Depot Antipsychotics (Long-Acting Injectables): Guidance for Prescribing, Administration and Medicines Management

Tees, Esk and Wear Valleys NHS Foundation Trust

General

- Pros/Cons
- First vs Second Generation
- Switching/Stopping
- Education and Training
- Frequency of Administration
- Tolerance Windows
- Deprescribing
- Case Load Standards
- Transferring Patients

Community

- Prescribing
- Communication
- Ordering
- Transportation of Medication
- Storage
- Administration

Inpatient

- Prescribing
- Communication
- Ordering
- Storage
- Administration

Drug Monographs

- FLUpentixol
- Haloperidol
- ZUCLOpenthixol
- Aripiprazole
- PALIperidone (Monthly)
- PALIperidone (THREE Monthly)
- RISperidone

Appendices

- Glossary
- Pre-administration Checklist
- Adjusting Intervals
- Pharmacokinetics
- Deprescribing Risk/Benefit Analysis
- Associated Resources and Guidelines

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Advantages and Disadvantages of Depots

Long-acting injectable (LAI) antipsychotics, or “depots”, are a useful and well-established form of administering antipsychotics in the management of schizophrenia and other indications. For the purposes of this guideline, the term “depot” will be used.

NICE CG178 recommends that consideration should be given to offering a depot / long-acting injectable antipsychotic to people with psychosis or schizophrenia who express a preference for such treatment after an acute episode. Long-acting injections are NOT recommended for treatment-resistant schizophrenia as they have been found to be ineffective for many of those patients. Prescribing should be underpinned by shared decision making (NICE NG197).

Advantages of Depots

- Provide an option where compliance with oral treatment is consistently poor
- Steady plasma levels compared to oral medication
- Increased bioavailability (less first-pass metabolism)
- Reduction in relapse rate, severity of relapse and rehospitalisation
- Stable therapeutic effects
- Better downward titration to minimise side-effects
- Some evidence that long-acting injections cause less brain tissue loss and deterioration (CATIE study, Lieberman, 2005)

Disadvantages of Depots

- Treatment cannot be stopped quickly if severe side-effects develop (dystonia, EPSE, NMS)
- Patient perception e.g. “being controlled” or possibly being punished.
- Pain at the site of injection, lasting possibly 10 days
- Tissue necrosis - over time hard plaques may form, which will reduce the ease of administration and the efficacy of the injection as well as causing discomfort.
- Loss of dignity with the gluteal route
- Need to be used with caution in combination with other medicines known to have a myelosuppressive potential, as these cannot rapidly be removed from the body in conditions where this may be required.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Counselling Patients

- Address potential stigma and provide supportive information to patient and carers
- Discuss reason for depot: patient preference and/or need to reduce non-adherence
- Agree treatment using shared decision-making
- Discuss benefits and risks, including EPS and metabolic side effects
- Assess and document attitude to regular IM injections
- Agree administration setting (clinic or home)
- Where licensed, offer choice of injection site, including deltoid where applicable
- Confirm capacity, understanding and legal compliance; signpost to decision aids
- **Document all discussions in the patients EPR**.

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Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Choosing the Right Depot

Suitability: Depots are suitable for any patient with an established response and tolerance to the same drug via oral administration, and where compliance with such treatment is consistently poor.

Choice and Medication patient leaflets may assist with shared decision making, including a handy chart for comparison of drugs used in psychosis which allows for comparison of adverse effects, and a short and long version of a handy fact sheet comparing depot injections with oral antipsychotics.

First Generation

(haloperidol, zuclopenthixol, flupentixol)

- Cheaper than SGAs but consider increased resources for shorter dose intervals/management of side effects
- Poorer tolerability e.g. EPSEs
- Variable dose intervals

Second Generation

(risperidone, paliperidone and aripiprazole)

- More expensive
- Reduced side effects but more prone to metabolic effects
- Longer dose intervals*

*Paliperidone should be used in preference to risperidone because it offers advantages such as increased concordance (due to a longer dose interval), reduced nurse time and easier storage / preparation requirements.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Switching Between Depots

Discontinued depots will continue to have therapeutic / adverse effects for some time after administration of the last dose (see pharmacokinetic information in individual monographs).

The dose of the discontinued depot should be used to calculate an approximate dose equivalence of the new depot; once the patient is established on the new depot the dose can be titrated according to clinical response

Test doses of the new depot may be required prior to the formal switch e.g. FGA's

If switching depot before steady state has been reached of the initial depot, please seek pharmacy advice.

Please refer to individual drug monographs for specific switching advice.

- Flupentixol
- Haloperidol
- Zuclopenthixol
- Aripiprazole
- Paliperidone (Monthly)
- Paliperidone (THREE Monthly)
- Risperidone

Stopping Antipsychotic Treatment Completely

If treatment with an antipsychotic depot is stopped without switching to another depot or to an oral antipsychotic, continue to monitor symptoms, mood and mental state for 2 years (may be undertaken in primary care if appropriate).

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

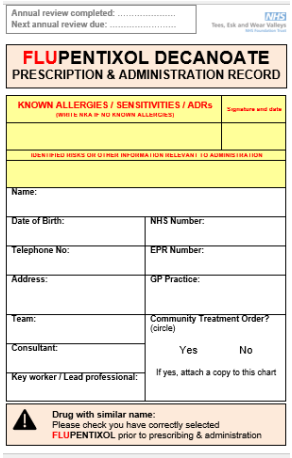
Return to Main Menu

Community Teams: Prescribing (1 of 2)

Initiation

A product-specific "**Depot Antipsychotic Prescription & Administration Record**" (hereafter referred to as "depot chart") must be completed and must be kept in a designated file, accessible to all members of the team as appropriate.

Blank depot charts can be ordered via Trust Pharmacy teams.


Annual review completed: .....
Next annual review due: .....

FLUPENTIXOL DECANOATE
PRESCRIPTION & ADMINISTRATION RECORD

KNOWN ALLERGIES / SENSITIVITIES / ADRs
(WRITE NKA IF NO KNOWN ALLERGIES)

Signature and date

IDENTIFIED RISKS OR OTHER INFORMATION RELEVANT TO ADMINISTRATION

Name:

Date of Birth:

NHS Number:

Telephone No:

EPR Number:

Address:

GP Practice:

Team:

Community Treatment Order? (circle)
Yes No
If yes, attach a copy to this chart

Consultant:

Key worker / Lead professional:

Drug with similar name:
Please check you have correctly selected
FLUPENTIXOL prior to prescribing & administration

Amendments

When the drug, dose or frequency is changed, the current prescription on the depot chart should be discontinued and a new prescription written (on a new chart if necessary).

Community Treatment Orders (CTO)

If there is a CTO in place, this should be located on Paris, printed and physically attached to the depot chart.

Annual Review

Depot charts are valid for 12 months and should be reviewed and rewritten at the annual review. A new chart should not be written before an annual review has been completed. Ensure this is booked in advance to avoid interruptions to treatment. As part of the annual review, consider how many doses have been administered within the last 12 months, inappropriate utilisation of tolerance windows can lead to doses unintentionally over or under those prescribed.

Inpatient Admission

If a patient gets admitted to an inpatient facility, discontinue and file the current depot chart and await details of ongoing prescription to be provided at discharge

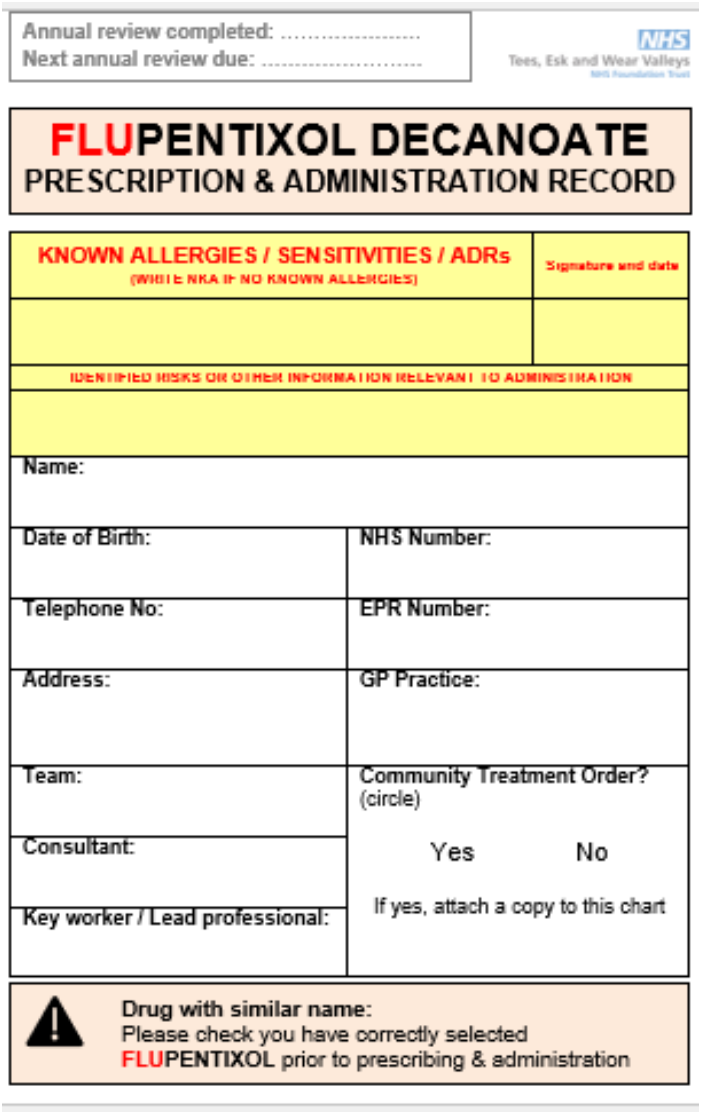
Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community Teams: Prescribing (2 of 2)

Notes for prescription writing (from chart):

1. Write in black ink and block letters. Sign, print and date each prescription
2. Include details of administration site within the prescription; pre-printed sites are those that are licensed for this product; decision and reason to use an unlicensed site should be clearly documented within electronic patient record.
3. Any changes in dose or frequency must be ordered as a new prescription, either in the next available column on the current chart, or on a new chart
4. Prescriptions are valid for TWELVE months and MUST be reviewed as part of an annual review; an extension of one month to cover a delay in the annual review may be applied to avoid a gap in treatment
5. Discontinue by drawing a line through the prescription box and initialling/dating the stop date box
6. **Suspend or discontinue this chart if the patient is admitted to hospital or otherwise unable to receive doses**



Annual review completed: .....
Next annual review due: .....

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FLUPENTIXOL DECANOATE
PRESCRIPTION & ADMINISTRATION RECORD

KNOWN ALLERGIES / SENSITIVITIES / ADRs (WRITE NKA IF NO KNOWN ALLERGIES)	Signature and date

IDENTIFIED RISKS OR OTHER INFORMATION RELEVANT TO ADMINISTRATION

Name:

Date of Birth:	NHS Number:
Telephone No:	EPR Number:
Address:	GP Practice:
Team:	Community Treatment Order? (circle)
Consultant:	Yes No
Key worker / Lead professional:	If yes, attach a copy to this chart

Drug with similar name:
Please check you have correctly selected
FLUPENTIXOL prior to prescribing & administration

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community Teams: Communication

Depot Notification Group

- A group on MS Teams or Outlook is recommended to facilitate communication within the team,
- If local processes are already in place that enable effective communication, then these can be maintained.
- The group should include staff involved in prescribing, ordering, storing, administering, and monitoring depot medication.
- All relevant information regarding the current depot prescription must be communicated with relevant members of the team via the agreed route.
- A nominated staff member will be responsible for the upkeep of the group.

Visual Control Board

- Use of a visual control board is recommended as an aide memoir for depot administration due dates. This could be a physical VCB, an electronic VCB or a shared Outlook calendar. Click for Example VCB to save and use locally.

Electronic Patient Records

- Each time a depot is administered it should be documented on the patients EPR as well as on the physical depot chart

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community Teams: Ordering

Prescribed By	Administered By	Supply Type
TEWV	TEWV	Stock*
TEWV (outpatient prescription) If supplied by a Trust dispensary, a copy of the current depot chart must be provided with the outpatient prescription	External Staff (e.g. care homes)	Named Patient**
Primary Care	TEWV (e.g. patients in care homes without qualified nursing staff)	Named Patient***

*Full boxes in original packaging supplied to reduce the risk of errors in product selection.

**Ensure a robust procedure is in place so supplies are maintained to enable consistent administration on the due date.

***Ensure a robust procedure is in place so repeat prescriptions are requested in a timely manner, so depot supplies, and administration are maintained.

The receipt of stock and named patient supplies by the community team does not need to be logged but stock must be stored appropriately as soon as possible. For further detail see pages on storage in TEWV sites and in the patients own home.

Community Teams: Transportation

Logistics

- Safe lockable bag and out of sight e.g. locked car boot
- Further details in Medicines Overarching Framework
- Routes planned with consideration of fridge lines.*

Packaging

- Single dose packs to remain in original packaging.
- Multidose packs Single ampoule to be transported in suitable receptable.
- Unused injections to be returned to clinic as soon as practicable

Paperwork

- Depot chart should be transported with the depot injection safely
- Chart to be returned to depot file by end of the working day
- If not returning to base on that day the chart must be kept secure in line with the Moving records and other sensitive information procedure.

Note: Risperdal Consta® cannot be administered cold, straight from the fridge. It should be removed from the fridge and allowed to sit at room temperature for at least 30 minutes before reconstituting. This must be built into the time allocated for the home visit.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

In-patient Teams: Prescribing – Admission & Discharge

Admission

• Pre-admission depot identified

• The relevant community team contacted to request a copy of the depot chart or verbally reconcile drug, dose, frequency, and date and site of last administration (e.g. left/right, deltoid/gluteal) against the electronic patient record (EPR). This is the responsibility of the prescriber but can be completed during the pharmacy medicines reconciliation if information is not readily available.

