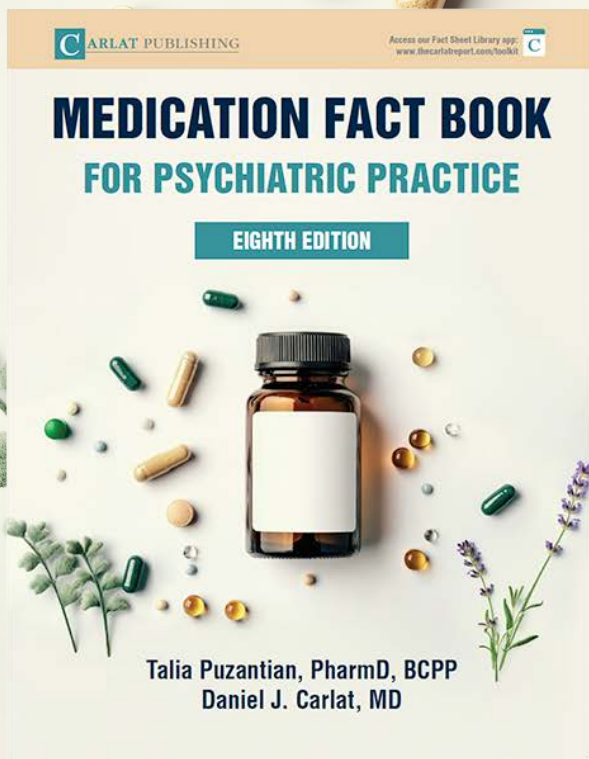


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**Talia Puzantian, PharmD, BCPP
Daniel J. Carlat, MD**

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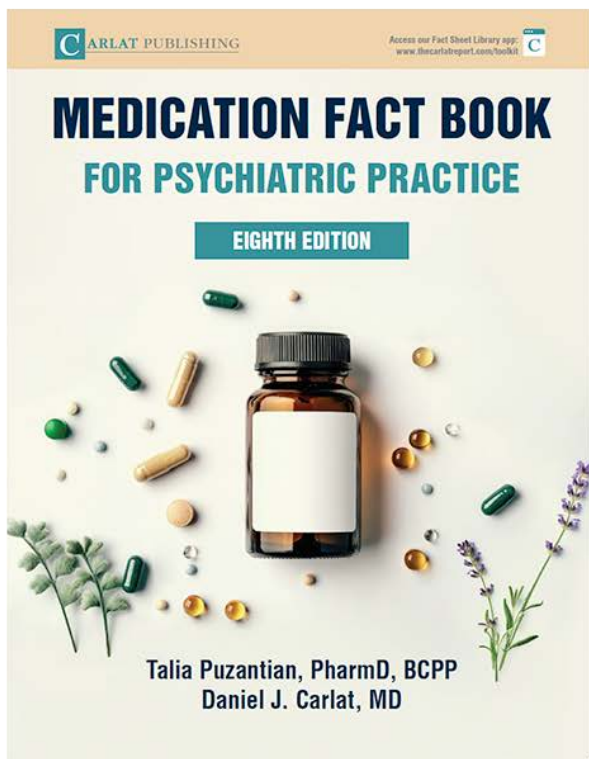
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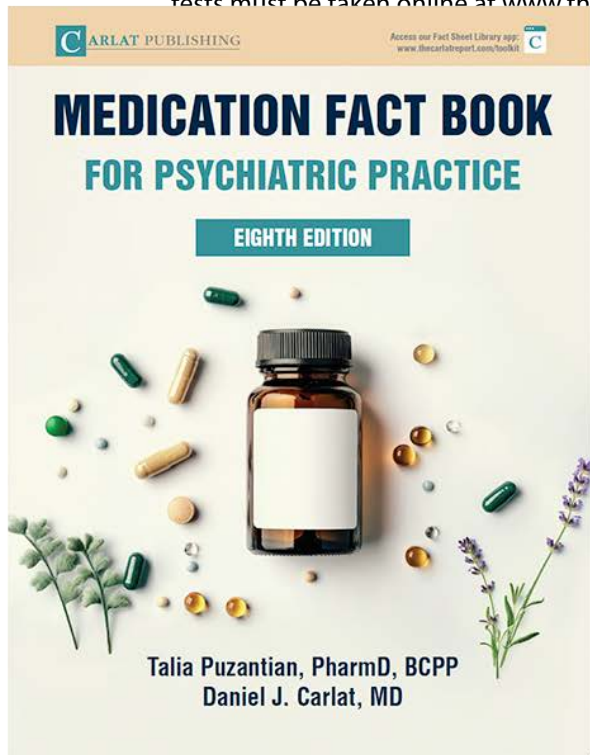
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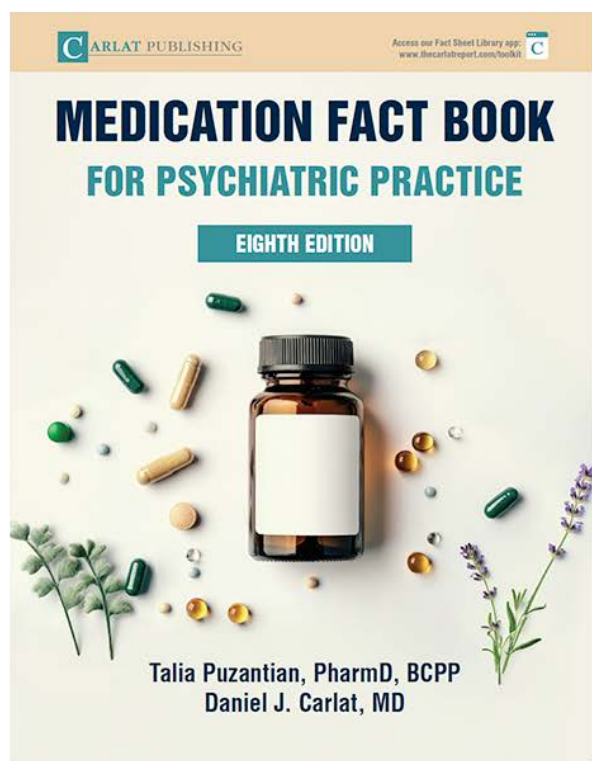
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Introduction

