# Prescribing Support Series: PSS 4

## Prescribing First Generation Antipsychotic depots (Flupentixol, Haloperidol, Zuclopenthixol)

Tees, Esk and Wear Valleys NHS Foundation Trust

Detailed prescribing information, including guidance on missed doses, can be found in the Trust Depot guidelines

Historically, very high doses of FGA depots were used in clinical practice following rapid dose escalation. We are aware of patients in the Trust who are prescribed:

- Dose > BNF maximum weekly dose equivalent (=HDAT)
- Dose > manufacturer's recommended maximum single dose e.g., zuclopenthixol 800mg every two weeks (=HDAT)
- Dose interval > product license e.g. zuclopenthixol every 5 weeks.

**Recommended Action** – prescribers should:

- Familiarise themselves with current prescribing guidance and licensed doses/dose intervals →→→
- Check that all patients currently prescribed FGA depots meet this guidance
- Review patients with a dosage that falls outside of current guidance and, where appropriate, adjust the dose and/or dose interval within licensed parameters; otherwise…..
- If necessary to continue with an "off-label" or HDAT dosage, discuss with the patient and document consent to continue in line with the Trust Guidance on unlicensed & off-label prescribing.

**Prescribing tips** (if in doubt, please seek pharmacy advice):

- Prescribe and administer a test dose before initiation of treatment.
- Begin with the lowest therapeutic dose (in many cases, low doses will be at least as effective as higher doses)
- Prescribe the longest possible licensed interval, without exceeding the maximum single dose (there is no evidence that shortening the dose interval improves efficacy)
- Only adjust doses after an adequate period of assessment (ensure patients are aware of potential time lag):
  - At the start of treatment, plasma drug levels increase over several weeks to months without any increase in dosage; dose increases during this period are not logical and cannot be properly evaluated.
  - Reduce dose if side effects occur, but it will take time for drug levels to decrease and side effects to resolve.
  - Doses should only be increased after careful assessment over at least one month, preferably longer.
  - Efficacy, adverse effects and physical health should be monitored throughout.
- Select the appropriate drug based on presenting symptoms:
  - **Flupentixol** – not recommended in excitable or agitated patients; same risk of suicidal thoughts, self-harm and suicidal attempts as antidepressants.
  - **Haloperidol** – do not use as monotherapy in patients where depression is predominant.
  - **Zuclopenthixol** – more sedating than flupentixol, preferrable in aggressive/agitated patients.

| | Flupentixol | Haloperidol | Zuclopenthixol |
|---|---|---|---|
| **Time to steady state:** | 10-12 weeks | 10-12 weeks | 10-12 weeks |
| **Licensed maintenance dose range:** | 50 mg every four weeks to 300 mg every two weeks. | 50-200 mg every four weeks. | 200 - 500 mg every one to four weeks |
| **Optimal dose range:** | Likely to be: 20-40 mg every two weeks. | Maximal effect is at 50 mg every four weeks. | Not defined* |
| **Maximum weekly dose:** | 400 mg | N/A (four weekly interval recommended) | 600 mg |
| **Maximum single dose:** | 400 mg | 300 mg | 600 mg |
| **Maximum interval:** | Four weeks | Four weeks | Four weeks |
| **Dose considered equivalent to 20 mg/day olanzapine (oral):** | 40 mg every two weeks | 150 mg every four weeks | 200 mg every two weeks |

***D2 receptor occupancy target range is 65-80%, 200 mg zuclopenthixol decanoate every two weeks results in estimated receptor occupancy of 91%.**

**Discontinuing an FGA depot:**

- Measurable plasma levels will be present for a period of time after discontinuation
- It takes as long for levels to fall on discontinuation as it did for them to get to steady state on initiation (see table above)
- This must be considered when another antipsychotic is initiated, especially in relation to reported adverse effects


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