Tranquillisation

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 MP10: Rapid Tranquilisation policy

## 4. Anti-manic Drugs

Treatment for Bipolar affective disorder should be in line with the NICE Clinical Guideline 185 Bipolar Disorder: Assessment and Management **(NGC185/bipolar disorder).**

If a patient is taking an antidepressant at the onset of an acute manic episode, the antidepressant should be stopped either abruptly or gradually (depending on the clinical need for stopping and the likelihood of withdrawal).

**Lithium carbonate** (prescribe by brand – Priadel®), **olanzapine, quetiapine** 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 vs depressive relapse
- physical risk factors, particularly renal disease, obesity and diabetes
- the patient's preference and history of adherence
- a brief assessment of cognitive state (such as the Mini-Mental State Examination) if appropriate, for example, for older people.

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 See MP4-lithium-policy for information on initiation, plasma monitoring and maintenance treatment.

**Valproate** (semisodium valproate/sodium valproate/valproic acid)

- Valproate must no longer be prescribed to women or girls of childbearing potential unless they are on the pregnancy prevention programme (PPP). For more information please see www.gov.uk- drug safety update valproate
- Prescribing of valproate to a woman of childbearing age requires a Name Patient Request to MMG
- All clinicians should use the consultation alert and checklist on carenotes when prescribing valproate for women of child-bearing potential.

## 5. Antidepressant Drugs

**Antidepressant selection**

Guidelines are currently being developed between CWP and primary care for the management of moderate to severe depression. These guidelines are based on the recommendations by NICE Clinical Guideline 90: Depression in Adults: The Treatment and Management of Depression in Adults, **(NICE CG 90)**. They should not be considered in isolation but as part of the care pathway for managing depression.

All antidepressants should be initiated in their generic form as they are seen to be equally effective as other antidepressants.

See appendix 1 for list of antidepressants that need a Named Patient Request to MMG

## 6. 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**

**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

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

Akathisia and tardive dyskinesia
Contact locality clinical pharmacist for advice. Avoid antimuscarinic drugs as these can worsen akathisia

**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

## 7. Drugs for Attention Deficit Hyperactivity Disorder

In 2008, NICE published guidance on ADHD (**NGC 72 attention deficit hyperactivity disorder diagnosis and management**). While the NICE guideline advises against the diagnosis and initiation of drug treatment at a primary care level, it does support GPs prescribing drug treatment via a shared care agreement. Shared Care Guidance exists for each CCG in the CWP footprint- please contact pharmacy for advice.

**Treatment of paediatric ADHD**

**First line**

**Methylphenidate (controlled drug – schedule 2)**

Immediate release tablets– up to 4 hours symptom control

- Medikinet®, Ritalin®, Tranquilyn® (depending on local shared care agreement)

*Immediate release preparations should be prescribed generically as methylphenidate.*

Modified release tablets- Up to 12 hours symptom control

- Xenidate®, Matoride®, Concerta XL® or Xaggitin XL® (depending on local shared care agreement)

Modified release capsules- Up to 8 hours symptom control

- Equasym XL® or Medikinet XL® (depending on local shared care agreement)

Contents of Equasym XL® and Medikinet XL® capsules can be sprinkled on a tablespoon of apple sauce, 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*

**Second line**

***Stimulants***

**Dexamphetamine**

**Lisdexamfetamine Dimesylate (Elvanse®)** (**Controlled drug schedule 2**)

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 swallowing difficulties.
c. In situations where 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 XL® (up to 12 hours).
d. If treatment with Atomoxetine has been ineffective and there are no contraindications for using stimulants.

***Non Stimulants***

**Atomoxetine**

**Guanfacine- Name Patient Request needed**

**Treatment of Adult ADHD**

Final for approval adult ADHD pathway

Y:\General Folders\Document Control\Shared Care Guidelines\ADHD - Adults\Final for approval adult ADHD pathway March 17.pdf

**First line treatment**

Immediate release tablets– up to 4 hours symptom control
Medikinet®, Ritalin®, Tranquilyn ® (depending on local shared care agreement)

*Immediate release preparations should be prescribed generically as methylphenidate*

Modified release tablets- Up to 12 hours symptom control
Xenidate®, Matoride® Concerta XL® or Xaggitin XL® (depending on local shared care agreement)

Modified release capsules- Up to 8 hours symptom control
Equasym XL® or Medikinet XL® (depending on local shared care agreement)

*Please note due to the different release characteristics of the modified release preparations it is essential that **brand** prescribing takes place*

**OR**

Lisdexamfetamine (Elvanse Adult®) to be used if >12 hours symptom control is needed.
This is currently approved only for use in Wirral.

**Second line treatment**

**Atomoxetine** can be used if stimulants are contraindicated or if failure to respond to first line treatment.

Note: Lisdexamfetamine (Elvanse Adult®) and Atomoxetine are both licensed for use in adults with ADHD.