HOW TO USE THIS BOOK

Medication information is presented in four ways in this book:

- **Fact sheets:** In-depth information for select medications, somatic treatments, and side effects. There are 179 fact sheets in this book. The medication fact sheets don't cover all psychiatric medications, but we have included most of the commonly prescribed and newer medications.
- **Quick-scan medication tables:** These are most often located at the beginning of each therapeutic category and list the very basics: generic and brand names, available strengths, starting doses, and target doses. These tables contain most of the commonly prescribed psychiatric medications.
- **General prescribing tips:** Located at the beginning of each therapeutic section, these provide practical guidance, clinical pearls, and therapeutic approaches specific to each medication category.
- **Treatment algorithms:** These quick-reference decision trees can serve as a memory aid and help in clinical decision making. They don't cover every medical nuance but serve as general overviews.

CHANGES AND ADDITIONS TO THE EIGHTH EDITION

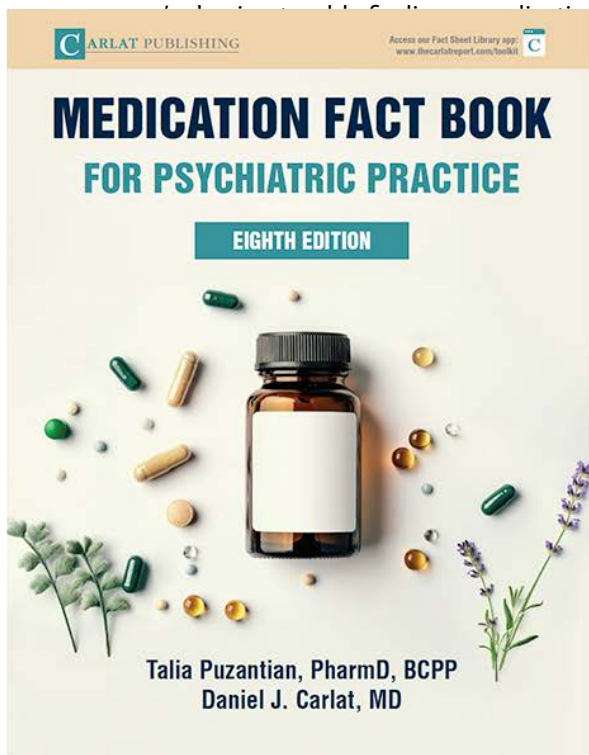
This eighth edition includes nine new fact sheets covering recently approved medications and important therapeutic options. Beyond adding content, we conducted a comprehensive review of our existing fact sheets to enhance their organization, clarity, and clinical utility. This extensive revision process involved systematically updating dosing guidance, refining clinical pearls, and ensuring consistency in formatting and presentation throughout the book.

Key updates include:

- All medication fact sheets reflect current availability of strengths, formulations, and generic options.
- We've expanded our coverage of several medication categories.
- This edition includes updated treatment algorithms incorporating the latest evidence and clinical practice guidelines.
- We offer an expanded collection of patient fact sheets for commonly prescribed medications, designed for use in informed consent and patient education (available for download online).

CATEGORIES OF MEDICATIONS

We did our best to categorize medications rationally. However, in some cases a medication can fall into more than one category. In such cases, we categorized the medication with the types of disorders for which it is most often used. If



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ADHD Medications

GENERAL PRESCRIBING TIPS

Generally, when you have a patient with ADHD symptoms, your first choice will be one of the psychostimulants, because these are usually more effective than the alternatives—atomoxetine, bupropion, clonidine, guanfacine, and viloxazine. Which psychostimulant should you choose? Here are some of the factors that will influence your decision:

Stimulants vs Nonstimulants

Stimulants are more effective than nonstimulants, with response rates of 70%–80% compared to 50%–60%, so they will be your first-line choice for most patients unless they are contraindicated.

