Bipolar Disorder - Medication Pathway for Adults

The aim of this pathway is to encourage safe and efficient prescribing by advising the best evidence-based pharmacological treatments for bipolar disorder.

**Patients aged over 65 years:** The majority of doses stated refer to adult dosing and the prescriber should consult the BNF for advice on doses & initiation of medicines for elderly patients. Prescribing in older people usually involves using medication at lower doses, taking into account the increased risk of drug interactions and the negative impact that anticholinergic medication or drugs with anticholinergic activity can have on cognitive function and mobility. Ensure that medical comorbidities have been recognised & treated.

**Key prescribing guidelines**

* At all steps, consider non-pharmacological options
* Before prescribing, request a full list of medical problems & medication from the GP
* Consider underlying physical health problems
* Ensure all pre-treatment and ongoing monitoring is carried out as per Trust guidance for each individual medicine
* Ensure all prescribing decisions take into account any advance directives, the person’s preference and clinical context (including physical comorbidity, previous response to treatment and side effects) where possible.
* **Consider MHRA (2018) &** [**Trust guidance**](http://flc-intouch:35000/Services/Clinical/Pharmacy/Documents/Medication%20Safety/Medication%20Safety%20Series/Medication%20Safety%20Series%20MSS13%20-%20Valproate%20PPP.pdf) **regarding valproate in female patients of child bearing potential – NB. Valproate in such patients is AMBER** [**(shared care)**](http://flc-intouch:35000/Docs/Documents/Policies/TEWV/Pharmacy/Valproate%20-%20shared%20care.pdf) **for safe transfer of prescribing.**
* Be aware of potential drug interactions when prescribing combination therapy, e.g. valproate + fluoxetine; olanzapine + lamotrigine,
* If initiating lamotrigine, follow BNF prescribing recommendations regarding dose escalation, dependent on other prescribed medicines, and advise the patient regarding the risks and action to take if they develop a rash.
* Once first line options are exhausted and other options are being considered, please note that options such as lurasidone and asenapine are both categorised as **PURPLE** (non-formulary) in the safe transfer of prescribing guidelines; an application for use and approval of a panel is needed before prescribing either of these drugs, prescribing cannot be transferred to primary care.
* Take into account toxicity in overdose when prescribing psychotropic medication during periods of high suicide risk. Assess the need to limit the quantity of medication prescribed, e.g. 7 days per prescription, to reduce the risk to life from overdose.
* If stopping long‑term pharmacological treatment:
  + Discuss with the person how to recognise early signs of relapse and what to do if symptoms recur
  + Stop treatment gradually and monitor the person for signs of relapse.
  + Discontinuation of any medicine should normally be tapered over at least 4 weeks, preferably longer
  + Continue monitoring symptoms, mood and mental state for 2 years after medication has stopped entirely (may be undertaken in primary care)
  + The risk of relapse remains even after years of sustained remission
* TEWV Level 1 & 2 NMPs cannot initiate lithium or clozapine; level 2 NMPs may adjust clozapine and lithium doses if this is detailed within their scope of practice and there is evidence that the consultant is aware of dose changes.

**Bipolar Depression**

**Patient not currently taking a drug for bipolar disorder**

**Moderate to severe and patient already taking:**

**LITHIUM**

**200-400 mg/day**

**Dose adjusted to serum lithium concentration**

**VALPROATE**

**750 mg/day (2-3 divided doses)**

**Max 1-2 grams/day**

**ADD**

**OR**

|  |
| --- |
| **Consider** (in any order based on patient profile and preference):   * **FLUOXETINE 20 mg daily; Max 60 mg/day + OLANZAPINE 5-20 mg daily; Max 20 mg/day** * **QUETIAPINE Immediate release, titrate to 300 mg over 4 days, then adjust according to response; max 600 mg/day** * **OLANZAPINE 10 mg daily; max. 20 mg daily** |

**IF NO RESPONSE, STOP & ADD**

**LAMOTRIGINE (can be used first line if patient prefers):**

**Slow titration up to 200 mg\* daily; Max 400 mg\* daily** (\*lower with valproate)

**& ADD**

**OPTIMISE**

**Add: VALPROATE**

**(Carbamazepine also licensed for prophylaxis, but use is restricted due to interactions, not NICE approved)**



**Replace with:**

**VALPROATE OR OLANZAPINE OR QUETIAPINE (if previously effective)**

**/ UNSUITABLE**

**IF POORLY TOLERATED**

**LITHIUM**

**LONG TERM TREATMENT (discuss within 4 weeks of resolution of symptoms of bipolar depression or mania):**

**IF INEFFECTIVE**

**New diagnosis:**

No current medication

**New diagnosis:**

Taking an antidepressant

**Existing diagnosis:**

Taking a mood stabiliser

(non-antipsychotic)