## 8. Drugs Used In Substance Dependence

### 8.1 Alcohol dependence

For more information see Alcohol withdrawal management in the in-patient setting **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**.**

### 8.1.2 Vitamin supplementation

See link to NICE guidance on alcohol use disorders- diagnosis and management of physical complications NGC100 alcohol use disorders diagnosis/management of physical complications. Offer thiamine to people at high risk of developing, or with suspected, Wernicke's encephalopathy. Thiamine should be given in doses toward the upper end of the BNF range.

Offer prophylactic oral thiamine to harmful or dependent drinkers:

- if they are malnourished or at risk of malnourishment
- if they have decompensated liver disease
- if they are in acute withdrawal
- before and during a planned medically assisted alcohol withdrawal
- if they attend an emergency department or are admitted to hospital with an acute illness or injury.

Offer parenteral thiamine to people with suspected Wernicke's encephalopathy. Maintain a high level of suspicion for the possibility of Wernicke's encephalopathy, particularly if the person is intoxicated. Parenteral treatment should be given for a minimum of 5 days, unless Wernicke's encephalopathy is excluded. Oral thiamine treatment should follow parenteral therapy.

**8.1.3 Withdrawal seizures**
In people with alcohol withdrawal seizures, consider offering a quick-acting benzodiazepine (such as lorazepam) to reduce the likelihood of further seizures. If alcohol withdrawal seizures develop in a person during treatment for acute alcohol withdrawal, review their withdrawal drug regimen.
Do not offer phenytoin to treat alcohol withdrawal seizures

**8.1.4 Prophylaxis treatment of reflux oesophagitis**
Lansoprazole - 15-30mg capsule daily (15mg in moderate to severe liver disease) for 7 days.

Or

Omeprazole - 20mg capsule daily (10mg in moderate to severe liver disease) for 7 days

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

**8.1.5 Nausea and vomiting**
Metoclopramide - 10mg three times a day or alternatively buccal prochlorperazine- 3mg, 1 to 2 tablets buccally twice daily.

**8.2 Drug dependence**

**8.2.1 In-patient and out of hours management**
For more information, see policy for in-patient and out of hours management of adult drug misusers
**Policy for in-patient and out of hours management of adult drug misusers**

**8.2.2 Opioid substitution**
Please see **DA4 Buprenorphine and Buprenorphine/Naloxone combination Suboxone prescribing guidance**

**8.3 Nicotine replacement therapy**
Please see **MP14: Nicotine Replacement Therapy (NRT)**

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| **Patches** | These are available as 16 hour or 24 hour patches. 16 hour patches are advised if sleep disturbances/nightmares are experienced or the 24 hour patch should be removed at bedtime. |
| **Lozenges** | These can be used every 1 to 2 hours when the urge to smoke occurs or to prevent cravings. Those who smoke >20cigarettes a day or fail to stop smoking with the lower strength lozenges should use the higher strength lozenges (4mg). |

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| **Nasal spray** | Has a fast onset of action but may cause local irritation. More expensive than patches and lozenges as combined use. |
| **Oral spray** | Contains <100mg ethanol per dose. More expensive than patches and lozenges as combined use. One spray pack lasts less than 3 days at maximum use. |
| **Sub-lingual tablets** | May be useful for those who have difficulty chewing gum or if gum is not allowed. Tablets can be used hourly and should be allowed to dissolve under the tongue. More expensive than patches and lozenges as combined use. |
| **Inhalator** | Simulates cigarette smoking but may cause local irritation of the mouth and throat. Replacement inhalators cannot be purchased separately. An alternative NRT product may be more suitable for those who regularly misplace the device, as the device will not be replaced through CWP supplies. More expensive than patches and lozenges as combined use. Repeat issuing of inhalators make this an even more expensive and potentially wasteful product |
| **Gum** | Comes as 2mg and 4mg strength. Those smoking >20cigarettes a day or requiring >15 pieces of the 2mg gum/day should use the 4mg strength. Use is to be assessed on a case by case basis as informed by risk assessment . (Not for use in secure services) |

Note varenicline and bupropion are not NRT but are medicines to assist in smoking cessation.

**Varenicline** will not be initiated for acute inpatients but can be considered for those patients who are mentally stable and resident on the rehabilitation wards as its use is cautioned in those with a history of mental illness, including depression.

CWP does not support the prescribing of **Bupropion**.

**Combinations of NRT and Varenicline or Bupropion** CWP do not utilise NRT, varenicline or bupropion in any combination as per NICE PH10 Smoking Cessation Guidance.

## 9. 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 (NG/TA217)

### 9.1 Treating behavioural and psychological problems 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, be aware that most are used "off-licence". Refer to **MP9.** 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

**9.2 Specific Medicine Treatment Issues**

- Typical antipsychotic medications are known to accelerate 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 elderly patients. In elderly 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.

- Increased risk of cognitive decline with long-term use of anticholinergic drugs. Consider all regular and PRN medication (see table below) as effect is cumulative.

