# PSYCHOTROPIC DOSAGE GUIDELINES

The following is a list of psychotropic drug dosages. These guidelines are not intended to establish rigid standards of treatment but to assist in monitoring the pharmacotherapy of the patient. Furthermore, guidelines for special patient populations are not intended to be absolute. For those medications that have a well established therapeutic serum range, the dosage should be based upon the desired serum range and response rather than a specific maximum administered daily dosage. These guidelines should be used in conjunction with sound clinical judgment and the prescriber's experience.

In children and adolescents, metabolic and physiologic differences from adults should be considered when prescribing. Dosing based on body weight may be more accurate when treating these patients.

Different dosage requirements are usually necessary in the geriatric population. Since there is no standard definition for "geriatric", the arbitrary age of 65 has been chosen to identify geriatric patients. In general, geriatric patient dosing guidelines should reflect a "go low, go slow" approach. Standard reference books should be consulted if needed for appropriate dosages when treating this population.

In general, when treating patients with developmental disabilities, a "go low, go slow" approach is recommended when increasing or decreasing psychotropic medication. The use of psychotropic medication can be therapeutic and empowering for a person with both mental retardation and a mental illness. The primary goal is to obtain an accurate diagnosis of behavioral and psychiatric symptoms so that the patients' treatment is appropriate. A functional analysis by a psychologist is vital prior to starting any psychotropic medication except in an emergency. The U. S. Health Care Financing Administration now states that the least intrusive and most positive intervention to treat behavioral or psychiatric symptoms in a person with mental retardation may be the use of a psychotropic medication.

Prescribing psychotropic medication should be based on the following resources:

TDMHMR Prescribing of Medications-Mental Health, Chapter 405, Subchapter A

TDMHMR Prescribing of Psychotropic Medication-Mental Retardation Facilities, Chapter 405, Subchapter B

Other useful resources that reflect current Standards of Care for the mentally ill include but are not limited to the following:

Treatment Guidelines of Various Psychiatric Disorders

Examples include:

APA Practice Guideline for the treatment of Patients with Schizophrenia. *Am J Psychiatry* 1997; 154: 4 (April supplement)

APA Practice Guideline for Major Depressive Disorder in Adults. *Am J Psychiatry*

1993; 150 (supplement)
Consensus Guidelines for Bipolar Disorder. *J Clin Psychiatry* 1996; 57 (suppl 12a)

Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook (Reiss and Aman, eds; AAMR, 202-387-1968)

Consensus Guidelines of Psychotropic Medication in Persons with Developmental Disabilities *AJMR*, May 2000 (special issue)

Texas Implementation of Medication Algorithms (TIMA):
www.mhmr.state.tx.us/CentralOffice/MedicalDirector/TIMA.html
(web site still under construction)

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## ANTIPSYCHOTICS

| Drug | Suggested Maximum Dose (mg/day)* |
|---|---|
| Aripiprazole (Abilify) | 30 |
| chlorproMAZINE (Thorazine) | 2,000 |
| Clozapine (Clozaril) - **RESERVE USE** | 900 |
| Fluphenazine[1] (oral) (Prolixin)<br><br>Fluphenazine Decanoate[1] (Prolixin, Permitil) | 60<br><br>100 (q 1 - 4 weeks) |
| Haloperidol[2] (oral) (Haldol)<br><br>Haloperidol Decanoate[2] (Haldol) | 100<br><br>450 mg per month |
| Loxapine (Loxitane) | 250 |
| Mesoridazine (Serentil)[3] **- RESERVE USE** | 500 |
| Molindone (Moban) | 225 |
| Olanzapine (Zyprexa) | 30 |
| Perphenazine (Trilafon) | 64 |
| Quetiapine (Seroquel) | 800 |
| Risperidone (Risperdal) | 8[4] |
| Thioridazine (Mellaril)[3]**- RESERVE USE** | (**ABSOLUTE**) 800 |
| Thiothixene (Navane) | 60 |
| Trifluoperazine (Stelazine) | 80 |
| Ziprasidone (Geodon) | 240 |

*except where noted
[1] Fluphenazine Therapeutic Concentration = 1 - 3 ng/mL
[2] Haloperidol Therapeutic Concentration = 3 - 15 ng/mL
[3] A boxed warning has been added to advise clinicians of prolongation of the QTc interval
[4] Risperidone doses >6 mg/day have increased risk of EPS

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## ANTIDEPRESSANTS

| Drug | Suggested Maximum Dose (mg/day) |
|---|---|
| Amitriptyline (Elavil) | 300 |
| Amoxapine (Asendin) | 600 |
| buPROPion (Wellbutrin)<br><br>buPROPion SR (Wellbutrin SR)<br>buPROPion XL (Wellbutrin XL) | 450/day<br>(with no single dose > 150)<br>400<br>450 |
| Citalopram (Celexa) | 60 |
| Desipramine (Norpramin) | 300*[1] |
| Doxepin (Sinequan, Adapin) | 300 |
| Escitalopram (Lexapro) | 20 |
| Fluoxetine (Prozac) | 80 |
| Fluvoxamine (Luvox) | 300 |
| Imipramine (Tofranil) | 300*[2] |
| Maprotiline (Ludiomil) | 225 |
| Mirtazapine (Remeron) | 45 |
| Nefazodone (Serzone) **- RESERVE USE** | 600 |
| Nortriptyline (Pamelor, Aventyl) | 200*[3] |
| Paroxetine (Paxil) | 50 |
| Phenelzine (Nardil) | 90 |
| Protriptyline (Vivactil) | 60 |
| Sertraline (Zoloft) | 200 |
| Tranylcypromine (Parnate) | 60 |
| Trazodone (Desyrel) | 600 |
| Trimipramine (Surmontil) | 300 |
| Venlafaxine (Effexor)<br>Venlafaxine XR (Effexor XR) | 375 |

*Plasma concentration monitoring is recommended if these doses are exceeded.
[1]Desipramine Therapeutic Concentration = 100-300 ng/mL
[2]Imipramine Therapeutic Concentration = 150-250 ng/mL
[3]Nortriptyline Therapeutic Concentration = 50-150 ng/mL

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