**Existing diagnosis:**

Taking an antidepressant +

mood stabiliser

(non-antipsychotic)

**Mania /**

**Hypomania**

**REVIEW / STOP ANTIDEPRESSANT**

**OPTIMISE**

**MOOD STABILISER**

**ADD**

|  |
| --- |
| **Consider** (in any order based on patient profile and preference):   * **OLANZAPINE 10 – 15 mg daily Usual range 5-20 mg/day Max 20 mg/day (assess risk/benefit for doses >15 mg/day); Use lower dose if female/ elderly / non-smoker** * **QUETIAPINE (Immediate release) Initiate at 50 mg b.d,** 🡡 **by 50 mg b.d. until day 4, then** 🡡 **by 200 mg/day according to response; Max 800 mg/day (in divided doses); titrate more slowly in elderly** * **RISPERIDONE 2 mg daily 🡡 in steps of 1 mg/day if required; Max 6 mg/day (NB. Elderly initiation 500 micrograms b.d. 🡡in steps of 500 micrograms b.d, max 1-2 mg bd)** * **ARIPIPRAZOLE 15 mg daily, Max 30 mg/day; not NICE approved, may be a suitable alternative in patients suffering metabolic adverse effects** * **HALOPERIDOL 2-10 mg daily (1-2 divided doses); Adjust every 1-3 days; Max 15 mg/day (assess risk/benefit for doses >10 mg/day)**   **IF INEFFECTIVE / NOT TOLERATED STOP INITIAL DRUG &**  **TRY ANOTHER** |

**VALPROATE**

**750 mg/day (2-3 divided doses)**

**Usual dose 1-2 grams/day**

**Some evidence for higher doses achieving a serum level of up to 120 mg/l**

**IF INEFFECTIVE / NOT TOLERATED STOP & ADD**

**IFSTILL INEFFECTIVE AT MAX DOSE & NOT ALREADY PRESCRIBED**

**ADD**

**LITHIUM**

**Dose adjusted to serum lithium concentration**

**(target: 0.8-1.0 mmol/L).**

**Some evidence for higher levels up to 1.2 mmol/L**



**Supporting Information**

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**Definitions**

* Off-label - prescribing a licensed medication for a condition outside its marketing authorisation (licence)
* Unlicensed - prescribing a medicine that does not have a UK marketing authorisation (licence)

**Off-label and Unlicensed Medicines**

Before prescribing off-label or unlicensed medicines the following conditions must be met:

* The medicine is better suited to the patient/client’s needs than an appropriately licensed alternative
* There is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy
* The reasons why medicines are not licensed for their proposed use should be explained to the patient/client, or parent/carer
* A clear and accurate record of medicines and the rational for use should be documented on Patient record (unless the medication is included in TEWV off-label permissions) as part of the Medication Treatment Plan
* Prescribing & monitoring arrangements for “off-label” and unlicensed medications are likely to remain in secondary care unless transfer has been agreed

NMPs may prescribe a medicine for use outside the terms of its licence (off label) providing they are satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety, efficacy and benefit to the patient (NMC, 2007, HPCP, 2016). All use of unlicensed and off label medications **must** be in accordance with the trust Drug & Therapeutic Committee’s approved off licence use and within the scope of practice and level of practice of the NMP.

**Useful links**

**NICE Guideline**

[Bipolar disorder](https://www.nice.org.uk/guidance/cg185) – assessment and management, (updated 2018). Clinical guideline 185.

**BAP Guidelines**

[Evidence based guidelines for treating bipolar disorder](https://www.bap.org.uk/pdfs/BAP_Guidelines-Bipolar.pdf), (2016)

[Guidelines for the management of weight gain](https://www.bap.org.uk/pdfs/BAP_Guidelines-Metabolic.pdf). (2016)

**Canadian Network for Mood and Anxiety Treatments (CANMAT)**

**and International Society for Bipolar Disorders (ISBD)**

[Guidelines for the management of patients with bipolar disorder](http://www.canmat.org/CANMAT%20and%20ISBD%20Bipolar%20GUIDELINES-%20YATHAM%20et%20al%202018.pdf) (2018)

**The Maudsley Prescribing Guidelines**

Taylor, D., Paton C. & Kapur S. (2018). Chapter 2 – Bipolar disorder. The Maudsley Prescribing Guidelines in Psychiatry, 13th Edition. London: CRC Press. [lib.myilibrary.com/Open.aspx](http://lib.myilibrary.com/Open.aspx?id=786015&src=0) (Athens account & login needed; contact library services if needed)

**Medication Information**

The Choice and Medication website has helpful information in agreeing choice of medication for bipolar disorder with patients [www.choiceandmedication.org.uk/tees-esk-and-wear-valleys/](http://www.choiceandmedication.org.uk/tees-esk-and-wear-valleys/) and you can print out medication information sheets. It also has information on driving whilst taking medication.