Table: Anticholinergic effect on cognition scores

3 - review and withdraw or switch

2 - review and withdraw or switch

1 - caution required

0 – safe to use

| Drugs with AEC score of 0 | | Drugs with AEC score of 1 | Drugs with AEC score of 2 | Drugs with AEC score of 3 |
|---|---|---|---|---|
| Alprazolam | Lovastatin | Amiodarone | Amantadine | Alimemazine (trimeprazine) |
| Amlodipine | Lurasidone | Aripiprazole | Chlorphenamine | Amitriptyline |
| Amoxycillin | Meloxicam | Bromocriptine | Desipramine | Atropine |
| Aspirin | Metoclopramide | Carbamazepine | Dicycloverine (dicyclomine) | Benztropine |
| Atenolol | Metoprolol | Citalopram | Dimenhydrinate | Chlorpromazine |
| Atorvastatin | Moclobemide | Diazepam | Diphenhydramine | Clemastine |
| Buproprion | Morphine | Domperidone | Disopyramide | Clomipramine |
| Cephalexin | Naproxen | Fentanyl | Levomepromazine (methotrimeprazine) | Clozapine |
| Cetirizine | Omeprazole | Fluoxetine | Olanzapine | Cyproheptadine |
| Chlordiazepoxide | Paracetamol | Fluphenazine | Paroxetine | Dothiepin |
| Cimetidine | Pantoprazole | Hydroxyzine | Pethidine | Doxepin |
| Ciprofloxacin | Pravastatin | Iloperidone | Pimozide | Hyoscine hydrobromide |
| Clopidogrel | Propranolol | Lithium | Prochlorperazine | Imipramine |
| Darifenacin | Rabeprazole | Mirtazapine | Promazine | Lofepramine |
| Diclofenac | Ranitidine | Perphenazine | Propantheline | Nortriptyline |
| Diltiazem | Risperidone | Prednisolone | Quetiapine | Orphenadrine |
| Enalapril | Rosiglitazone | Quinidine | Tolterodine | Oxybutynin |
| Entacapone | Simvastatin | Sertindole | Trifluoperazine | Procyclidine |
| Fexofenadine | Theophylline | Sertraline | | Promethazine |
| Fluvoxamine | Thyroxine | Solifenacin | | Trihexyphenidryl (benzhexol) |
| Furosemide | Tramadol | Temazepam | | Trimipramine |
| Gabapentin | Trazodone | | | |
| Gliclazide | Trimethoprim | | | |
| Haloperidol | Trospium | | | |
| Ibuprofen | Venlafaxine | | | |
| Ketorolac | Valproate | | | |
| Lamotrigine | Warfarin | | | |
| Levadopa | Ziprasidone | | | |
| Lisinopril | Zolpidem | | | |
| Loperamide | | | | |
| Loratadine | | | | |
| Lorazepam | | | | |
| Losartan | | | | |

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## 10. Treatment of Alzheimer's Disease

**TA217 NICE Technology Appraisal Guidance: Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimers Disease, last updated May 2016 gives the following recommendations** (NG/TA217) **:**

- Donepezil, galantamine and rivastigmine are now recommended as options for managing mild as well as moderate Alzheimer's disease.

- Memantine is now recommended as an option for managing moderate Alzheimer's disease for people who can't take AChEi (Acetylcholinesterase inhibitors), and as an option for managing severe Alzheimer's disease.

NOTE: If prescribing an AChEi, start with the drug with the lowest acquisition cost.

### 10.1 Mild to moderate Alzheimer's

**First line**

**Donepezil** - 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 problems with ordinary tablets. In all cases the generic orodispersible tablet should be prescribed unless there is a documented reason in the clinical notes why the branded product should be used.*

**Second line**

**Rivastigmine**

- 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**- 4mg twice daily for 4 weeks; maintenance 8 - 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.**

**10.2 Moderate to severe Alzheimer's**

**Memantine**- 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**

**10.3 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** capsules are licensed for symptomatic treatment of mild to moderately severe dementia in patients with idiopathic Parkinson's disease. Patches are also available but the parenteral formulation is only licensed for Alzheimer's disease.

# Mental Health Medicines Formulary – Appendix 1

**Edition 2.2**

**Publication date - July 2014**

**Revision date – May 2018**

**Approved – Medicines Management Group November 2017**

**Please note: the contents of this document are accurate at the time of writing only.**

**Name Patient Request to MMG required :**

**Non-formulary Antipsychotics -**

- Aripiprazole 30mg tablets, orodispersible tablets and liquid, depot (Abilify Maintena®)
- Asenapine
- Denzapine® preparations (nb: formulary choice is Clozaril® but an NPR is **NOT** required if patient comes in on Denzapine® or needs a liquid formulation of clozapine)
- Lurasidone (nb:. currently non-formulary across Central and East CCG's whilst for Wirral and West it is available subject to shared care agreement)
- Quetiapine MR formulations
- Olanzapine palmoate depot (ZypAdhera®)
- Risperidone depot (Risperidal Consta®)
- Paliperidone oral preparations
- Paliperidone palmitate depot (Xeplion®)

**Non-formulary Antidepressants -**

- Vortioxetine
- Agomelatine
- Buspirone
- Bupropion
- Liothyronine
- Trazodone- liquid formulation only

**Other non- formulary medications:**

- Guanfacine
- Gabapentin/Pregabalin for MH indications
- Melatonin (community patients only- see formulary for details)
- Modafinil
- Sidenafil
- Semi and Sodium valproate for women of child-bearing age