• **CMHT advised to discontinue and file the current depot chart**

• Depot to be prescribed on the EPMA system and added to ward Visual Control Board (Click Here for further detail regarding communication).

Discharge

CMHT and GP to be notified on the electronic patient record, the discharge letter, or other agreed route, the current:

- Drug
- Dose
- Frequency
- Last date and site of administration
- If new, start date of depot

This information should be included even if no changes have been made.

See further guidance on patient transfers.

For guidance on transferring prescribing to primary care or a CMHT refer to

Safe Transfer of Psychotropic Medication MSS18

and

Safe Transfer of Prescribing Guidelines

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

In-patient Teams: Communication

Use of a visual control board is recommended as an aide memoir for depot administration due dates. This could be a physical VCB, an electronic VCB or a shared Outlook calendar. Click for Example VCB

Acute hospital teams can be supported to manage depot medication using Mental Health Medicines: Safety Guidance for Acute Hospital Teams.

If advice is sought on management, please refer to this guidance for reference.

If depot administration is required during admission, TEWV stock and CMHT members may attend acute Trusts to administer dose to avoid delays in treatment. Ensure that administration is documented in all relevant patient clinical notes and on any discharge or transfer documentation.

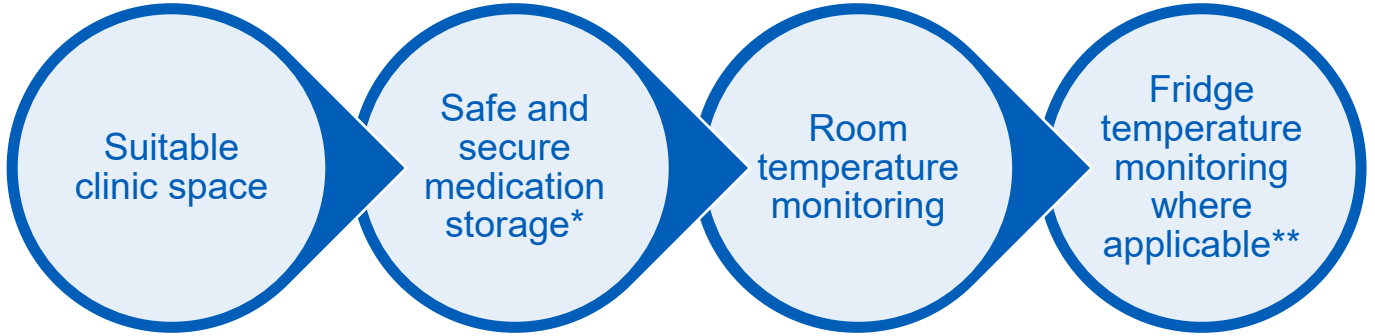
In-patient Teams: Ordering

Depot injections which are on the ward stock list are topped up to a minimum level by the Trust pharmacy team.

Any depot injections not kept as ward stock will be ordered and dispensed on a named patient basis. This will routinely be done by pharmacy as part of their ward visits but can be done by wards by sending an email to the dispensary email address, if necessary (e.g. at a weekend).

Community and In-patient Teams: Storage in TEWV sites

All depot medication on Trust premises should be stored in accordance with both manufacturer and Trust medication storage requirements. These will include:



- E.g. appropriately sized medication cabinets which meet legal storage requirements. See Medicines - Ordering, Storage, Security, Transporting and Disposal Procedure for more details

** E.g. Risperdal Consta to be refrigerated until 30 mins pre-administration

All paperwork must be securely stored for audit purposes. Patient identifiable information will need to be stored for the minimum period, depending on the record type. See Medicines – Retention of Records Policy for more details.

Any surplus named patient (non-stock) supplies should be held in a quarantine area to be processed by the Trust pharmacy team.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community and In-patient Teams: Storage in TEWV sites
Look Alike Sound Alike (LASA)

Certain medications have names that 'look alike, sound alike' e.g. Zuclopenthixol Decanoate and Zuclopenthixol Acetate.
To avoid administration errors the following steps can be taken:

Click on images above for label templates.
Labels are to placed on shelving not individual drug boxes

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community Teams: Storage in Patients Own Home

Depot injections prescribed and supplied by primary care but administered by TEWV staff may be stored in the patients own home environment.

The administering staff member should confirm with the patient that the medication has been stored according to manufacturer's requirements in terms of temperature, exposure to light.

All paperwork must be securely stored for audit purposes. Patient identifiable information will need to be stored for the minimum period, depending on the record type. See Medicines – Retention of Records Policy for more details.

Depot injections supplied to the community team as stock must never be left or stored in a patient's home.

Any surplus named patient supplies should be returned to the GP surgery or dispensing pharmacy by the patient.
Refer to Patients Own Drugs Procedure (appendix 9) and Medicines - Ordering, Storage Security, Transporting and Disposal (Appendix 1) guidance
Check local agreements with primary care.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community Teams: Administration

First (including test dose) and second dose of new depot:

Administer in a clinical setting with access to emergency adrenaline (1mg/ml) for anaphylaxis.
In exceptional circumstances, this may need to be done in a patient's own home. Ensure the following steps are taken for patient safety.

Complete risk assessment → The responsible nurse should ensure they have appropriate training for managing anaphylaxis[1] → Ensure immediate access to adrenaline 1 mg in 1ml[2]

Preparation for home administration:

For information on transportation of medication, click here

Ensure drug & strength selected is compatible with drug and dose prescribed → Check expiry date → Have another staff member provide a 'second check'[3] → Ensure all consumables required are available and within expiry date e.g. needles/syringes[4] → Sign depot chart out of file using log sheet and signed back in on return to base[5]

1) as defined in the Resuscitation Policy.
2) supply may need to be ordered on prescription for the individual rather than taking emergency supplies away from the team base.
3) self-checking is acceptable if staff/service pressures do not allow this.
4) see individual drug monograph for details of consumables required if not supplied with medication. Always use smallest syringe size to accommodate volume. administered. If consumables are supplied with medication, these must be used to administer.
5) If not returning to base on that day, the chart must be kept secure in line with the Moving records and other sensitive information procedure.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community and Inpatient Teams: Administration

Tips for Administration of Depot Injections (Community)

Tips for Administration of Depot Injections (Inpatient)

When a depot is to be administered in a clinic environment, the following should be confirmed:

If unable to obtain a second check from another member of staff, due to staff/service pressures, extra vigilance is required to self check. See Appendix for self-check checklist

When appropriate, immediately prior to administration, it is recommended that the drug, dose, frequency and expiry date are also checked with the patient/carer.

Best practice when using more than one ampoule is to use from the same batch. If this is not possible, and an adverse reaction occurs, consider if it is a batch related reaction.

All nurses and nursing associated are expected to follow good practice guidance for the task of administrating injections. Here are some useful policies:

- Hand Hygiene procedure,
- Standard (Universal) Precautions for Infection Prevention and Control policy,
- Safe Handling of Sharps,
- Accidental inoculation,
- Trust Resuscitation policy,
- Medicines – Ordering, storage, transfer, security, and disposal
- Medicines – management of alerts, recalls, reporting and shortages
- Medicines Preparation and Administration

- Ensure arrangements are in place for any post-injection monitoring where applicable (e.g. Olanzapine depot requires 3 hours post-injection observation – see separate guidelines).
- For administration outside of a clinic setting, any sharps etc should be safely disposed of and removed from the administration location.
- Under no circumstances should the administration of each dose be split between two or more injection sites

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community and Inpatient Teams: Site of Administration

Site of administration is important for several reasons including, maximum volume that can be administered, rate of absorption and patient preference.

Variable absorption can mean changes to dose/administration frequency may be required after a change in site, and some sites may not be suitable/unlicensed for certain medications.

If **a patient requests** an alternative/unlicensed site of administration, confirm with pharmacy/prescriber prior to administration.

Patient consent must be obtained and clearly documented for any unlicensed use.
Guidelines on Unlicensed and Offlabel Use of Medicines

Site	Muscle Used	Maximum Volume	Comments
Deltoid	Deltoid	0.5ml to 2ml	Fastest uptake
Dorsogluteal	Gluteus maximus	1ml to 3ml	Potential for delayed uptake due to subcutaneous fat
Lateral thigh	Vastus lateralis	1ml to 3ml	Slower uptake than deltoid, faster than gluteal
Ventrogluteal	Gluteus medius & minimus	1ml to 3ml	Maybe the best site for cachectic adults

		Deltoid	Lateral Thigh	Ventrogluteal	Dorsogluteal
BMI under 18.5	**Men**	16 mm	25mm (1 inch)	25mm (1 inch)	25mm (1 inch)
	Women	16 mm	25mm (1 inch)		
BMI ≥ 18.5 but < 25	**Men**	25mm (1 inch)	40mm (1.5 inch)	32mm (1.25 inch)	40mm (1.5 inch)
	Women	25mm (1 inch)	40mm (1.5 inch)		
BMI ≥ 25 but < 30	**Men**	No specific recommendations for this BMI range. Use needle size as above or below as appropriate.			
	Women			40mm (1.5 inch)	
BMI ≥ 30	**Men**	40mm (1.5 inch)	50mm (2 inch)	50mm (2 inch)	
	Women	40mm (1.5 inch)	50mm (2 inch)		

*When needle is not supplied in manufacturers pack – (use hypodermic safety needle)

Low BMI patients:

There is minimal advice and guidance regarding IM depot administration in patients who are emaciated or of low BMI. However, the following suggestions should be considered:

- Avoid muscles that are emaciated or atrophied; they will absorb medications poorly.
- IM injection sites should be rotated to decrease the risk of hypertrophy.
- Older adults and thin patients may only tolerate up to 2 ml in a single injection.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Community and Inpatient Teams: Considerations When Administering

Is it appropriate to administer?

- Are they able to consent?
- Can they sit still during administration?
- Are they under the influence of alcohol or illicit substances? This is not in itself a contraindication if the above conditions can be met. See below for more detail
- If any doubt, contact the prescriber or the pharmacy team

What to consider when your patient is under the influence of alcohol or illicit substances

- Is this abnormal/sign of deterioration of mental health?
- Does this occur regularly? Would a certain appointment time minimise prior drinking/substance misuse?
- Support and signpost: is a referral to drug and alcohol services appropriate?
- It is not an absolute contraindication to administer

Following administration:

- Add details of next due date to the VCB/diary
- Entry made on EPR
- Entry made in inpatient records/community depot card
- Include signature of second checker where applicable

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Training and Education

The medicines management Nurses provide depot/injections training as follows:

- Depot and injections training is facilitated on the preceptorship medicines management day for all newly qualified Nurses and Nursing associates.

- Site specific sessions are provided twice a month across the trust – details of these can be found and subsequently booked on the trust training and education pages.

- The medicine management nurses can be contacted directly to arrange bespoke sessions on a 1:1 or team basis this is done by emailing: tewv.mmnurses@nhs.net

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Frequency of Administration

Calendar examples for different administration frequencies:

1st Generation	Administer	e.g.
Weekly	Every 7 days	5th Feb, 12th Feb, 19th Feb, 26th Feb
Two Weekly	Every 14 days	5th Feb, 19th Feb 5th March
Three Weekly	Every 21 days	5th Feb 26th Feb 19th March
Four Weekly	Every 28 days	5th Feb 5th March 2nd April

2nd Generation	Administer	e.g.
2 weekly	Every 14 days	5th Feb, 19th Feb 5th March
Monthly	Administer the same DATE each month	5th Feb 5th March 5th April
Eight weekly	Administer every 56 days	5th Feb 2nd April 28th May
Three Monthly	Administer the same DATE every 3 months	5th Feb 5th May 5th August
Six Monthly	Administer the same DATE every 6 months	5th Feb 5th August

Refer to individual drug monographs for licensed intervals.

When a depot is licensed as monthly, this should be followed and NOT administered every 28 days. Shorter intervals (less than monthly) can result in additional doses given within the year. Any dose interval shorter than 28 days is considered as HDAT and is therefore not suitable for shared care.

Please refer to High Dose Antipsychotic Prescribing Guideline for further information on HDAT.

Definition of Tolerance and Missed Dose

Definition of tolerance: a window of time agreed by the Trust to enable the administration of a dose, if the administration due date is missed, without the need for a prescriber. E.g. patient non-attendance. See individual drug monographs/community depot chart for details.

Definition of a missed dose: When a patient has gone past the window of tolerance for their prescribed drug and frequency. A prescriber must be informed and a 'once only' dose must be prescribed on the inpatient prescription chart or community depot chart. See individual drug monographs/community depot chart for details.

Every effort should be made to administer doses of a depot injection on the due date. However, it is recognised this is not always be possible for different reasons. This policy covers three circumstances whereby tolerances may be appropriately utilised.

An incident form must be completed if a dose is not given within tolerances due to staff or service error.

Different Settings for Depot Administration:

Inpatients

Every effort should be made to administer the dose on the correct day. Try to avoid organising patient leave when a depot is due. If this is unavoidable, the administration tolerances can be used to give the dose before the period of leave, or a soon as they return, whichever is more appropriate

Community – Flexible appointments/home visits

Every effort should be made to administer the dose on the correct day. When a patient cannot be located/DNA/is on holiday, in single, isolated events, assess the risk of the patient not receiving their depot on the due date and utilise acceptable tolerances to continue treatment with minimal disruption. Consider asking patients during appointments if they have any upcoming holidays.