Consider nonstimulants for specific situations:

- Atomoxetine for patients with substance use disorders
- Bupropion for comorbid depression, tobacco use, or weight concerns
- Alpha agonists (guanfacine, clonidine) for comorbid insomnia or tics

Among nonstimulants:

- Atomoxetine has the strongest evidence base
- Viloxazine may have faster onset of action, although this was not based on head-to-head data
- Alpha agonists are used more frequently for children

Long-Acting vs Short-Acting Stimulants

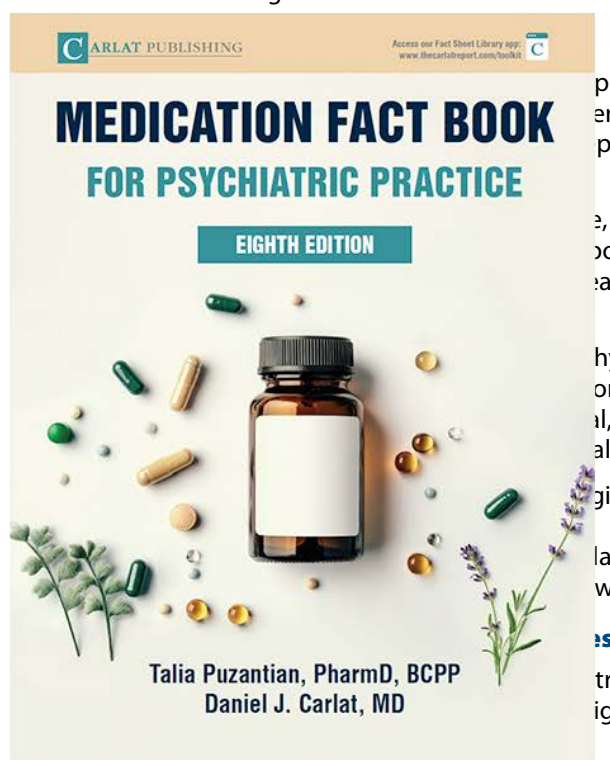
Choosing between long- and short-acting stimulants is more art than science. Trial and error, combined with patient preference, will dictate the final regimen.

Long-acting stimulants work best for:

- Adults needing all-day coverage without workplace medication doses
- Adolescents wanting to avoid medication stigma at school
- Patients requiring consistent coverage throughout the day
- Those who struggle with medication adherence

Short-acting stimulants make sense for:

- Children who need coverage during school but appetite at mealtimes
- Sensitive patients needing low starting doses not available in long-acting forms
- Patients wanting flexible late-afternoon coverage
- Establishing the best dose before converting to a long-acting formulation

