Partners in improving local health

Medicines Optimisation Update

Atypical Antipsychotics

NHS Cumbria Clinical Commissioning Group

What this includes:

Generic standard release atypical antipsychotics as a % of all atypical antipsychotics: Total number of prescription items for immediate release atypical antipsychotics as a percentage of all atypical antipsychotics

Identifying the problem:

- PrescQIPP. Antipsychotic Drugs Audit. July 2014 http://www.prescqipp.info/resources/viewcategory/248-antipsychotic-drugs

Suggested actions:

- There is no first line choice of antipsychotic drug that will be suitable for all patients. Choice should be based on indication, product licensing, co-morbidities, risk factors, likely benefits, side effect profile, cost, previous patient response and individual patient preference, and with involvement from mental health trust clinicians.
- Identify patients currently prescribed:
  - Modified release (MR) formulations of quetiapine tablets
  - Dispersible antipsychotic tablets (e.g. olanzapine, aripiprazole or risperidone), or liquids (e.g. amisulpride)
  - Olanzapine lyophilisate orodispersible tablets.
- Quetiapine immediate release (IR) is the preferred first line choice of antipsychotic over the modified release (MR) because there is a significant cost difference between the IR and MR formulations of quetiapine.
- Clinicians may switch patients they have on quetiapine MR to IR if they are comfortable to do so and unless there are compelling clinical reasons not to do so, e.g. compliance issues where twice daily adherence to therapy may cause a problem.
- If they are not comfortable to do this, they can refer the patient(s) to Cumbria Partnership Foundation Trust (CPFT) clinicians for review who can then make the decision to switch.
- Primary care colleagues are asked to inform the CPFT prescriber if they switch any patient who is currently under the care of a CPFT clinician to quetiapine IR, or indeed if the switch to IR has not been successful. This is to ensure effective communication between primary and secondary care and hence patient safety.
- Once-daily dosing with quetiapine MR tablets is equivalent to twice-daily dosing with quetiapine IR tablets. Research findings indicate that modifying the formulation has little difference in efficacy or side effects.
- Quetiapine IR is licensed for:
  - Once daily dosing for the treatment of depression in bipolar disorder. Twice daily dosing is licensed in mania and schizophrenia (once daily IR dosing in these patients should only be prescribed where absolutely necessary).
- If an MR formulation is deemed necessary by a CPFT psychiatrist, they should explain the clinical justification in discharge letters or outpatient correspondence.
- When switching a patient from MR to IR, the first dose of the IR formulation should be given approximately 24 hours after the last dose of the MR formulation.

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Suggested actions:

Table 1. Summary of example switching regimens from quetiapine MR to IR formulations for schizophrenia, acute mania, or for preventing relapse in bipolar disorder.

Current MR dose	IR dose with no sleeping problems	IR dose with sleeping problems
400mg once daily	200mg twice daily	150mg morning + 250mg at night
600mg once daily	300mg twice daily	250mg morning + 350mg at night

Table 2: Summary of example switching regimes from quetiapine MR to IR formulations for depression in bipolar or for major depressive episodes.

Current MR dose	IR dose
200mg once daily	200mg at night
300mg once daily	300mg at night

- Patients currently prescribed dispersible tablets (e.g. olanzapine, aripiprazole or risperidone), or liquids (e.g. amisulpride) should switched to immediate release tablets after a clinical review, unless they have swallowing difficulties or compliance issues relating to preparation.
- Orodispersible and liquid formulations should not be used for new patients unless absolutely necessary. Patients who need a soluble olanzapine formulation should be prescribed olanzapine orodispersible NOT olanzapine oral lyophilisates sugar free as there is a major cost difference.
- All antipsychotics should be prescribed generically where possible.

Resources:

- Prescription pad number 39. http://medicines.necsu.nhs.uk/download/prescription-pad-no-39/
- PrescQIPP. Antipsychotic Drugs Bulletin. July 2014 http://www.prescqipp.info/resources/viewcategory/248-antipsychotic-drugs
- National Institute for Health and Care Excellence (NICE). Clinical Guideline 178. Psychosis and schizophrenia in adults. February 2014. http://guidance.nice.org.uk/CG1718
- CPFT letter from medical director re quetiapine MR: http://medicines.necsu.nhs.uk/guidelines/cumbria-guidelines/

References:

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- Taylor D, Paton C, Kapur S. The South London and Maudsley NHS Foundation Trust & OMReas NHS Foundation Trust Prescribing Guidelines in Psychiatry. 11th ed. London: Wiley-Blackwell; 2012
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- Factors affecting therapeutic compliance: A review from the patient's perspective. Jin, J et al. Therapeutics and Clinical Risk Management 2008:4(1) 269–286.
- Use of quetiapine XR and quetiapine IR in clinical practice for hospitalized patients with schizophrenia: a retrospective study Lars Eriksson, Teresa Hallerbäck, Leif Jørgensen and Andreas Carlborg. Ther Adv Psychopharmacol (2012) 2(6) 217–226
- Comparative Efficacy and Risk of Harms of Immediate versus Extended-Release Second-Generation Antidepressants: A Systematic Review with Network Meta-Analysis. Nussbaumer, B et al. CNS Drugs (2014) 28:699–712.
- Sustained-Release, Extended Release, and Other Time-Release Formulations in Neuropsychiatry. Clinical and Practical Psychopharmacology. J Clin Psychiatry 2015;76(8):e995-e999.
- AstraZeneca Pharmaceuticals product information for Seroquel XL 2009
- SPC for Seroquel XL 50 mg, 150mg, 200 mg, 300 mg, 400 mg prolonged-release tablets and SPC for SEROQUEL 25 mg, 100 mg, 150 mg, 200 mg, 300 mg film-coated tablets. https://www.medicines.org.uk/emc/

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