Community – FIXED DAY clinic model, e.g. every Thursday

To support the running of a weekly clinic model, tolerances may be routinely utilised when a regular clinic slot is being used, see 'Example utilisation of tolerances to enable fixed day clinics ' for more detail.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Example Utilisation of Tolerances to Enable FIXED DAY Clinics

Community – FIXED DAY clinic model, e.g. every Thursday

1st Generation	Administer	e.g.
Weekly	Every 7 days	Thursday 5th Feb, Thursday 12th Feb, Thursday 19th Feb, Thursday 26th Feb
Two Weekly	Every 14 days	Thursday 5th Feb, Thursday 19th Feb Thursday 5th March
Three Weekly	Every 21 days	Thursday 5th Feb Thursday 26th Feb Thursday 19th March
Four Weekly	Every 28 days	Thursday 5th Feb Thursday 5th March Thursday 2nd April

2nd Generation	Administer	e.g.
2 weekly	Every 14 days	Thursday 5th Feb, Thursday 19th Feb Thursday 5th March
Monthly (Do not administer four weekly)	Administer the same week of each month e.g. 2nd Thursday of the month	Thursday 12th Feb Thursday 12th March Thursday 9th April
8 weekly	Every 56 days	Thursday 5th Feb Thursday 2nd April Thursday 28th May
Three Monthly	Administer the same week of each month e.g. 2nd Thursday of the month every three months	Thursday 12th Feb Thursday 14th May Thursday 13th August
Six Monthly	Administer the same week of each month e.g. 2nd Thursday of the month every six months	Thursday 12th Feb Thursday 13th August

2nd Generation (monthly) – administer at a fixed clinic slot e.g. 2nd Tuesday of the month. (acceptable regular use of tolerances whilst still ensuring a maximum of 12 doses are administered a year)

Summary of Acceptable Tolerance Use

Depot medication administered on due date.

Due date of next dose calculated based on prescribed frequency and added to the team VCB/calendar.

For inpatients, try to avoid organising patient leave when a depot is due. If this is unavoidable, the administration tolerances can be used to give the dose before the period of leave, or a soon as they return, whichever is more appropriate.

For community patients, an appointment should be arranged based on staff and patient availability (e.g. patient planned holidays) utilising the administration tolerances if necessary.

In community clinic FIXED DAY setting:
second-generation antipsychotic depots (aripiprazole, paliperidone, risperidone) can be administered by routine use of agreed tolerances, allowing management of workload within a team's usual depot clinic. Click here for a calendar example.

An incident form must be completed if a dose is not given within tolerances due to staff or service error.

Administration due date missed.

Within tolerance window of that prescribed drug and frequency:

Yes

Utilise tolerance and administer dose. Document on VCB and EPR.

No

Refer to 'Management of missed doses' in individual drug monographs for guidance.

Refer to prescriber as 'once only' doses and/or short-term oral supplementation may need prescribing.

Due date of next dose calculated from the **actual** date of administration, then added to the team VCB/calendar.

Continue at the prescribed frequency from the new due date.

If the original schedule needs to be reinstated e.g. to align to clinic/patient availability, this can be done via utilisation of tolerance for the following dose.

If this is not possible via tolerances, discuss with prescriber/pharmacy.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Deprescribing

When to review?

- A minimum of annually
- Assess for safety and tolerability
- Risk/benefit assessment on current treatment dose . See Appendix for example assessment considerations

Supratherapeutic dose?

- Consider dose reduction in stable patients requiring continued antipsychotic treatment as there is a possibility that the patient is receiving supratherapeutic doses (doses higher than required)
- Dosage of continued treatment should be at least 50% of the standard daily dosage for the condition being managed. Reduction below this level is associated with a greater risk of relapse.

Follow Up

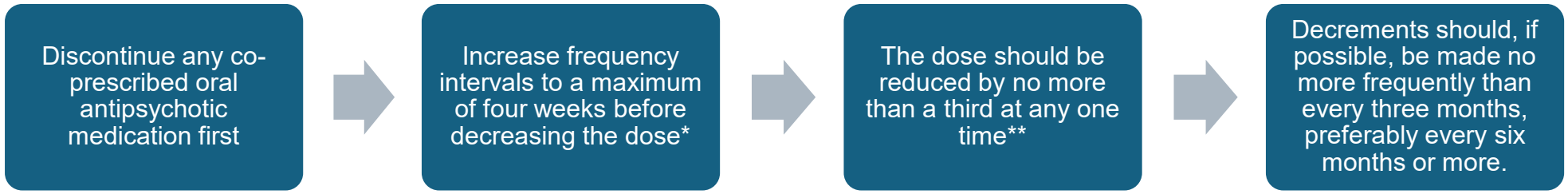
- Long-term follow up is recommended when antipsychotic dosage is decreased.
- Particularly to very low doses - such reduction is associated with a greater risk of treatment failure, hospitalisation and relapse, which may only become evident over the longer term

Goal

- To identify the minimum effective dose
- Discontinuation should not be the ultimate goal
- An intermittent, targeted (symptom-triggered) treatment approach with antipsychotics is not as effective as continuous treatment but may be preferable to no treatment.

Deprescribing flow chart

If after careful consideration the decision is taken to reduce the dose, where appropriate, the patient's family or carer (s) should be involved in this decision and a clear explanation of actions to take if/when symptoms return or worsen should be given. The following steps can then be taken:



* Where product license allows (e.g. flupentixol/zuclopenthixol)

**(Special considerations apply to Risperdal Consta). Dose adjustments may be limited by product availability e.g. paliperidone is only available in fixed-dose pre-filled syringes at doses of 50mg, 75mg, 100mg & 150mg/month.

If the patient becomes symptomatic during the dose reduction process
This should not be seen as a failure but as an important step in determining the minimum effective dose required by that patient.

Increasing the dose back to one that was previously effective may be appropriate.

Due to the time lag to reach steady state following dose adjustment of the LAI/depot, it may be appropriate to consider a short top up course of oral medication to cover this period e.g. similar to the cross-over recommended when initiating the LAI/depot (See individual drug monograph).

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Transferring from Inpatient

To Community Team

- Ascertain which team will be responsible for depot in community.
- Advise them of the upcoming transfer/discharge, invite them to attend the discharge planning meeting – document contact on EPR.
- The electronic discharge letter (EDL) must include **date of treatment initiation, drug name, dose, frequency** and **date & site of last administration**. This must be added in the "comments" section of the medication grid on EDL.
- The CMHT and inpatient team should work together as per local arrangements to ensure the **date and place** of the next injection is organised and communicated to the patient.
- Arrangements for a new community depot chart should be made as per local arrangements, examples in Safe Transfer of Psychotropic Medication MSS18

To Primary Care

- NOTE: Newly initiated/changed treatment should be transferred to a community team.
- Only appropriate if transfer to primary care had already occurred prior to admission and there has been no change to the depot prescription during the admission.
- The electronic discharge letter (EDL) must include **date of treatment initiation, drug name, dose, frequency** and **date & site of last administration**. This must be added in the "comments" section of the medication grid on EDL.
- Consider utilisation of tolerance windows to administer dose prior to discharge to facilitate transfer

To Acute Trust

- **If patient is returning to TEWV:**
- Maintain regular contact with the ward on which the patient is residing and prompt them when the depot is due. Provide ward with contact details and document conversations of EPR.
- **On return to TEWV,** a reconciliation of medication should be undertaken to ensure that the details of any depot doses administered whilst under the care of the acute trust.
- If the patient is like to be **discharged from the Acute Trust to a community team**, ascertain which team will take over the depot management and advise them of the potential discharge. This should also be documented on EPR.
- If the patient is **being discharged from TEWV inpatient on transfer to the Acute Trust**, treat in the same manner as above 'Transfer to community team'.
- Note: Guidance is provided to acute hospital teams on how to manage depot medication via the following guidelines: Mental Health Medicines: Safety Guidance for Acute Hospital Teams.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Transferring from Community Teams

To Inpatients

- If responsibility for prescribing sits with the GP, contact the relevant surgery to suspend prescription issues while the patient is in hospital.
- Contact the relevant in-patient unit to ensure that staff are aware of the current depot injection, dosage, and frequency which the patient should be receiving, including next due date.
- Discontinue community depot chart

To a TEWV Community Team

- The depot chart should be transferred from the current community team to the new community team and can continue to be used until the prescription expires (after 12 months) or is changed.
- A corresponding entry should be made on the electronic patient record when this has been completed. The current community team retains responsibility until the transfer of care has taken place.

To another Mental Health NHS Trust

- A referral should be made, marking if urgent, clearly identifying depot medication, prescribed dosage, last date administered and next due date. The existing team retains responsibility until the transfer of care acknowledged and received.

To Primary Care

- May be transferred to primary care after 3 months or once treatment is stabilised, whichever is longer.
- Complete drug-specific shared care request. Transfer request should be sent at least one month in advance of patient needing their first dose from GP; GP asked to respond to this request within 2 weeks.
- If refused, continue administration by community team. If accepted, document transfer on EPR and cancel depot chart.

To Acute Trust

- Discontinue community depot chart until discharge.
- The community team should ensure they maintain regular contact with the acute care team
- Contact the relevant GP surgery, if applicable, to suspend prescriptions while the patient is in hospital.
- Note: Guidance is provided to acute hospital teams on how to manage depot medication via the following guidelines: Mental Health Medicines: Safety Guidance for Acute Hospital Teams.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Caseload Standards

The following standards have been agreed for the assessment of compliance with these procedures at team level. These standards will be assessed as part of the Pharmacy audit programme every 12-18 months

Community teams

For all patients (or an appropriate sample):

1. Current depot treatment (provided by TEWV) has been communicated to the patient's GP (correctly appears on SCR/GNCR/YHCR)
2. Date of prescriber signature of original prescription or the most recent signed review on current chart is within the last 12 months
3. A full assessment of side-effects, using a recognised rating scale, has been completed within the last 12 months
4. All dose administrations in the last 12 months have been recorded in EPR

Overall team:

5. Depot products (stock and non-stock) are stored in an appropriate cupboard, in date and clearly segregated / labelled to avoid selection errors

Inpatient teams

For all current patients:

1. All doses administered during the current inpatient stay have been recorded in EPMA and the EPR (over the last 4 weeks on long-stay wards, e.g. SIS)
2. A full assessment of side-effects, using a recognised rating scale, has been completed within two weeks of admission/initiation (within the last 12 months for long-stay wards, e.g. SIS)

For recently discharged patient (within last four weeks):

3. Evidence of communication in the EPR, to community team or GP, of drug, dose, frequency and date of next dose

Overall team:

4. Depot products (stock and non-stock) are stored in an appropriate cupboard, in date and clearly segregated / labelled to avoid selection errors (including Clopixol Acuphase if stored with depots)

FLUpentixol Decanoate (Depixol®, Psytixol®) 1 of 9

Amber Shared Care

Prescribing	Dosing	Administration	Pharmacokinetics	Monitoring
Available preparations	Dosage information	Switching Strategies	Duration of Action	Adverse Drug Reactions
Licensed Indications	Renal & Hepatic Considerations	Tolerance Windows	Peak & Steady State	Effects on QT
Cautions & Contraindications	Pregnancy & Breastfeeding	Managing Missed Doses	Elimination half-life	Drug Monitoring
		Needle Size	Initiation Phase	Clinical Tips
		Storage		

Prescribing Support Series: PSS 4

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

Return to Main Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

FLUpentixol Decanoate (Depixol®, Psytixol®) 2 of 9

Amber Shared Care

Available Presentations:
20 mg in 1 ml ampoule
40 mg in 2 ml ampoule
50 mg in 0.5 ml ampoule (concentrate)
100 mg in 1 ml ampoule (concentrate)
200 mg in 1 ml ampoule (low volume)

Store in outer container to protect from light

Licensed Indication: Treatment and maintenance of schizophrenia and other psychoses in those stabilised on oral therapy.

Licensed Site of Administration: Deep intramuscular injection into the upper outer buttock (dorsogluteal) or lateral thigh (vastus lateralis)*.
Pre-approved off-label administration site: Deltoid****

As with all oil-based injections it is important to ensure, by aspiration before injection, that inadvertent intravascular entry does not occur.

For further information: Flupentixol Decanoate SPC (select appropriate brand/strength)

Usual dose interval	Maximum single dose	Max. volume per single injection site	Needle/ syringe supplied in pack	Licensed administration sites*	Needle requirements	Storage requirements***
2-4 weeks	400 mg	2 ml	No	Gluteal	Usually 21-gauge, needle length dependent on BMI/sex**	Room Temperature
				Lateral thigh	Usually 21-gauge, 25 mm (1 inch) – 38 mm (1.5 inch) needle, dependent on BMI	

* For more information on selecting appropriate administration site click here
** For information regarding recommended needle length for gluteal injections click here
*** For additional information on storage on TEWV sites or patients own home
**** Guidelines on Unlicensed and Off-Label Use of Medicines

Return to Main Menu

Return to FLUpentixol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

FLUpentixol Decanoate (Depixol®, Psytixol®) 3 of 9

Amber Shared Care

Dosing Information	<65 years old	>65 years old, cachectic, frail
Oral dose equivalence	Oral 2 – 3 mg/day = depot 10-20 mg/week	Oral 2 – 3 mg/day = depot 10-20 mg/week
Initiation/Test Dose	Test dose recommended: 20mg, then wait one week before starting maintenance dose	Test dose recommended: 5-10mg, then wait one week before starting maintenance dose
Maintenance	50 mg 4-weekly to 300 mg 2-weekly. Some patients may be maintained on 20-40mg every 2-4 weeks.	10–20mg every 2–4 weeks* Dose increased gradually according to response and tolerability in steps of 5–10mg every 2 weeks*
Maximum	400 mg/week (in terms of dopamine blockade, this is a much higher dose equivalence than other depots)	40mg every 2 weeks* (extend frequency to every 3–4 weeks if EPS develops) (occasionally up to 50 or 60mg every 2 weeks* may be used if tolerated)
Maximum single dose	400 mg	400mg

Click here for guidance on adjusting intervals between injections

*There is no specific information available in the literature for these drug doses in elderly patients. The doses stated are a guide only. Where there are no data, the maximum doses are conservative and may be exceeded if the drug is well tolerated and following clinician's assessment.