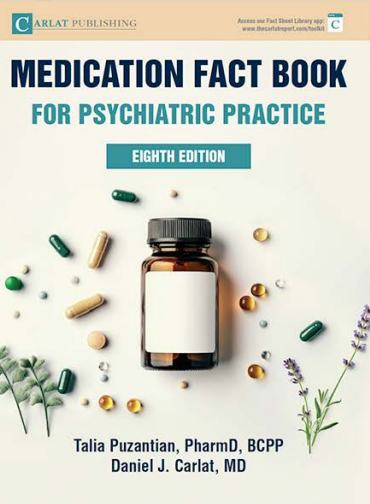
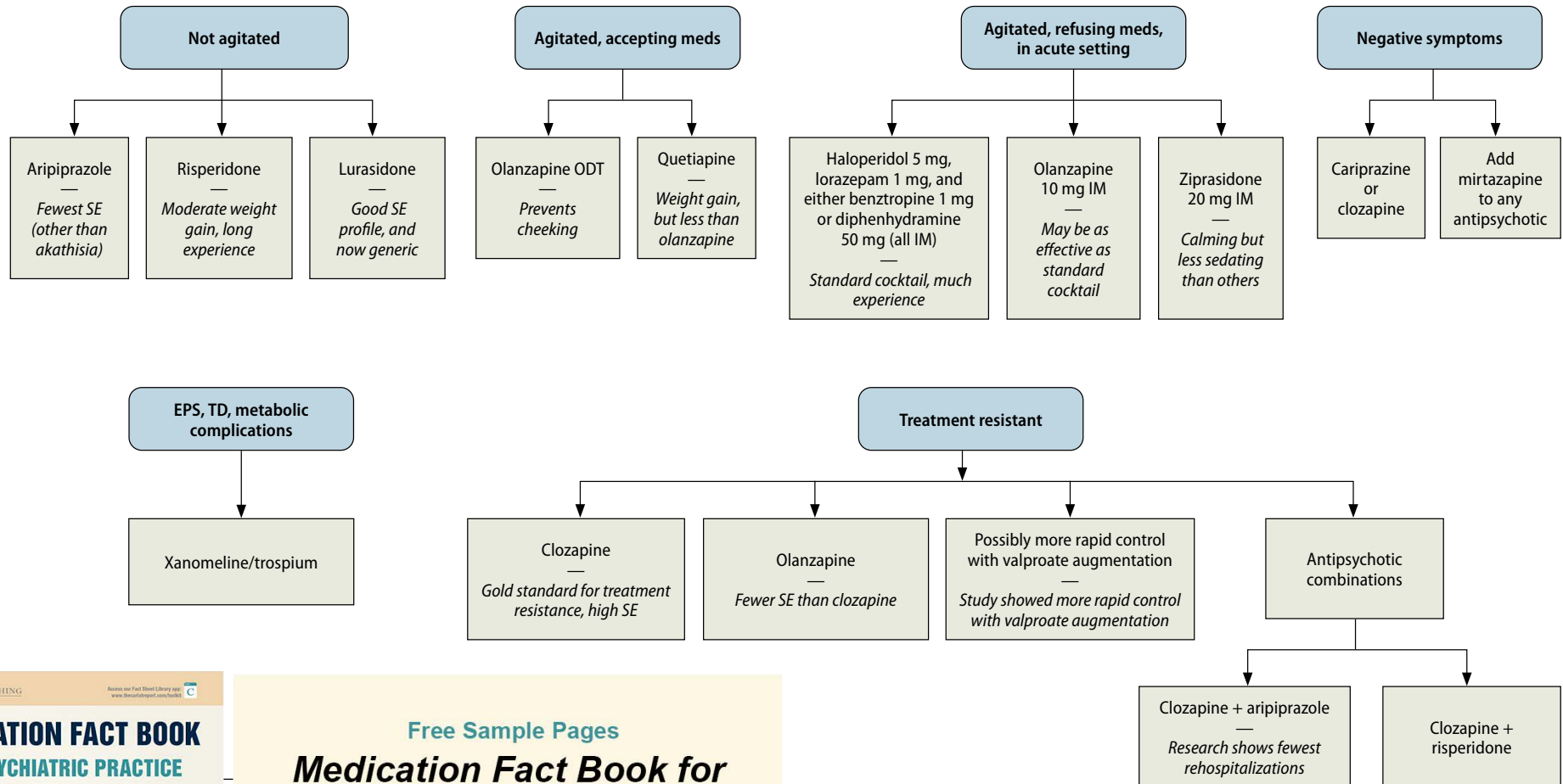


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Psychosis Treatment Algorithm

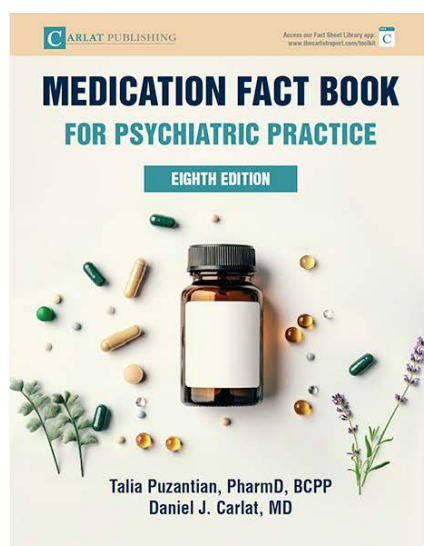


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MOLINDONE (Moban) Fact Sheet [G]

- Bottom Line:** Molindone is an effective, well-tolerated first-generation antipsychotic (FGA) of medium potency—a solid medication that some clinicians have gained experience with and favor for select patients. Recently it has been reintroduced into the market, and is still generic and inexpensive.
- FDA Indication:** Schizophrenia.
- Off-Label Uses:** Bipolar disorder; behavioral disturbances; impulse control disorders.
- Dosage Forms:** Tablets (G): 5 mg, 10 mg, 25 mg.
- Dosage Guidance:** Start 50–75 mg/day divided 2–4 times daily; increase to 100 mg/day in 3 or 4 days. Maximum 225 mg/day divided 3–4 times daily.
- Monitoring:** No routine monitoring recommended unless clinical picture warrants. **Cost:** \$\$\$\$\$
- Side Effects:**
- Most common: Sedation (dose related), extrapyramidal symptoms (EPS), agitation.
 - Serious but rare: See class warnings in chapter introduction. Rare reports of leukopenia and leukocytosis.
 - Pregnancy/breastfeeding: Not enough data to recommend.
- Mechanism, Pharmacokinetics, and Drug Interactions:**
- Dopamine D2 antagonist.
 - Metabolized primarily through CYP2D6; half-life: 1.5 hours.
- Clinical Pearls:**
- Molindone is an intermediate-potency FGA; this leads to less EPS compared to high-potency agents (eg, fluphenazine, haloperidol) and to less sedation, less orthostasis, and fewer anticholinergic side effects compared to low-potency agents (eg, chlorpromazine).
 - Unlike most antipsychotics, molindone has been shown to reduce weight in some patients.
- Fun Fact:** In 2010, the only manufacturer of molindone in the US (as brand Moban), Endo Pharmaceuticals, announced that they would be discontinuing production because of poor sales. In December 2015, Core Pharma launched a new generic version, bringing molindone back to life.