FLUpentixol Decanoate (Depixol®, Psytixol®) 4 of 9

Amber Shared Care

Hepatic Considerations

Extensively hepatically metabolised. Reduce doses by 50% in patients with compromised hepatic function.

Depot preparations are best avoided, as altered pharmacokinetics will make dosage adjustment difficult and adverse effects from accumulation more likely.

Note: Liver function tests (LFTs) are a poor marker of hepatic metabolising capacity. LFTs help evaluate hepatic damage but tell us little about hepatic function.

Seek further advice from pharmacy

Renal Considerations

Dose in normal renal function for GFR >10 ml/min. Start with 25-50% of dose and titrate slowly if <10 ml/min

May cause hypotension and sedation in renal impairment and can accumulate. Manufacturer advises caution in renal failure because of increased cerebral sensitivity to antipsychotics. Avoid depot preparations in renal impairment

Seek further advice from pharmacy

Pregnancy and Breastfeeding Resources

Refer to the perinatal team any patient prescribed an antipsychotic depot.
One-off preconception appointments can be arranged for patients who are considering becoming pregnant.
Do not stop depot medication without discussion with the perinatal team first.

Contact details
Tees: tewv.teesperinatal@nhs.net
Durham and Darlington:
tewv.durhamdarlingtonperinatal@nhs.net
North Yorkshire & York:
tewv.northyorksperinatal@nhs.net
If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am 5pm:
Tees: 01642 368303
Durham & Darlington: 0191 451 0400
North Yorkshire & York: 01904 556 724

Addition Resources
Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period
Handy Fact Sheet - Treating Symptoms of Psychosis in Pregnancy and Breastfeeding*

* Choice and Medication leaflets are commissioned for TEWV patients only.

Return to FLUpentixol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

FLUpentixol Decanoate (Depixol®, Psytixol®) 5 of 9

Amber Shared Care

Cautions

- Use with caution in patients with physical health co-morbidities
- May increase risk of suicide/suicidal thoughts/self-harm in early weeks of treatment and following dose changes – alert patient (and carers) to report any clinical worsening
- See product information (select brand/strength) for details

Click here for more information on hepatic, renal and pregnancy/breastfeeding considerations.

Contraindications

- Hypersensitivity to the active substance or to any of the excipients. (Base oil: Depixol® – thin vegetable oil from coconut; Psytixol® – triglycerides, medium chain)
- Circulatory collapse, depressed level of consciousness due to any cause (e.g., intoxication with alcohol, barbiturates, or opiates), coma.
- Not recommended for initiation in excitable or agitated patients.

Very common/common adverse effects:	Increased appetite, increased weight, insomnia, depression, nervousness, agitation, libido decreased, somnolence, akathisia, hyperkinesia, hypokinesia, tremor, dystonia, dizziness, headache, disturbance in attention, visual accommodation disorder, vision abnormal, tachycardia, palpitations, dyspnoea, dry mouth, salivary hypersecretion, constipation, vomiting, dyspepsia, diarrhoea, hyperhidrosis, pruritus, myalgia, micturition disorder, urinary retention, asthenia, fatigue.
QT prolongation impact: (Trust guidance)	Low effect <10 msec at therapeutic doses or in overdose
Monitoring & review requirements:	See Trust psychotropic drug monitoring guidance / shared care guidance

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to FLUpentixol Menu

Return to Main Menu

FLUpentixol Decanoate (Depixol®, Psytixol®) 6 of 9

Amber Shared Care

Pharmacokinetic Information	
Duration of action	3 – 4 weeks
Peak	7 – 10 days
Time to Steady State *	8-12 weeks
Elimination half-life	8 days (single dose); 17 days (multiple dose)
Initiation Phase	2nd- 4th dose
Maintenance	5th dose onwards

*** Full effect of depot dose may not be clinically apparent until steady state is reached.**

FLUpentixol Decanoate (Depixol®, Psytixol®) 7 of 9

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching to Flupentixol depot:	From oral:	Continue oral flupentixol for ONE week after the first flupentixol depot injection.
	From another depot (not risperidone – see below):	Give flupentixol on the due date of the next dose of the original depot, instead of the original depot; do not give any more doses of the original depot.
	From risperidone 2-weekly depot:	Give flupentixol depot 2–4 weeks after the last injection of risperidone 2-weekly depot was due. i.e. 4-6 weeks after the last injection of risperidone was given; do not give any more risperidone. (The last injection of risperidone 2-weekly depot provides therapeutic plasma levels for 4 - 6 weeks with a post dose peak at 5 weeks).
Switching from Flupentixol depot to oral:	From weekly injection:	Stop depot; start half the oral equivalent dose on the day when the next weekly injection was due; after one week of half-dose, increase to full equivalent dose daily.
	From two weekly injection:	Stop depot; start half the oral equivalent dose on the day when the next two weekly injection was due; after one week of half-dose, increase to full equivalent dose daily.
	From three weekly injection:	Start a full equivalent oral dose 3 weeks after last depot given (i.e. on the day the next depot was due).
	From four weekly injection:	Start a full equivalent oral dose 4 weeks after last depot given (i.e. on the day the next depot was due).

Click here for more guidance on switching depots

Return to FLUpentixol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

FLUpentixol Decanoate (Depixol®, Psytixol®) 8 of 9

Amber Shared Care

	Dosing Frequency	
Administration window to maintain therapeutic levels:	**Weekly:**	+/- 2 days
	Two to four weekly:	-2 days / +7 days
Management of missed doses (outside of above windows):	**Weekly / two weekly:**	Give up to 50% extra (max. 400 mg in total) at next scheduled dose, then continue with normal dose & frequency
	Three weekly:	Up to 35 days since last dose – give the normal dose; then the next dose should be reduced by 50% and given on the date it would have been due with a 3-weekly schedule (i.e. 42 days after the previous dose); then continue with usual dose every 3 weeks. If >35 days since last dose – give usual dose +33-50%; then continue with usual dose every 3 weeks If >42 days since last dose - start again with normal dose every 3 weeks
	Four weekly:	Up to 42 days since last dose - give normal dose, then 2 weeks later give 50% of normal dose, then continue with normal dose every 4 weeks If >42 days since last dose, start again with normal dose every 4 weeks.

Click here for guidance on appropriate use of tolerance windows.

Return to FLUpentixol Menu

Return to Main Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

FLUpentixol Decanoate (Depixol®, Psytixol®) 9 of 9

Amber Shared Care

Clinical Tips

- They don't work instantly, not even with a loading dose.
- On stopping Flupentixol depot, the washout period can last between 2 – 3 months
- Optimal dose range is likely to be 20-40mg every two weeks – less may be more!
- If extending dose interval, it may not be necessary to increase dose, due to long-acting nature, the depot may work for up to 4 weeks. Intervals can be increased and dose increased with clinical need.
- Dose changes take time to have effect, allow 8 – 12 weeks for a new steady state to be reached before changing the dose again.
- May have an activating effect (aggression/mood elevation), not recommended in excitable or agitated patients.
- An increased incidence of extrapyramidal side-effects (EPSEs) compared to zuclopenthixol and second-generation antipsychotics.
- Similar risk of suicidal thoughts, self-harm and suicidal attempts as antidepressants.

ZUCLOPENTHIXOL DECANOATE (1 of 9)

Amber Shared Care

Prescribing	Dosing	Administration	Pharmacokinetics	Monitoring
Available preparations	Dosage information	Switching Strategies	Duration of Action	Adverse Drug Reactions
Licensed Indications	Renal & Hepatic Considerations	Tolerance Windows	Peak & Steady State	Effects on QT
Cautions & Contraindications	Pregnancy & Breastfeeding	Managing Missed Doses	Elimination half-life	Drug Monitoring
		Needle Size	Initiation Phase	Clinical Tips
		Storage		

Prescribing Support Series: PSS 4

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

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ZUCLOPENTHIXOL DECANOATE (2 of 9)

Amber Shared Care

Available Presentations:
200 mg per 1 ml ampoule
500 mg per 1 ml ampoule (Clopixol® Conc)

Licensed Indication: Maintenance treatment of schizophrenia and paranoid psychoses.

Licensed Site of Administration: Deep intramuscular injection into the upper outer buttock (dorsogluteal) or lateral thigh (vastus lateralis)*.
Pre-approved off-label administration site: Deltoid****

As with all oil-based injections it is important to ensure, by aspiration before injection, that inadvertent intravascular entry does not occur

For further information: Zuclopenthixol Decanoate SPC (select appropriate brand/strength)

Usual dose interval	Maximum single dose	Max. volume per single injection site	Needle/ syringe supplied in pack	Licensed administration sites*	Needle requirements	Storage requirements***
1 – 4 weeks	600mg	2ml	No	Gluteal	Usually 21-gauge, needle length dependent on BMI/sex*	Room temperature
				Lateral thigh	Usually 21-gauge, 25mm (1 inch) - 38mm (1.5 inch) needle, dependent on BMI	

* For more information on selecting appropriate administration site click here
** For information regarding recommended needle length for gluteal injections click here
*** For additional information on storage on TEWV sites or patients own home
**** Guidelines on Unlicensed and Off-Label Use of Medicines

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Zuclopenthixol Menu

Return to Main Menu

ZUCLOPENTHIXOL DECANOATE (3 of 9)

Amber Shared Care

Dosing Information	<65 years old	>65 years old, cachectic, frail
Oral dose equivalence	Oral 25 mg daily (range 25-60 mg) = depot 100 mg per week (range 40-100 mg)	
Initiation/Test Dose	Test dose recommended: 100 mg, an interval of at least one week should be allowed before the second injection is given at a dose consistent with the patient's condition.	Initiation dose reduced to 25-50mg
Maintenance	200 mg every 3 weeks to 600 mg every week	After at least 7 days of test dose:50–200mg every2–4 weeks* Same as <65 years but with cautious titration and close supervision as especially prone to experience such adverse effects as sedation, hypotension, confusion and temperature changes
Maximum	600 mg/week	200mg every2 weeks*
Maximum single dose	600 mg	600mg

Click here for guidance on adjusting intervals between injections

*There is no specific information available in the literature for these drug doses in elderly patients. The doses stated are a guide only. Where there are no data, the maximum doses are conservative and may be exceeded if the drug is well tolerated and following clinician's assessment.

Return to Zuclopenthixol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ZUCLOPENTHIXOL DECANOATE (4 of 9)

Amber Shared Care

Hepatic Considerations

Use with caution in patients with liver disease. Patients with compromised hepatic function should receive half the recommended dosages.

Seek further advice from pharmacy

Renal Considerations

Standard doses can be given to patients with reduced renal function. When GFR <10ml/min start with 50% dose and titrate slowly.

Seek further advice from pharmacy

Pregnancy and Breastfeeding Resources

Refer to the perinatal team any patient prescribed an antipsychotic depot.
One-off preconception appointments can be arranged for patients who are considering becoming pregnant.
Do not stop depot medication without discussion with the perinatal team first.

Contact details
Tees: tewv.teesperinatal@nhs.net
Durham and Darlington:
tewv.durhamdarlingtonperinatal@nhs.net
North Yorkshire & York:
tewv.northyorksperinatal@nhs.net
If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am 5pm:
Tees: 01642 368303
Durham & Darlington: 0191 451 0400
North Yorkshire & York: 01904 556 724

Addition Resources
Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period
Handy Fact Sheet - Treating Symptoms of Psychosis in Pregnancy and Breastfeeding*

* Choice and Medication leaflets are commissioned for TEWV patients only.

Return to Zuclopenthixol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ZUCLOPENTHIXOL DECANOATE (5 of 9)

Amber Shared Care

Cautions

- Physical health comorbidities including hyperthyroidism; hypothyroidism; QT interval prolongation – see product literature (select brand/strength) for details

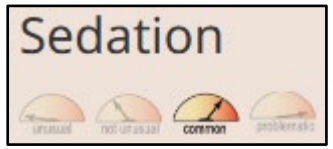
Click here for more information on hepatic, renal and pregnancy/breastfeeding considerations.

Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in product literature (select brand/strength) for details

Circulatory collapse, depressed level of consciousness due to any cause (e.g. intoxication with alcohol, barbiturates or opiates), coma

Very common/common adverse effects:	Agitation; amenorrhoea; arrhythmias; constipation; dizziness; drowsiness; dry mouth; erectile dysfunction; fatigue; galactorrhoea; gynaecomastia; hyperglycaemia; hyperprolactinaemia; hypotension (dose-related); insomnia; leucopenia; movement disorders; muscle rigidity; neutropenia; parkinsonism; postural hypotension (dose-related); QT interval prolongation; rash; seizure; tremor; urinary retention; vomiting; weight increased.
QT prolongation impact: **(Trust guidance)**	No known effect/unknown
Monitoring & review requirements:	See Trust psychotropic drug monitoring guidance / shared care guidance



Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Zuclopenthixol Menu

Return to Main Menu

ZUCLOPENTHIXOL DECANOATE (6 of 9)

Amber Shared Care

Pharmacokinetic Information	
Duration of action	3 weeks
Peak	4 – 7 days
Time to Steady State*	3 months
Elimination half-life	19 days
Initiation Phase	2nd – 4th dose
Maintenance	5th dose onwards

*** Full effect of depot dose may not be clinically apparent until steady state is reached.**

ZUCLOPENTHIXOL DECANOATE (7 of 9)

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching to Zuclopenthixol depot:	From oral:	Continue oral zuclopenthixol for THREE weeks after the first zuclopenthixol depot injection.
	From another depot (not risperidone – see below):	Give zuclopenthixol depot on the due date of the next dose of the original depot, instead of the original depot. Do not give any more doses of the original depot.
	From risperidone 2-weekly depot:	Give zuclopenthixol depot 2–4 weeks after the last injection of risperidone 2-weekly depot was due. i.e., 4-6 weeks after the last injection of risperidone was given; do not give any more risperidone. (The last injection of risperidone 2-weekly depot provides therapeutic plasma levels for 4 -6 weeks with a post dose peak at 5 weeks).
Switching from Zuclopenthixol depot to oral:	From weekly injection:	Stop depot, start half the equivalent oral dose on the day when the next depot injection is due. After a week of half-dose, increase to full equivalent daily dose.
	From two weekly injection:	Stop depot, start half the equivalent oral dose on the day when the next depot injection is due. After a week of half-dose, increase to full equivalent oral dose daily.
	From three weekly injection:	Start an equivalent oral dose 3 weeks after the last depot (i.e. on the day the next depot was due)
	From four weekly injection:	Start the full equivalent oral dose 4 weeks after the depot (i.e. on the day next depot was due)

Click here for more guidance on switching depots

Return to Zuclopenthixol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ZUCLOPENTHIXOL DECANOATE (8 of 9)

Amber Shared Care

	Dosing Frequency	
Administration window to maintain therapeutic levels:	**Weekly:**	+/- 2 days
	Two to four weekly:	-2 days / +7days

Management of missed doses (outside of above windows):	**Weekly / two weekly:**	Consider giving up to 50% extra (max. 600 mg in total) at next scheduled dose, then revert to normal dose & frequency
	Three weekly:	Up to 35 days since last dose – give the normal dose 2 weeks late; then the next dose should be reduced by 50% and given on the date it would have been due with a 3- weekly schedule (i.e. 42 days after the previous dose); then continue with usual dose every 3 weeks. If >35 days since last dose – give usual dose +33-50% when next due (i.e. 6 weeks after last dose); then continue with usual dose every 3 weeks If >42 days since last dose, start again with normal dose every 3 weeks
	Four weekly:	Up to 42 days since last dose - give normal dose, then 2 weeks later give 50% of normal dose, then continue with normal dose every 4 weeks If >42 days since last dose, start again with normal dose every 4 weeks.

Click here for guidance on appropriate use of tolerance windows.

Return to Zuclopenthixol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ZUCLOPENTHIXOL DECANOATE (9 of 9)

Amber Shared Care

Clinical Tips

- They don't work instantly, not even with a loading dose.
- On stopping Zuclopenthixol depot, the washout period can last approx. 100days.
- 200 mg zuclopenthixol decanoate every two weeks results in estimated D2 receptor occupancy of 91%.
- Since Zuclopenthixol depot is a long-acting medication, it may not be necessary to increase the dose when the dosage interval has been extended e.g. for convenience reasons.
- Dose changes take time to have effect, allow 8 – 12 weeks for a new steady state to be reached before changing the dose again.
- Zuclopenthixol decanoate is included in the Trust off-label register for deltoid administration as follows, if this is used, the patient needs to be advised that it is off-label and the dose mustn't exceed the maximum volume recommended for the deltoid site, which is 0.5-2ml in practice
- More sedating than flupentixol, therefore preferable in aggressive/agitated patients.
- Be aware of differences in preparations :

Zuclopenthixol Decanoate (Clopixol)	**Zuclopenthixol Acetate (Clopixol Acuphase)**
Long-acting depot preparation	Short acting for acute use
The maintenance treatment of schizophrenia and paranoid psychoses.	For the initial treatment of acute psychoses including mania and exacerbation of chronic psychoses, particularly where a duration of effect of 2-3 days is desirable.

Return to Zuclopenthixol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

HALOPERIDOL DECANOATE (1 of 9)

Amber Shared Care

Prescribing	Dosing	Administration	Pharmacokinetics	Monitoring
Available preparations	Dosage information	Switching Strategies	Duration of Action	Adverse Drug Reactions
Licensed Indications	Renal & Hepatic Considerations	Tolerance Windows	Peak & Steady State	Effects on QT
Cautions & Contraindications	Pregnancy & Breastfeeding	Managing Missed Doses	Elimination half-life	Drug Monitoring
		Needle Size	Initiation Phase	Clinical Tips
		Storage		

Prescribing Support Series: PSS 4

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

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

HALOPERIDOL DECANOATE (2 of 9)

Amber Shared Care

Available Presentations:
50 mg per 1 ml ampoule
100 mg per 1 ml ampoule

Licensed Indication: Maintenance treatment of schizophrenia and schizoaffective disorder in adult patients currently stabilised with oral haloperidol

Licensed Site of Administration: Deep intramuscular injection into the gluteal region*
Pre-approved off-label administration site: Deltoid****

As with all oil-based injections it is important to ensure, by aspiration before injection, that inadvertent intravascular entry does not occur

For further information: Haloperidol Decanoate SPC (select appropriate brand/strength)

Usual dose interval	Maximum single dose	Max. volume per single injection site	Needle/ syringe supplied in pack	Licensed administration sites*	Needle requirements	Storage requirements***
4 weeks	300mg	3ml	No	Gluteal	Usually 21-gauge, needle length dependent on BMI/sex**	Room temperature

* For more information on selecting appropriate administration site click here
** For information regarding recommended needle length for gluteal injections click here
*** For additional information on storage on TEWV sites or patients own home
**** Guidelines on Unlicensed and Off-Label Use of Medicines

HALOPERIDOL DECANOATE (3 of 9)

Amber Shared Care

<table>
<tr><th>Dosing Information</th><th><65 years old</th><th>>65 years old, cachectic, frail</th></tr>
<tr><td>Oral dose equivalence</td><td colspan="2">Manufacturer recommends a depot dose 10-15 x the oral daily dose, i.e. depot dose will be 25 to150 mg for most patients. Reference sources advise the following equivalence:
<table>
<tr><td>Oral Dose</td><td>Manufacturer</td><td>PDD (Bazire)</td><td>Maudsley</td><td>Meyer</td></tr>
<tr><td>10 mg/day</td><td>25-37.5 mg /week</td><td>40-60 mg/week</td><td>75 mg/week</td><td>50 mg/week</td></tr>
</table></td></tr>
<tr><td>Initiation/Test Dose</td><td>Test dose recommended: 25 mg. After a test dose, wait 4-10 days before titrating to maintenance dose.</td><td>Low initiation dose of 12.5-25 mg</td></tr>
<tr><td>Maintenance</td><td>50-200 mg every four weeks; maximal effect at 50 mg every 4 weeks, no evidence that doses above 100 mg every four weeks have any additional effects</td><td>12.5 - 75 mg every four weeks most effective dose range</td></tr>
<tr><td>Maximum</td><td>300 mg but recommended to make an individual risk - benefit analysis for doses >200 mg</td><td>Max 50mg every 4 weeks. Doses >75 mg every four weeks should only be considered in patients who have tolerated higher doses and after reassessment of the patient's individual benefit-risk profile.</td></tr>
<tr><td>Maximum single dose</td><td>300 mg</td><td>75mg as per HDAT guidelines/Maudsley's</td></tr>
</table>

*There is no specific information available in the literature for these drug doses in elderly patients. The doses stated are a guide only. Where there are no data, the maximum doses are conservative and may be exceeded if the drug is well tolerated and following clinician's assessment.

Click here for guidance on adjusting intervals between injections

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Haloperidol Menu

Return to Main Menu

HALOPERIDOL DECANOATE (4 of 9)

Amber Shared Care

Hepatic Considerations

Extensively hepatically metabolised. Halve initial doses, adjust dose with smaller increments and at longer intervals.

Transient and asymptomatic elevations in LFTs reported in 20% of patients. 28 Isolated reports of cholestasis, acute hepatic failure, hepatitis and abnormal LFTs

Seek further advice from pharmacy

Renal Considerations

Less than 1% excreted unchanged in the urine. Manufacturer advises caution in renal failure.

Dosing: GFR 10–50mL/min dose as in normal renal function; GFR <10mL/min start with a lower dose as can accumulate with repeated dosing.

A case report of haloperidol use in renal failure suggests starting at a low dose and increasing slowly.

Avoid depot preparations in renal impairment.

Seek further advice from pharmacy

Pregnancy and Breastfeeding Resources

Refer to the perinatal team any patient prescribed an antipsychotic depot.
One-off preconception appointments can be arranged for patients who are considering becoming pregnant.
Do not stop depot medication without discussion with the perinatal team first.

Contact details
Tees: tewv.teesperinatal@nhs.net
Durham and Darlington: tewv.durhamdarlingtonperinatal@nhs.net
North Yorkshire & York: tewv.northyorksperinatal@nhs.net
If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am 5pm:
Tees: 01642 368303
Durham & Darlington: 0191 451 0400
North Yorkshire & York: 01904 556 724

Addition Resources
Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period
Handy Fact Sheet - Treating Symptoms of Psychosis in Pregnancy and Breastfeeding*

* Choice and Medication leaflets are commissioned for TEWV patients only.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Haloperidol Menu

Return to Main Menu

HALOPERIDOL DECANOATE (5 of 9)

Amber Shared Care

Cautions and Contraindications

Use with caution in patients with physical health co-morbidities – see product information for details.

- Hypersensitivity to the active substance or to any of the excipients (benzyl alcohol, sesame oil). • Comatose state, central nervous system (CNS) depression, Parkinson's disease, dementia with Lewy bodies, progressive supranuclear palsy • Known QTc interval prolongation or congenital long QT syndrome, recent acute myocardial infarction, uncompensated heart failure, history of ventricular arrhythmia or torsades de pointes, uncorrected hypokalaemia, concomitant treatment with medicinal products that prolong the QT interval

Click here for more information on hepatic, renal and pregnancy/breastfeeding considerations.

Very common/common adverse effects:	Extrapyramidal disorder, weight increased, Sexual dysfunction, muscle ridigty, injection site reaction, antimuscarinic effects, depression, insomnia.
QT prolongation impact: **(Trust guidance)**	Moderate effect – 10-20 msec at therapeutic doses. Contra-indicated with other QT-prolonging drugs.
Monitoring & review requirements:	See Trust psychotropic drug monitoring guidance / shared care guidance

HALOPERIDOL DECANOATE (6 of 9)

Amber Shared Care

Pharmacokinetic Information	
Duration of action	6 weeks
Peak	3 – 9 days
Time to Steady State*	2-4 months
Elimination half-life	21 days
Initiation Phase	2nd- 4th dose
Maintenance	5th dose onwards

*** Full effect of depot dose may not be clinically apparent until steady state is reached.**

HALOPERIDOL DECANOATE (7 of 9)

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching to Haloperidol depot:	From oral:	Continue oral haloperidol for FOUR weeks from the first depot injection. N.B. the combined total dose of haloperidol from both formulations must not exceed the equivalent to the maximum oral dose of 20 mg/day.
	From another depot (not risperidone – see below):	Give haloperidol depot on the due date of the next dose of the original depot, instead of the original depot. Do not give any more doses of the original depot.
	From risperidone 2-weekly depot:	Give haloperidol depot 2–4 weeks after the last injection of risperidone 2-weekly depot was due. i.e., 4-6 weeks after the last injection of risperidone was given; do not give any more risperidone. (The last injection of risperidone 2-weekly depot provides therapeutic plasma levels for 4-6 weeks with a post dose peak at 5 weeks).
Switching from Haloperidol depot to oral:	From weekly injection:	Start 25% target oral dose equivalent on the date the next depot is due for one week, then 33% for one week, then 66% for one week, then 100% oral target dose.
	From two weekly injection:	Start 25% target oral dose equivalent on the date the next depot is due for one week, then 50% for two weeks, then 100% oral target dose.
	From three weekly injection:	Start 50% target oral dose equivalent on the date the next depot is due for one week, then increase to 100% oral target dose
	From four weekly injection:	Start 50% target oral dose equivalent on the date the next depot is due for one week, then increase to 100% oral target dose.

Click here for more guidance on switching depots

Return to Haloperidol Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

HALOPERIDOL DECANOATE (8 of 9)

Amber Shared Care

	Dosing Frequency	
Administration window to maintain therapeutic levels:	**Weekly:**	+/- 2 days
	Two weekly:	- 2 days / + 6 days
	Three weekly	- 2 days / + 7 days
	Four weekly	- 2 days / + 14 days

Management of missed doses (outside of above windows):	**Weekly:**	Consider giving up to 50% extra (max.300 mg in total) at next scheduled dose, then revert to normal dose weekly If >14 days since last dose, give double the normal dose (max. 300 mg in total), then revert to normal dose weekly
	Two weekly:	Consider giving up to 50% extra (max.300 mg in total) then revert to normal dose every two weeks. If >28 days since last dose, give up to 75% extra (max.300 mg in total), then revert to normal dose every two weeks
	Three weekly:	If two weeks late, give 75% of usual dose then resume as before (i.e. give usual one week after the 75% dose has been given) If three weeks late, restart at usual dose plus 50%, then revert to usual dose every three weeks
	Four weekly:	If >42 days since last dose, give 60-75% of normal dose, then 1 week later give the full normal dose, then revert to normal dose every 4 weeks.

Click here for guidance on appropriate use of tolerance windows.

HALOPERIDOL DECANOATE (9 of 9)

Amber Shared Care

Clinical Tips

- They don't work instantly, not even with a loading dose.
- On stopping Haloperidol depot, the washout period can last approx. 100days.
- Maximal effect is at 50 mg every four weeks, little evidence for higher doses and increased risks of ADRs
- Dose changes take time to have effect, allow 8 – 12 weeks for a new steady state to be reached before changing the dose again.
- The off-label use of haloperidol decanoate via deltoid administration is on the Trust pre-approved list. If this is used, the patient needs to be advised that it is off-label and the dose mustn't exceed the maximum volume recommended for the deltoid site, which is 0.5-2ml in practice
- Consider augmentation with oral medication and/or management of side-effects with anticholinergics.
- Baseline ECG essential.
- If your patient is receiving both haloperidol depot and orally, use the Ready Reckoner to calculate the % BNF Max, referring to the oral and depots separately. i.e. do not convert depot to oral equivalent first. See below for example,

	BNF % as per Ready Reckoner	BNF Total %
Haloperidol 2mg OD	10	26.5 (not HDAT)
Haloperidol decanoate 50mg every 4 weeks	16.5	

ARIPIPRAZOLE (Monthly) 1 of 9

Amber Shared Care

Prescribing	Dosing	Administration	Pharmacokinetics	Monitoring
Available preparations	Dosage information	Switching Strategies	Duration of Action	Adverse Drug Reactions
Licensed Indications	Renal & Hepatic Considerations	Tolerance Windows	Peak & Steady State	Effects on QT
Cautions & Contraindications	Pregnancy & Breastfeeding	Managing Missed Doses	Elimination half-life	Drug Monitoring
		Needle Size	Initiation Phase	Clinical Tips
		Storage		

Return to Main Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

ARIPIPRAZOLE (Monthly) 2 of 9

Amber Shared Care

Available Presentations:
400 mg pre-filled syringe
300mg pre-filled syringe
400 mg vial
720mg pre-filled syringe

Licensed Indication: Maintenance treatment of schizophrenia in adult patients stabilised with oral aripiprazole.