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PIMAVANSERIN (Nuplazid) Fact Sheet



Bottom Line:

Pimavanserin is the only antipsychotic with virtually no effect on dopamine receptors. It is the only approved medication for psychosis in Parkinson's disease, but we do not yet know if it has any efficacy advantages over quetiapine, which has generally been the go-to antipsychotic for this syndrome. Its lack of weight gain is a side effect advantage, but there are some concerns about increases in hospitalization and higher mortality in patients with Parkinson's disease psychosis.



FDA Indications:

Hallucinations and delusions associated with Parkinson's disease psychosis.



Off-Label Use:

Depression.



Dosage Forms:

- Tablets: 10 mg.
- Capsules: 34 mg.



Dosage Guidance:

Start and continue with 34 mg once daily (no titration). Use 10 mg tablet in patients taking concurrent CYP3A4 inhibitors.



Monitoring: Fasting glucose, lipids.

Cost: \$\$\$\$



Side Effects:

- Most common: Nausea, peripheral edema, confusion.
- Serious but rare: QT prolongation (dose related; mean prolongation of 5–8 msec at usual dose); class warning regarding increased mortality in elderly.
- Pregnancy/breastfeeding: Not enough data to recommend.



Mechanism, Pharmacokinetics, and Drug Interactions:

- Second-generation antipsychotic with combination of inverse agonist and antagonist activity at 5-HT_{2A} and, less so, at 5-HT_{2C} receptors.
- Metabolized by 3A4 and 3A5; half-life: 57 hours (200 hours for active metabolite).
- Caution with potent inhibitors or inducers of 3A4 (adjust dose per above). Avoid use with other medications that may increase QT interval.



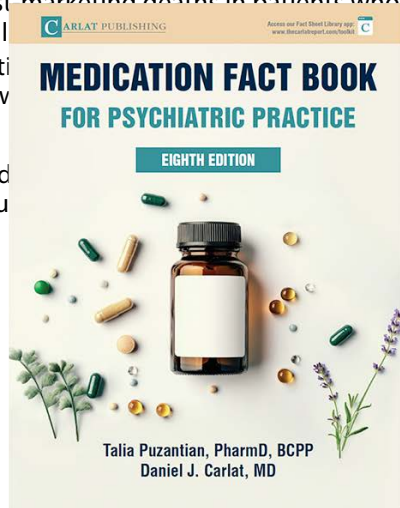
Clinical Pearls:

- FDA approval based on a 6-week placebo-controlled outpatient study of 185 patients that showed only modest (but statistically significant) improvement in hallucinations and delusions compared to placebo.
- The study didn't find any difference (improvement or worsening) in motor function between those who received Nuplazid or placebo.
- All in all, though, pimavanserin did not show statistically significant benefit in three out of four pre-approval clinical studies.
- Reports of post-marketing deaths in patients who had taken Nuplazid have sparked investigation and controversy, though we still
- Multiple negative studies of pimavanserin v



Fun Fact:

The FDA rejected effect in some su



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Table 13: Anxiolytic and Hypnotic Medications

Generic Name (Brand Name) Year FDA Approved <i>[G] denotes generic availability</i>	Relevant FDA Indication(s)	Available Strengths (mg)	Onset of Action (oral)	Half-Life (hours)	Duration of Action (hours)	Usual Dosage Range (starting–max) (mg)
Antihistamines						
Diphenhydramine [G] (Benadryl, others) 1946 Available OTC and Rx	Insomnia (adults and children age 12+)	Capsule: 25, 50 Tablet: 25 Liquid: 12.5 mg/mL	1 hour	3.5–9	4–6	25–50 QHS
Doxepin [G] (Silenor) 2010/1969	Insomnia (sleep maintenance)	Tablet: 3, 6 Capsule: 10, 25, 50, 75, 100, 150 Liquid: 10 mg/mL	1 hour	15	4–6	3–6 QHS
Doxylamine [G] (Unisom, others) 1978 Available OTC and Rx	Insomnia	Tablet: 25	1 hour	10	4–6	25–50 QHS
Hydroxyzine [G] (Atarax, Vistaril) 1956	GAD	Capsule: 25, 50, 100 Tablet: 10, 25, 50 Liquid: 10 mg/5 mL Injection: 25 mg/mL, 50 mg/mL	30 min	7–20	4–6	25–50 Q4–6H PRN or up to 25–100 QID
Benzodiazepines						
Alprazolam [G] (Xanax, Xanax XR) 1981	GAD Panic disorder	Tablet: 0.25, 0.5, 1, 2 ER tablet: 0.5, 1, 2, 3 ODT: 0.25, 0.5, 1, 2 Liquid: 1 mg/mL	30 min (IR, ODT) 1–2 hours (XR)	11–16	3–4 (IR) 10 (XR)	0.25–2 TID 0.5–3 QD (XR)
Clonazepam [G] (Klonopin, Klonopin Wafers) ¹ 1975	Panic disorder Insomnia (off-label)	Tablet: 0.5, 1, 2 ODT: 0.125, 0.25, 0.5, 1, 2	1 hour	20–80	4–8	0.5 BID–2 TID 0.25–1 QHS
Diazepam [G] (Valium) 1963	GAD Alcohol withdrawal	Tablet: 2, 5, 10 Liquid: 5 mg/5 mL, 5 mg/mL Injection: 5 mg/mL	30 min	>100	4–6	2 BID–10 QID
Flurazepam [G] (Dalmane ¹) 1970	Insomnia (short term)	Capsule: 15, 30	30–60 min	40–100	7–8	15–30 QHS
Lorazepam [G] (Ativan, Loreev XR) 1977	GAD Insomnia (off-label)	Tablet: 0.5, 1, 2 ER capsule: 1, 1.5, 2, 3 Liquid: 2 mg/mL Injection: 2 mg/mL, 4 mg/mL	30–60 min	10–20	4–6	1–5 BID (QD for XR) 1–4 QHS
Temazepam [G] (Restoril) 1981	Insomnia (short term)	Capsule: 7.5, 15, 22.5, 30	30–60 min	9–18	4–6	15–30 QHS
Triazolam [G] (Halcion) 1982	Insomnia (short term)	Tablet: 0.125, 0.25	15–30 min	1.5–5.5	Unknown	0.25–0.5 QHS
Dual Orexin Receptor Antagonists						
Daridorexant (Quviviq) 2022						–50 QHS
Lemborexant (Dayvigo) 2019						10 QHS
Suvorexant (Belsomra) 2014						–20 QHS
Z-Hypnotics						
Eszopiclone [G] (Lunesta) 2004						3 QHS

**MEDICATION FACT BOOK
FOR PSYCHIATRIC PRACTICE**

EIGHTH EDITION



Talia Puzantian, PharmD, BCPP
Daniel J. Carlat, MD

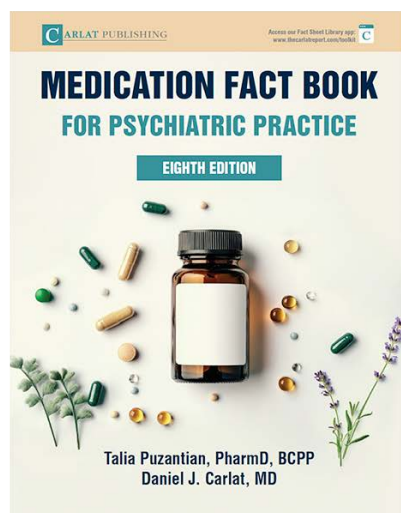
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Generic Name (Brand Name) Year FDA Approved <i>[G] denotes generic availability</i>	Relevant FDA Indication(s)	Available Strengths (mg)	Onset of Action (oral)	Half-Life (hours)	Duration of Action (hours)	Usual Dosage Range (starting–max) (mg)
Zaleplon [G] (Sonata) 1999	Insomnia (short term, sleep onset)	Capsule: 5, 10	30 min	1	4	10–20 QHS
Zolpidem [G] (Ambien, Ambien CR, Edluar) 1992	Insomnia (IR: short term, sleep onset; CR: sleep onset and maintenance)	Tablet: 5, 10 ER tablet: 6.25, 12.5 SL tablet: 5, 10	30 min	2.5–3	6–8	10, 12.5 CR (5, 6.25 in women)
Zolpidem low dose [G] 2011	Difficulty falling asleep after middle-of-the-night awakening	SL tablet: 1.75, 3.5	30 min	2.5	4	1.75 women; 3.5 men
Others						
Buspirone [G] (BuSpar ¹) 1986	GAD	Tablet: 5, 7.5, 10, 15, 30	1–2 weeks+	2–3	N/A	5–20 TID
Clonidine (Catapres, Kapvay) 1974	Anxiety (off-label)	Tablet: 0.1, 0.2, 0.3 ER tablet: 0.1, 0.2 Patch: 0.1 mg/day, 0.2 mg/day, 0.3 mg/day	30–60 min (oral) 1–2 days (patch)	6–13	8–12 (IR) 8–24 (patch)	0.1–0.2 Q4–6H PRN (IR) 0.1–0.2 QD–BID
Gabapentin [G] (Neurontin) 1993	Anxiety (off-label)	Capsule: 100, 300, 400 Tablet: 600, 800 Oral solution: 50 mg/mL ER tablet: 300, 600	1–2 hours	5–7	5–8	100 QHS–1200 TID
Prazosin [G] (Minipress) 1976	PTSD (off-label)	Capsule: 1, 2, 5	1–2 hours	2–3	4–6	1–10 mg/day QHS or divided BID
Pregabalin [G] (Lyrica) 2004	Anxiety (off-label)	Capsule: 25, 50, 75, 100, 200, 225, 300 Oral solution: 20 mg/mL	1–2 hours	6	8–12	75–300 BID
Propranolol [G] (Inderal) 1973	Performance anxiety (off-label)	Tablet: 10, 20, 40, 60, 80	60 min	3–6	4–6	10–40 PRN
Ramelteon [G] (Rozerem) 2005	Insomnia (sleep onset)	Tablet: 8	30 min	1–2.6	Unknown	8 QHS
Trazodone [G] (Desyrel ¹ , Oleptro ¹) 1981/2010	Depression Insomnia (off-label)	Tablet: 50, 100, 150, 300 ER tablet: 150, 300	1 hour	7–10	Unknown	25–200 QHS