Licensed Site of Administration: Gluteal and deltoid muscles

Single Application Form required when initiating treatment

For further information: Aripiprazole SPC (select appropriate brand/strength)

Usual dose interval	Maximum single dose	Max. volume per single injection site	Needle/ syringe supplied in pack	Licensed administration sites*	Needle requirements	Storage requirements****
Monthly	400mg	Fixed Dose	Yes**	Gluteal	38 mm (1.5 inch), 22-gauge safety needle. BMI >28: 51 mm (2 inch), 21-gauge safety needle.***	Room temperature
				Deltoid	25 mm (1 inch), 23-gauge safety needle. BMI> 28: 38 mm (1.5 inch), 22-gauge safety needle.	

* For more information on selecting appropriate administration site click here
** Supplied needles must be used for administration
*** For information regarding recommended needle length for gluteal injections click here
**** For additional information on storage on TEWV sites or patients own home

Return to Aripiprazole Menu

Return to Main Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

ARIPIPRAZOLE (Monthly) 3 of 9

Amber Shared Care

Dosing Information	<65 years old		>65 years old, cachectic, frail
Oral dose equivalence	400 mg monthly depot = 20 mg daily oral (guided by previous oral use)		
Initiation/Test Dose (Adjust initiation dose in patients taking concomitant strong CYP2D6 inhibitors, strong CYP3A4 inhibitors, and/or CYP3A4 inducers for more than 14 days - See manufacturers information).	**One injection start:** <u>Day 1:</u> **1 x 400 mg** into the gluteal or deltoid muscle. <u>Day 1 – 14:</u> **10-20 mg/day** oral aripiprazole (maintains therapeutic concentrations during initiation of therapy)	**Two injection start:** Only recommended in working age adults where oral treatment cannot be given. <u>Day 1:</u> **2 x 400 mg** at separate injection sites (i.e. two different sites/two different muscles, e.g. one deltoid/one gluteal or two different deltoid) **1 X 20 mg** dose of oral aripiprazole.	No formal recommendations are available for dosing in older adults However, there is no detectable effect of age on pharmacokinetics. Off-label use in this group is pre-approved using the <u>one injection start only.</u>
Maintenance	300-400 mg once per calendar month If adverse effects with 400 mg dose, reduction to 300 mg/month should be considered		
Maximum	400 mg per month		
Maximum single dose	400 mg		

Do not prescribe doses below 300mg/month except if interactions – seek further advice from pharmacy.

Return to Aripiprazole Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ARIPIPRAZOLE (Monthly) 4 of 9

Amber Shared Care

Hepatic Considerations

Extensively hepatically metabolised. Limited data that hepatic impairment has minimal effect on pharmacokinetics.

Manufacturer states no dosage reduction required in mild to moderate hepatic impairment, but caution required in severe impairment.

Seek further advice from pharmacy

Renal Considerations

Less than 1% of unchanged aripiprazole renally excreted. Manufacturer states no dose adjustment required in renal failure as pharmacokinetics are similar in healthy and severely renally diseased patients.

Avoid depot formulation where possible.

Seek further advice from pharmacy

Pregnancy and Breastfeeding Resources

Refer to the perinatal team any patient prescribed an antipsychotic depot.
One-off preconception appointments can be arranged for patients who are considering becoming pregnant.
Do not stop depot medication without discussion with the perinatal team first.

Contact details
Tees: tewv.teesperinatal@nhs.net
Durham and Darlington:
tewv.durhamdarlingtonperinatal@nhs.net
North Yorkshire & York:
tewv.northyorksperinatal@nhs.net
If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am 5pm:
Tees: 01642 368303
Durham & Darlington: 0191 451 0400
North Yorkshire & York: 01904 556 724

Addition Resources
Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period
Handy Fact Sheet - Treating Symptoms of Psychosis in Pregnancy and Breastfeeding*

* Choice and Medication leaflets are commissioned for TEWV patients only.

Return to Aripiprazole Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ARIPIPRAZOLE (Monthly) 5 of 9

Amber Shared Care

Cautions

Use with caution in patients with physical health comorbidities – see product information (select formulation/strength) for details.

Click here for more information on hepatic, renal and pregnancy/breastfeeding considerations.

Contraindications

Known hypersensitivity to aripiprazole or excipients (carmellose sodium, mannitol, sodium dihydrogen phosphate monohydrate, sodium hydroxide, water for injections)

Very common/common adverse effects:	Weight increased, diabetes mellitus, weight decreased, agitation, anxiety, restlessness, insomnia, extrapyramidal disorder, akathisia, tremor, dyskinesia, sedation, somnolence, dizziness, headache, dry mouth, musculoskeletal stiffness, erectile dysfunction, injection site pain, injection site induration, fatigue, blood creatine phosphokinase increased.
QT prolongation impact: **(Trust guidance)**	Low effect <10 msec at therapeutic doses or only in overdose.
Monitoring & review requirements:	See Trust psychotropic drug monitoring guidance / shared care guidance

ARIPIPRAZOLE (Monthly) 6 of 9

Amber Shared Care

Pharmacokinetic Information	
Duration of action	6–8 weeks
Peak	4–7 days (continuous treatment - 4 days deltoid; 7 days gluteal)
Time to Steady State*	4-5 months
Elimination half-life	30 days (300 mg monthly); 47 days (400 mg monthly)
Initiation Phase	Dose 1 to 3
Maintenance	Dose 4 onwards

*** Full effect of depot dose may not be clinically apparent until steady state is reached.**

ARIPIPRAZOLE (Monthly) 7 of 9

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching to Aripiprazole depot:	From oral:	If switching from a different oral antipsychotic, cross taper from that antipsychotic to oral aripiprazole over 2 weeks (e.g. start 5mg/day aripiprazole increasing stepwise to e.g. 15mg/day, reducing the previous antipsychotic by 25% twice a week). **One injection start:** Start the aripiprazole depot, continue oral aripiprazole for two more weeks then stop. **Two injection start:** Start the aripiprazole depot as above, stop oral aripiprazole
	From another depot (not risperidone – see below):	Start oral aripiprazole for two weeks, starting on the day the last depot dose is due. **One injection start**: Start the aripiprazole depot after two weeks of oral treatment, stop the oral aripiprazole two weeks later. **Two injection start**: Start the aripiprazole depot as above after two weeks of oral treatment, stop oral aripiprazole.
	From risperidone 2-weekly depot:	Start oral aripiprazole 2-4 weeks after the last injection of risperidone 2-weekly depot was due, i.e. 4-6 weeks after the last injection of risperidone was given. Do not give any more risperidone (The last injection of risperidone provides therapeutic plasma levels for 4 -6 weeks with a post dose peak at 5 weeks). **One injection start:** Start the aripiprazole depot two weeks later, stop the oral aripiprazole two weeks after that. **Two injection start:** Start the aripiprazole depot as above after two weeks of oral treatment, stop oral aripiprazole.
Switching from monthly Aripiprazole depot to oral:		Restart oral aripiprazole at 5-10mg/day when the next injection would have been due, increase dose after 1-2 weeks as needed

Return to Aripiprazole Menu

Click here for more guidance on switching depots

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ARIPIPRAZOLE (Monthly) 8 of 9

Amber Shared Care

	Dosing Frequency	
Administration window to maintain therapeutic levels:	**Dose two & three:**	26 - 35 days since previous dose.
	Dose four onwards:	26 – 42 days since previous dose.

Management of missed doses (outside of above windows):	**Second or third dose:**	**>4 weeks and < 5 weeks since last injection:** The injection should be administered as soon as possible and then the monthly injection schedule should be resumed. **> 5 weeks since last injection:** Concomitant oral aripiprazole should be restarted for 14 days with next administered injection or two separate injections given at one time, along with a single dose of 20 mg oral aripiprazole. Monthly injection schedule should then resume.
	Fourth dose onwards:	**>4 weeks and < 6 weeks since last injection:** The injection should be administered as soon as possible and then the monthly injection schedule should be resumed. (If given up to two weeks late, restart monthly injection on the previous planned monthly date, i.e. 2-4 weeks after the late dose, leaving 4 weeks before the next dose can lead to some subtherapeutic levels for several months). **> 6 weeks since last injection:** Concomitant oral aripiprazole should be restarted for 14 days with administered injection or two separate injections given at one time, along with a single dose of 20 mg oral aripiprazole. Monthly injection schedule should then resume. (If it is 6-8 weeks since last injection, oral aripiprazole may be needed for up to 4 weeks while resuming monthly injection on the previous dates).

Click here for guidance on appropriate use of tolerance windows.

Return to Aripiprazole Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

ARIPIPRAZOLE (Monthly) 9 of 9

Amber Shared Care

Clinical Tips

- They don't work instantly, not even with a loading dose.
- Aripiprazole has been detected in plasma in adult patients up to 34 weeks after a single-dose administration
- Dose changes take time to have effect, allow 8 – 12 weeks for a new steady state to be reached before changing the dose again.
- Aripiprazole is a partial D2 Agonist combining with other D2 antagonist antipsychotics could reverse their actions and thus often makes sense not to combine with other antipsychotics
- Well accepted in clinical practice when wanting to avoid weight gain and sedation but can be activating, which can be reduced by lowering the dose or starting at a lower dose. Do not prescribe 200mg monthly unless there are interacting medications, see below.
- Adjust dose in patients who are taking concomitant strong CYP2D6 inhibitors, strong CYP3A4 inhibitors, and/or CYP3A4 inducers for more than 14 days. (See product literature for more information).
- If prior response and tolerability to aripiprazole are known, pre-injection oral aripiprazole may not be required. However, for the one injection start regimen, attainment of effective aripiprazole plasma levels is dependent upon four weeks of oral supplementation. For the two injection start regimen, the pharmacokinetic modelling study was based on plasma levels from oral aripiprazole being at steady state on the day of initiation.
- The recommended dose interval for aripiprazole depot is “monthly” (same calendar date each month), not 28 days. Further guidance is available on monthly dosing regimens and how to appropriately utilise tolerance windows to accommodate FIXED day clinics.

Return to Aripiprazole Menu

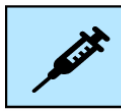
Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 1 of 12

Amber Shared Care

Prescribing	Dosing	Administration	Pharmacokinetics	Monitoring
Available preparations	Dosage information	Switching Strategies	Duration of Action	Adverse Drug Reactions
Licensed Indications	Renal & Hepatic Considerations	Tolerance Windows	Peak & Steady State	Effects on QT
Cautions & Contraindications	Pregnancy & Breastfeeding	Managing Missed Doses	Elimination half-life	Drug Monitoring
		Needle Size	Initiation Phase	Clinical Tips
		Storage		



Paliperidone Long-Acting Injection

Prescribing Support Series - 2

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 2 of 12

Amber Shared Care

Available Presentations:

50 mg in 0.5 ml, 75 mg in 0.75 ml, 100 mg in 1 ml & 150 mg in 1.5 ml pre-filled syringe

Licensed Indication: Maintenance treatment of schizophrenia in adult patients stabilised with paliperidone or risperidone.

Licensed Site of Administration: Deltoid or gluteal muscle
Both initial loading doses are to be given via deltoid muscle.

Single Application Form required when initiating treatment

For further information: Paliperidone SPC (select appropriate brand/strength)

Usual dose interval	Maximum single dose	Max. volume per single injection site	Needle/ syringe supplied in pack	Licensed administration sites*	Needle requirements	Storage requirements****
Monthly	150 mg	Pre-filled syringe	Yes**	Gluteal	38mm (1.5 inch), 22-gauge needle ***	Room Temperature
				Deltoid	**Weight < 90 kg:** 25mm (1 inch), 23-gauge needle **Weight ≥ 90 kg**: 38mm (1.5 inch), 22-gauge needle	

* For more information on selecting appropriate administration site click here
** Supplied needles must be used for administration
*** For information regarding recommended needle length for gluteal injections click here
**** For additional information on storage on TEWV sites or patients own home

Return to Paliperidone (Monthly) Menu

Return to Main Menu

PALIPERIDONE (monthly) 3 of 12

Amber Shared Care

Dosing Information	<65 years old	>65 years old, cachectic, frail
Oral dose equivalence	Depot paliperidone 100 mg/month or 350 mg/3 months = oral risperidone 4 mg/day or risperidone depot 50 mg/2 weeks	
Initiation/Test Dose	It is recommended that patients try at least 3 days oral risperidone for tolerability prior to depot preparation. Patients should be initiated on the MONTHLY injection, 150 mg on treatment day 1 and 100 mg one week later (day 8), both administered in the deltoid muscle to attain therapeutic concentrations rapidly. (Improvement in psychotic symptoms has been seen as early as day 4). The third dose should be administered one month after the second initiation dose.	Dose based on renal function: Because elderly patients may have diminished renal function, they are dosed as in mild renal impairment even if tests show normal renal function*
Maintenance	The recommended MONTHLY maintenance dose is 75 mg; some patients may benefit from lower or higher doses within the recommended range of 25 to 150 mg based on individual patient tolerability and/or efficacy. Patients who are overweight or obese may require doses in the upper range. After 4 identical monthly injections, review for THREE monthly preparation.	Loading doses: Day 1: 100mg Day 8: 75mg (lower loading doses may be appropriate in some
Maximum	150 mg per month	25–100mg monthly*
Maximum single dose	150 mg per month	100mg monthly*

*There is no specific information available in the literature for these drug doses in elderly patients. The doses stated are a guide only. Where there are no data, the maximum doses are conservative and may be exceeded if the drug is well tolerated and following clinician's assessment.