¹Brand discontinued; available as generic only



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ALPRAZOLAM (Xanax) Fact Sheet [G]

-  **Bottom Line:**
Alprazolam is fast acting and effective for generalized anxiety disorder (GAD) and panic disorder, but its short duration of action may contribute to breakthrough symptoms between doses and make withdrawal more difficult.
-  **FDA Indications:**
GAD; panic disorder.
-  **Off-Label Uses:**
Other anxiety disorders; insomnia; acute mania or psychosis; catatonia.
-  **Dosage Forms:**
- Tablets (G): 0.25 (scored), 0.5 mg (scored), 1 mg (scored), 2 mg (scored).
 - Extended-release tablets (Xanax XR, [G]): 0.5 mg, 1 mg, 2 mg, 3 mg.
 - Orally disintegrating tablets (G): 0.25 mg, 0.5 mg, 1 mg, 2 mg.
 - Oral concentrate (G): 1 mg/mL.
-  **Dosage Guidance:**
- GAD: Start 0.25–0.5 mg 3 times daily; increase by 0.25–0.5 mg/day increments every 3–4 days as needed and tolerated to maximum 4 mg/day divided 3–4 times daily.
 - Panic disorder: Start 0.5 mg 3 times daily; increase by increments of no more than 1 mg/day every 3–4 days as needed to target dose 4–6 mg/day divided 3–4 times daily. Maximum 10 mg/day.
 - Panic disorder using extended-release: Start 0.5–1 mg once daily; increase by increments of no more than 1 mg/day at intervals of 3–4 days to target dose 3–6 mg once daily.
-  **Monitoring:** No routine monitoring recommended unless clinical picture warrants.  **Cost:** \$
-  **Side Effects:**
- Most common: Sedation, somnolence, memory impairment, slurred speech, incoordination, dependence.
 - Serious but rare: Anterograde amnesia, increased fall risk, paradoxical reaction (irritability, agitation), respiratory depression (avoid in patients with sleep apnea or on opioids).
 - Pregnancy/breastfeeding: Potential risks with exposure in early and late pregnancy; use caution in breastfeeding.
-  **Mechanism, Pharmacokinetics, and Drug Interactions:**
- Binds to benzodiazepine receptors to enhance gamma-aminobutyric acid effects.
 - Metabolized primarily through CYP3A4; half-life: 11–16 hours.
 - Avoid use with other central nervous system depressants, including alcohol and opioids (additive effects). Potent 3A4 inhibitors (eg, fluvoxamine, erythromycin) may increase alprazolam levels; 3A4 inducers (eg, carbamazepine) may decrease alprazolam levels.
-  **Clinical Pearls:**
- Schedule IV controlled substance.
 - Withdrawal seizures can occur with abrupt discontinuation, particularly with short-acting benzodiazepines like alprazolam. Always taper gradually over weeks to months.
 - Benzodiazepines are very effective immediately for GAD and panic disorder, particularly in the early weeks of selective serotonin reuptake inhibitor therapy while awaiting onset of therapeutic effect.
 - Breakthrough anxiety between doses is common due to short half-life; consider switching to longer-acting clonazepam if this occurs.
 - Paradoxical reaction of aggression, agitation, and combativeness is more likely to occur in the elderly or those with brain injury.
 - While benzodiazepines are highly abusable, patients with panic disorder rarely self-increase their dose when treated adequately, indicating that tolerance to anxiolytic effects does not occur.
-  **Fun Fact:**
There are many slang terms for alprazolam; some of the more common ones are bars, Z-bars, zannies, footballs, blues, and blue footballs.

OMEGA-3 FATTY ACIDS (Fish Oil) Fact Sheet [G]



Bottom Line:

Omega-3 fatty acids form the lipid bilayers of cell membranes, and supplementing our natural dietary supply may have psychological and cardiological benefits. Based on the limited data available, the best use of omega-3 fatty acids (particularly 1–2 g with at least 60% eicosapentaenoic acid [EPA]) is as an adjunct in the treatment of unipolar and bipolar depression. Evidence for other psychiatric uses is limited.



FDA Indication:

High triglycerides (as Lovaza).



Off-Label Uses:

Unipolar and bipolar depression; may reduce antipsychotic-related weight gain and metabolic effects.



Dosage Forms:

- Over the counter: Softgel capsules in 500 mg, 1000 mg, 1200 mg doses (of total fish oil).
- Prescription: Lovaza: 1000 mg softgel capsules.
- Note: Labels often reflect total fish oil content—not omega-3 content. For example, a 1000 mg capsule may only contain 300 mg EPA + docosahexaenoic acid (DHA). Dosing recommendations are based on mg of fish oil.



Dosage Guidance:

Depression: Start at 500 mg/day; increase to 1–2 g/day of omega-3s, with at least 60% EPA content. Doses greater than 3 g/day should be used with caution due to bleeding risk. Divide twice daily to three times daily to minimize gastrointestinal side effects. Choose a product with 100% EPA or an EPA:DHA ratio that is at least 2:1.



Monitoring: No routine monitoring recommended unless clinical picture warrants.

Cost: \$



Side Effects:

- Most common: Nausea, loose stools, and fishy aftertaste. Well tolerated up to 4 g/day.
- Serious but rare: Risk of bleeding at higher doses; use caution in seafood-allergic individuals.
- Pregnancy/breastfeeding: Considered relatively safe.



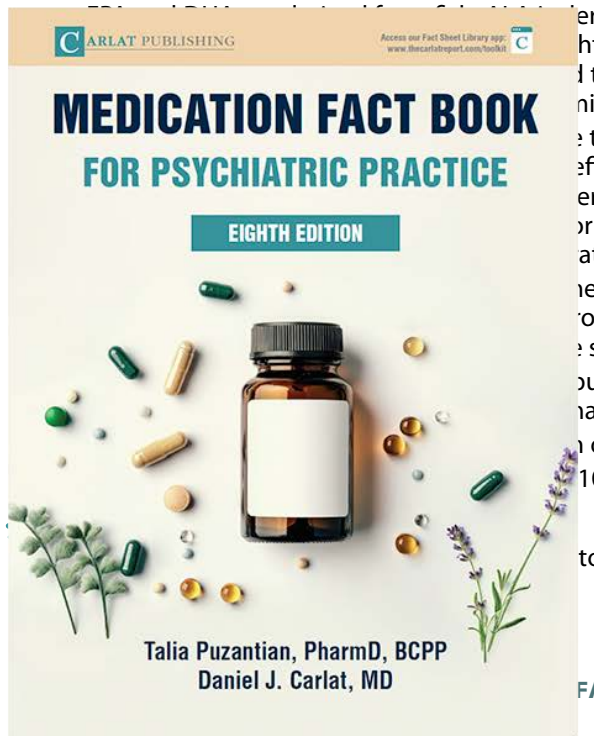
Mechanism, Pharmacokinetics, and Drug Interactions:

- May improve cell membrane fluidity, enhance neurotransmitter function, and reduce inflammation.
- Metabolism is hepatic, primarily through CYP450; half-life: unknown.
- For most patients, drug interactions not likely an issue; however, may prolong bleeding time. Fish oils may lower blood pressure and have additive effects when used with antihypertensives.



Clinical Pearls:

- Fish oils contain EPA and DHA; both are omega-3 fatty acids. Although the body can synthesize these fats from alpha-linolenic acid (ALA), this is believed to be inefficient in many people.



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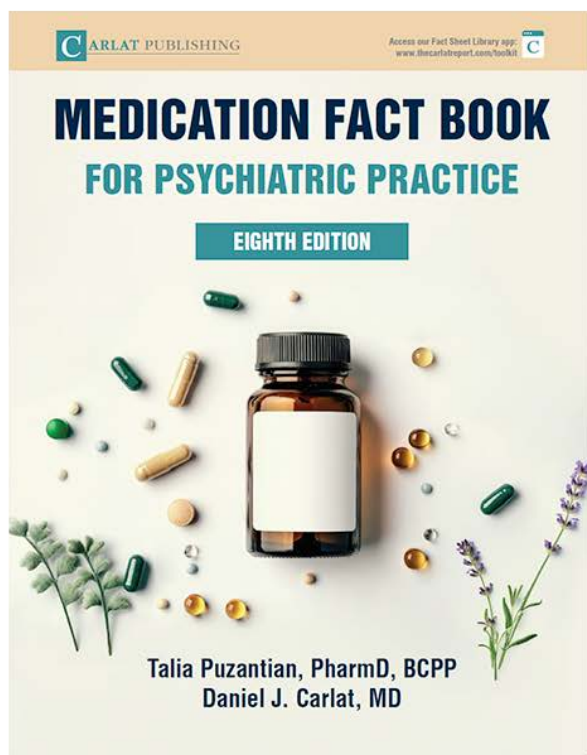
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