Return to Paliperidone (Monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 4 of 12

Amber Shared Care

Hepatic Considerations

Mainly excreted unchanged so no dosage adjustment required for mild to moderate impairment. May be a good choice for patients with pre-existing hepatic disease.

However, no data are available with respect to severe hepatic impairment, so caution required.

Seek further advice from pharmacy

Renal Considerations

Paliperidone is a metabolite of risperidone. 59% excreted unchanged in urine.

Dosing: GFR 50–80mL/min. Dose as in normal renal function for maintenance dose, reduce loading dose.

Manufacturer contraindicates monthly, 3-monthly and 6-monthly depot preparations if GFR <50mL/min.

Use with caution as clearance is reduced by 71% in severe kidney disease.

Seek further advice from pharmacy

Pregnancy and Breastfeeding Resources

Refer to the perinatal team any patient prescribed an antipsychotic depot.
One-off preconception appointments can be arranged for patients who are considering becoming pregnant.
Do not stop depot medication without discussion with the perinatal team first.

Contact details
Tees: tewv.teesperinatal@nhs.net
Durham and Darlington:
tewv.durhamdarlingtonperinatal@nhs.net
North Yorkshire & York:
tewv.northyorksperinatal@nhs.net
If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am 5pm:
Tees: 01642 368303
Durham & Darlington: 0191 451 0400
North Yorkshire & York: 01904 556 724

Addition Resources
Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period
Handy Fact Sheet - Treating Symptoms of Psychosis in Pregnancy and Breastfeeding*

* Choice and Medication leaflets are commissioned for TEWV patients only.

Return to Paliperidone (Monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 5 of 12

Amber Shared Care

Cautions and Contraindication

Use with caution in patients with physical health co-morbidities – see product information (select brand/strength) for details.

Click here for more information on hepatic, renal and pregnancy/breastfeeding considerations.

Very common/common adverse effects:	Weight gain, depression, fatigue, EPSE, slowed reaction times, sexual dysfunction hyperprolactinaemia, reduction in bone density, incontinence.
QT prolongation impact: **(Trust guidance)**	Low effect <10 msec at therapeutic doses or only in overdose.
Monitoring & review requirements:	See Trust psychotropic drug monitoring guidance / shared care guidance

Return to Paliperidone (Monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 6 of 12

Amber Shared Care

Pharmacokinetic Information	
Duration of action	Up to 4 months
Peak	13 days
Time to Steady State*	5 months (loading doses increase therapeutic levels rapidly but time to steady state is unaffected)
Elimination half-life	25-49 days
Initiation Phase	Dose 1 and 2
Maintenance	Dose 3 onwards

*** Full effect of depot dose may not be clinically apparent until steady state is reached.**

Return to Paliperidone (Monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 7 of 12

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching to Paliperidone depot:	From oral risperidone:	Follow initiation process, no oral supplementation is necessary during initiation of MONTHLY paliperidone depot. Consider 'bridging with 7 days oral risperidone if switching from oral treatment >4mg/day. Shown to reduce hospital days. Prescribers should have awareness that this is High Dose Antipsychotic Treatment.
	From Oral Paliperidone:	Follow initiation process, no oral supplementation is necessary during initiation of MONTHLY paliperidone depot.
	From another oral antipsychotic:	Follow initiation process above, reduce the oral antipsychotic over 1-2 weeks (four-week dose reduction recommended for olanzapine, quetiapine & clozapine to minimise any rebound) following the first injection of MONTHLY paliperidone depot.
	From another depot (not risperidone – see below):	Start MONTHLY paliperidone depot at the maintenance dose on the due date of the next injection of the original depot, instead of the original depot . No initiation doses are required, do not give another dose of the previous depot.
	From risperidone 2-weekly depot:	No initiation doses of paliperidone depot are necessary. Begin an equivalent dose of MONTHLY paliperidone depot 2-4 weeks after the last injection of risperidone 2- weekly depot was due. i.e., 4-6 weeks after the last injection of risperidone was given. (The last injection of risperidone 2-weekly depot provides therapeutic levels for 4-6 weeks with a post dose peak at 5 weeks). Do not give any more risperidone

Return to Paliperidone (Monthly) Menu

Click here for more guidance on switching depots

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 8 of 12

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching to monthly Paliperidone depot:	From THREE MONTHLY paliperidone depot (Trevicta®):	If the last dose of paliperidone THREE monthly depot (Trevicta) is:	Initiate monthly paliperidone depot 3 months later at the following dose
		175 mg	50 mg
		263 mg	75 mg
		350 mg	100 mg
		525 mg	150 mg
	From SIX MONTHLY paliperidone depot (Byannli®):	If the last dose of paliperidone SIX monthly depot is:	Initiate monthly paliperidone depot 6 months later at the following dose
		700 mg	100 mg
		1000 mg	150 mg

Click here for more guidance on switching depots

Return to Paliperidone (Monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 9 of 12

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching <u>from</u> Paliperidone (MONTHLY) depot to:	To oral (RISPERIDONE):	Stop paliperidone depot; start oral on the date next dose of depot was due and gradually titrate up dose e.g., 25% target oral dose for three weeks, 50% target oral dose for three weeks, 75% target oral dose for three weeks, then 100% target oral dose
	To paliperidone THREE - monthly depot (Trevicta®): Only for patients adequately treated on monthly paliperidone palmitate injectables.	The THREE-MONTHLY depot should be initiated in place of the next scheduled dose of the monthly depot (± 7 days). The dose should be based on the previous monthly dose using a 3.5-fold conversion factor as shown in the following table: If the last dose of monthly paliperidone depot is: → Initiate Paliperidone THREE monthly depot at the following dose 25mg → No equivalent dose 50mg → 175 mg 75mg → 263 mg 100mg → 350mg 150mg → 525mg

Click here for more guidance on switching depots

Return to Paliperidone (Monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 10 of 12

Amber Shared Care

	Dosing Frequency	
Administration window to maintain therapeutic levels:	**Dose 2:**	3-11 days after dose 1
	Dose 3 onwards:	ONE month +/- 7 days

		<4 weeks from first injection:	4-7 weeks from first injection:	7 weeks from first injection:
Management of missed doses (outside of above windows):	**Missed Dose 2**	• Administer second injection of 100 mg in the deltoid muscle as soon as possible. • A third dose of 75 mg in either the deltoid or gluteal muscles should be administered FIVE WEEKS after the first injection (regardless of the timing of the second injection), • then follow normal monthly cycle in either deltoid or gluteal muscle, dose based on tolerability/efficacy.	• Resume dosing with a deltoid injection of 100 mg as soon as possible, • then another deltoid injection of 100 mg ONE WEEK (+/- 4 days) later, • then follow normal monthly cycle, dose based on tolerability/efficacy.	Restart using standard initiation doses and dosing schedule as described in initiation section.

Click here for guidance on appropriate use of tolerance windows.

Return to Paliperidone (Monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (monthly) 11 of 12

Amber Shared Care

Management of missed doses (outside of above windows):	**Missed <u>Dose 3</u> onwards:**	**1 month to 6 weeks since last injection:**	**Missed monthly maintenance dose (> 6 weeks to 6 months) & usual maintenance dose 25-100 mg/month:**	**Missed monthly maintenance dose (> 6 weeks to 6 months) & usual maintenance dose 150 mg/month:**	**Missed monthly maintenance dose > 6 months:**
		• Administer previously stabilised dose as soon as possible, followed by injections at monthly intervals (i.e., move the next due date to a month after most recent injection).	• Administer a <u>deltoid</u> injection as soon as possible at the same dose the patient was previously stabilised on, • then another <u>deltoid</u> injection (same dose) ONE WEEK later (day 8), • then follow normal monthly cycle in either deltoid or gluteal muscle, dose based on tolerability/efficacy.	• Administer a <u>deltoid</u> injection as soon as possible at the 100 mg dose, • then another <u>deltoid</u> injection ONE WEEK later (day 8) at the 100 mg dose, • then follow normal monthly cycle in either deltoid or gluteal muscle, dose based on tolerability/efficacy.	• Restart using standard initiation doses and dosing schedule as described in initiation section.

Return to Paliperidone (Monthly) Menu

Return to Main Menu

PALIPERIDONE (monthly) 12 of 12

Amber Shared Care

Clinical Tips

- They don't work instantly, not even with a loading dose.
- On stopping paliperidone (MONTHLY) depot, the washout period can last approx. 100days.
- Dose changes take time to have effect, allow 8 – 12 weeks for a new steady state to be reached before changing the dose again.
- Some patients respond to paliperidone or tolerate paliperidone better than the parent drug risperidone.
- It is recommended that patients try at least 3 days oral risperidone for tolerability. In selected adult patients with schizophrenia and previous responsiveness to oral paliperidone or risperidone, the depot may be started without prior stabilisation with oral treatment if psychotic symptoms are mild to moderate and a long-acting injectable treatment is needed.
- Adjusting dose vs dose interval will have different effects on pharmacokinetics. E.g. 125mg monthly vs 150mg 5 weekly.
  For further information: Full article: Proposing a novel approach for the long-term use of monthly paliperidone palmitate: adjusting injection dose versus adjusting injection interval
- Paliperidone 125mg monthly is NOT possible with available pre-filled syringes. Seek pharmacy advice for further information.
- The recommended dose interval for aripiprazole depot is “monthly” (same calendar date each month), not 28 days. Further guidance is available on monthly dosing regimens and how to appropriately utilise tolerance windows to accommodate FIXED day clinics.

Return to Paliperidone (Monthly) Menu

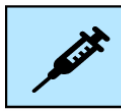
Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (THREE monthly) 1 of 9

Amber Shared Care

Prescribing	Dosing	Administration	Pharmacokinetics	Monitoring
Available preparations	Dosage information	Switching Strategies	Duration of Action	Adverse Drug Reactions
Licensed Indications	Renal & Hepatic Considerations	Tolerance Windows	Peak & Steady State	Effects on QT
Cautions & Contraindications	Pregnancy & Breastfeeding	Managing Missed Doses	Elimination half-life	Drug Monitoring
		Needle Size	Initiation Phase	Clinical Tips
		Storage		



Paliperidone Long-Acting Injection

Prescribing Support Series - 2

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (THREE monthly) 2 of 9

Amber Shared Care

Available Presentations:
Trevicta® (3-monthly injection) - 175 mg in 0.875 ml, 263 mg in 1.315 ml, 350 mg in 1.75 ml & 525 mg in 2.625 ml pre-filled syringe

Licensed Indication: Maintenance treatment of schizophrenia in adult patients stabilised with paliperidone or risperidone.

Licensed Site of Administration: deltoid or gluteal muscle.

Single Application Form required when initiating treatment

For further information: Paliperidone SPC (select appropriate brand/strength)

Usual dose interval	Maximum single dose	Max. volume per single injection site	Needle/ syringe supplied in pack	Licensed administration sites*	Needle requirements	Storage requirements****
3 months	525mg	Pre-filled syringe	Yes**	Gluteal	38mm (1.5 inch), 22-gauge needle***	Room temperature
				Deltoid	Weight < 90 kg: 25mm (1 inch), 23-gauge needle Weight ≥ 90 kg: 38mm (1.5 inch), 22-gauge needle	

* For more information on selecting appropriate administration site click here
** Supplied needles must be used for administration
*** For information regarding recommended needle length for gluteal injections click here
**** For additional information on storage on TEWV sites or patients own home

Return to Paliperidone (THREE monthly) Menu

Return to Main Menu

PALIPERIDONE (THREE monthly) 3 of 9

Amber Shared Care

<table>
<tr><th>Dosing Information</th><th><65 years old</th><th>>65 years old, cachectic, frail</th></tr>
<tr><td>Oral dose equivalence</td><td colspan="2">Depot paliperidone 100 mg/month or 350 mg/3 months = oral risperidone 4 mg/day or risperidone depot 50 mg/2 weeks</td></tr>
<tr><td>Initiation/Test Dose</td><td>Patients who are clinically stable after at least four identical doses of the monthly injection may be transferred to the THREE-MONTHLY preparation</td><td>Dose based on renal function: Because elderly patients may have diminished renal function, they are dosed as in mild renal impairment even if tests show normal renal function*</td></tr>
<tr><td>Maintenance</td><td>
<table>
<tr><th>Monthly dose patient stable on:</th><th>Suitable 3 monthly Preparation:</th></tr>
<tr><td>50mg</td><td>175mg</td></tr>
<tr><td>75mg</td><td>263mg</td></tr>
<tr><td>100mg</td><td>350mg</td></tr>
<tr><td>150mg</td><td>525mg</td></tr>
</table>
</td><td>350mg 3 monthly*</td></tr>
<tr><td>Maximum</td><td>525 mg every 3 months</td><td>350mg 3 monthly*</td></tr>
<tr><td>Maximum single dose</td><td>525 mg every 3 months</td><td>350mg 3 monthly*</td></tr>
</table>

*There is no specific information available in the literature for these drug doses in elderly patients. The doses stated are a guide only. Where there are no data, the maximum doses are conservative and may be exceeded if the drug is well tolerated and following clinician's assessment.

Return to Paliperidone (THREE monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (THREE monthly) 4 of 9

Amber Shared Care

Hepatic Considerations

Mainly excreted unchanged so no dosage adjustment required for mild to moderate impairment. May be a good choice for patients with pre-existing hepatic disease.

However, no data are available with respect to severe hepatic impairment, so caution required.

Seek further advice from pharmacy

Renal Considerations

Paliperidone is a metabolite of risperidone. 59% excreted unchanged in urine.

Dosing: GFR 50–80mL/min. Dose as in normal renal function for maintenance dose, reduce loading dose.

Manufacturer contraindicates monthly, 3-monthly and 6-monthly depot preparations if GFR <50mL/min.

Use with caution as clearance is reduced by 71% in severe kidney disease.

Seek further advice from pharmacy

Pregnancy and Breastfeeding Resources

Refer to the perinatal team any patient prescribed an antipsychotic depot.
One-off preconception appointments can be arranged for patients who are considering becoming pregnant.
Do not stop depot medication without discussion with the perinatal team first.

Contact details
Tees: tewv.teesperinatal@nhs.net
Durham and Darlington:
tewv.durhamdarlingtonperinatal@nhs.net
North Yorkshire & York:
tewv.northyorksperinatal@nhs.net
If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am 5pm:
Tees: 01642 368303
Durham & Darlington: 0191 451 0400
North Yorkshire & York: 01904 556 724

Addition Resources
Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period
Handy Fact Sheet - Treating Symptoms of Psychosis in Pregnancy and Breastfeeding*

* Choice and Medication leaflets are commissioned for TEWV patients only.

Return to Paliperidone (THREE monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (THREE monthly) 5 of 9

Amber Shared Care

Cautions and Contraindications

Use with caution in patients with physical health co-morbidities – see product information (select brand/strength) for details.

Contraindicated in anyone with hypersensitivity to the active substance, to risperidone or to any of the excipients:
Polysorbate 20
Macrogol
Citric acid monohydrate
Disodium phosphate
Sodium dihydrogen phosphate monohydrate
Sodium hydroxide (for pH adjustment)
Water for injections

Click here for more information on hepatic, renal and pregnancy/breastfeeding considerations.

Very common/common adverse effects:	Weight gain, depression, fatigue, EPSE, slowed reaction times, sexual dysfunction hyperprolactinaemia, reduction in bone density, incontinence.
QT prolongation impact: **(Trust guidance)**	Low effect <10 msec at therapeutic doses or only in overdose.
Monitoring & review requirements:	See Trust psychotropic drug monitoring guidance / shared care guidance

Return to Paliperidone (THREE monthly) Menu

Return to Main Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

PALIPERIDONE (THREE monthly) 6 of 9

Amber Shared Care

Pharmacokinetic Information	
Duration of action	Up to 18 months
Peak	30-33 days (median, Cmax 11-12 % higher with deltoid compared with gluteal injection.)
Time to Steady State*	should be at steady state when transferred from monthly paliperidone
Elimination half-life	84-95 days (Deltoid), 118-139 days (Gluteal)
Initiation Phase	not applicable
Maintenance	all doses

*** Full effect of depot dose may not be clinically apparent until steady state is reached.**

Return to Paliperidone (THREE monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (THREE monthly) 7 of 9

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching <u>from</u> Paliperidone THREE monthly depot (Trevicta®):	To oral:	If THREE-monthly paliperidone depot is discontinued, its prolonged release characteristics must be considered. (For example, when switching to paliperidone oral, the manufacturer recommends starting daily dosing of oral medication three months after the last injection, and a gradual dose increase, after 7 weeks, then 13 weeks, dependent on depot dose and individual patient response).	
Switching <u>from</u> Paliperidone SIX monthly depot (Byannli®): [N.B. the SIX-MONTHLY preparation, Byannli® is not approved for use in the Trust; approval for use in exceptional, named-patient cases must be requested using the single application form. If approved, shared care would not apply]	To Oral:	If SIX-monthly paliperidone depot is discontinued, its prolonged release characteristics must be considered. (For example, when switching to paliperidone oral, the manufacturer recommends starting daily dosing of oral medication six months after the last injection, and a gradual dose increase, at 3 months intervals, dependent on depot dose and individual patient response).	
	To paliperidone THREE-monthly depot (Trevicta®):	If the last dose of paliperidone SIX monthly depot is:	Initiate Three-monthly paliperidone depot 6 months later at the following dose
		700 mg	350 mg
		1000 mg	525 mg

Click here for more guidance on switching depots

Return to Paliperidone (THREE monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (THREE monthly) 8 of 9

Amber Shared Care

	Dosing Frequency	
Administration window to maintain therapeutic levels:	**Three Months:**	THREE months +/- 14 days

Management of missed doses (outside of above windows):

> 3½ months up to 4 months after last injection:

- The injection should be administered as soon as possible,
- then resume the 3-monthly injection schedule.

4 months to 9 months after last injection:

Last dose of Paliperidone THREE-monthly was	Administer monthly paliperidone depot, two doses one week apart (into deltoid muscle)		Then administer Paliperidone THREE- monthly depot (into deltoid or gluteal muscle)
	Day 1	Day 8	1 month after day 8
175 mg	50 mg	50 mg	175 mg
263 mg	75 mg	75 mg	263 mg
350 mg	100 mg	100 mg	350 mg
525 mg	100 mg	100 mg	525 mg

> 9 months since last injection:

- Restart and stabilise on paliperidone MONTHLY depot,
- after a minimum of FOUR months, can switch back to THREE-monthly paliperidone depot.

Return to Paliperidone (THREE monthly) Menu

Click here for guidance on appropriate use of tolerance windows.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

PALIPERIDONE (THREE monthly) 9 of 9

Amber Shared Care

Clinical Tips

- The THREE monthly should not be prescribed unless the patient has been stable on the same dose of the monthly preparation for at least FOUR months.
- On stopping paliperidone (THREE monthly) depot, the washout period can last up to approx. 2 years.
- The long-acting nature of the depot means a patient's response to an adjusted dose may not be apparent for multiple months.
- Some patients respond to paliperidone or tolerate paliperidone better than the parent drug risperidone
- The recommended dose interval for paliperidone depot is "THREE monthly" (same calendar date every three months). Further guidance is available on dosing regimens and how to appropriately utilise tolerance windows to accommodate FIXED day clinics.

Return to Paliperidone (THREE monthly) Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

RISPERIDONE (TWO-weekly) 1 of 9

Amber Shared Care

Prescribing	Dosing	Administration	Pharmacokinetics	Monitoring
Available preparations	Dosage information	Switching Strategies	Duration of Action	Adverse Drug Reactions
Licensed Indications	Renal & Hepatic Considerations	Tolerance Windows	Peak & Steady State	Effects on QT
Cautions & Contraindications	Pregnancy & Breastfeeding	Managing Missed Doses	Elimination half-life	Drug Monitoring
		Needle Size	Initiation Phase	Clinical Tips
		Storage		

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

RISPERIDONE (TWO-weekly) 2 of 9

Amber Shared Care

Available Presentations:
25 mg, 37.5 mg and 50 mg vials

Single Application Form required when initiating treatment

Licensed Indication: Maintenance treatment of schizophrenia in patients currently stabilised with oral antipsychotics.

Licensed Site of Administration: Deltoid or gluteal injection.

For further information: Risperdal Consta SPC (select appropriate brand/strength)

Usual dose interval	Maximum single dose	Max. volume per single injection site	Needle/ syringe supplied in pack	Licensed administration sites*	Needle requirements	Storage requirements****
2 weeks	50mg	Fixed Dose	Yes**	Gluteal	51 mm (2 inch) 20-gauge safety needle***	Store in a refrigerator (2- 8°C)..
				Deltoid	25 mm (1 inch) 21 8°C). -gauge safety needle	

* For more information on selecting appropriate administration site click here
** Supplied needles must be used for administration
*** For information regarding recommended needle length for gluteal injections click here
**** For additional information on storage on TEWV sites or patients own home

Return to Risperidone Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

RISPERIDONE (TWO-weekly) 3 of 9

Amber Shared Care

Dosing Information	<65 years old	>65 years old, cachectic, frail
Oral dose equivalence	Manufacturer suggests 25 mg / 2 weeks depot = 4 mg daily oral, 37.5-50 mg depot – be guided by previous oral use	
Initiation/Test Dose	For most patients the recommended dose is 25 mg intramuscular every two weeks. For those patients on a fixed dose of oral risperidone for two weeks or more, see above for recommended dose equivalence. Monitor renal function in >65yrs	
Maintenance	25-50 mg every TWO weeks	25mg every 2 weeks
Maximum	50 mg	Consider 37.5mg every 2 weeks in patients treated with oral risperidone doses >4mg/day
Maximum single dose	50 mg	37.5mg

*There is no specific information available in the literature for these drug doses in elderly patients. The doses stated are a guide only. Where there are no data, the maximum doses are conservative and may be exceeded if the drug is well tolerated and following clinician's assessment.

Return to Risperidone Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

RISPERIDONE (TWO-weekly) 4 of 9

Amber Shared Care

Hepatic Considerations

Hepatically metabolised.
No dose reduction necessary in mild impairment.
Infrequent reports of cholelithiasis.

Reduce dose in moderate impairment (two fold increase in active metabolites) and avoid completely in severe hepatic impairment (no studies done).

Renal Considerations

Clearance of risperidone and the active metabolite of risperidone (9-OH-) is reduced by 60% in patients with moderate to severe renal disease.

20 – 50 (ml/min) Initially 50% of dose, increases should also be 50% less and at a slower rate. Use with caution. See 'Other information' for IM dosing.

10 – 20 (ml/min) Initially 50% of dose, increases should also be 50% less and at a slower rate. Use with caution. See 'Other information' for IM dosing.

<10 (ml/min) Initially 50% of dose, increases should also be 50% less and at a slower rate. Use with caution.

Note: If a dose of 2 mg daily orally is tolerated then a dose of 25 mg (IM) every 2 weeks can be used initially in renal impairment.

Pregnancy and Breastfeeding Resources

Refer to the perinatal team any patient prescribed an antipsychotic depot.
One-off preconception appointments can be arranged for patients who are considering becoming pregnant.
Do not stop depot medication without discussion with the perinatal team first.

Contact details
Tees: tewv.teesperinatal@nhs.net
Durham and Darlington:
tewv.durhamdarlingtonperinatal@nhs.net
North Yorkshire & York:
tewv.northyorksperinatal@nhs.net
If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am 5pm:
Tees: 01642 368303
Durham & Darlington: 0191 451 0400
North Yorkshire & York: 01904 556 724

Addition Resources
Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period
Handy Fact Sheet - Treating Symptoms of Psychosis in Pregnancy and Breastfeeding*

* Choice and Medication leaflets are commissioned for TEWV patients only.

Return to Risperidone Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

RISPERIDONE (TWO-weekly) 5 of 9

Amber Shared Care

Cautions and Contraindications

Use with caution in patients with physical health co-morbidities – see product information (select strength) for details.

Hypersensitivity to the active substance or to any of the excipients - [poly-(d, l-lactide-co-glycolide), polysorbate 20, carmellose sodium, disodium hydrogen phosphate dihydrate, citric acid anhydrous, sodium chloride, sodium hydroxide, water for injection.

Click here for more information on hepatic, renal and pregnancy/breastfeeding considerations.

Very common/common adverse effects:	The most frequently reported adverse drug reactions (ADRs) (incidence ≥ 1/10) are: insomnia, anxiety, headache, upper respiratory tract infection, parkinsonism, and depression. ADRs that appeared to be dose-related included parkinsonism and akathisia.
QT prolongation impact: **(Trust guidance)**	Low effect <10 msec at therapeutic dose or only in overdose.
Monitoring & review requirements:	See Trust psychotropic drug monitoring guidance / shared care guidance

RISPERIDONE (TWO-weekly) 6 of 9

Amber Shared Care

Pharmacokinetic Information	
Duration of action	4–6 weeks
Peak	5–6 weeks
Time to Steady State*	6–8 weeks
Elimination half-life	4 days
Initiation Phase	2nd to 4th dose
Maintenance	5th dose onwards

*** Full effect of depot dose may not be clinically apparent until steady state is reached.**

Return to Risperidone Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

RISPERIDONE (TWO-weekly) 7 of 9

Amber Shared Care

Switching strategies:

N.B when selecting a dose of the new depot, the most recent dose of the current depot should be used to calculate an approximate dose equivalence; once the patient is established on the new depot the dose can be titrated according to clinical response.

Switching to Risperidone depot:	From oral risperidone:	Give the equivalent dose of risperidone depot, continue with the oral risperidone for at least 3 weeks then taper down over 1-2 weeks. Be prepared to continue oral risperidone for longer if necessary.	
	From another oral antipsychotic:	**Option 1:** • Switch to oral risperidone and titrate to an effective dose, • if tolerated and effective prescribe an equivalent dose of risperidone depot and continue with the oral risperidone for at least 3 weeks then, • taper down over 1-2 weeks, be prepared to continue oral risperidone for longer if necessary	**Option 2:** • Give an appropriate dose of risperidone depot and then, • slowly discontinue the oral antipsychotic after 3 - 4 weeks. • Be prepared to continue the oral antipsychotic for longer if necessary.
	From another depot:	Give risperidone 2-weekly depot one week before the last injection of previous depot is given.	
Switching from Risperidone depot to oral:	To oral:	Plasma levels start to drop below the steady state about five weeks after the last dose of depot is given and fall to near baseline after 7-8 weeks. This must be considered when adding an oral antipsychotic to avoid the risk of additive ADRs and NMS.	
	To another depot	Switch protocol: Risperidone LAI (Consta®) to Paliperidone LAI (monthly)	

Return to Risperidone Menu

Click here for more guidance on switching depots

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

RISPERIDONE (TWO-weekly) 8 of 9

Amber Shared Care

	Dosing Frequency	
Administration window to maintain therapeutic levels:	**2 Weekly:**	2 weeks +/- 2 days

	ONE dose missed	TWO doses missed:	THREE doses missed:
Management of missed doses (outside of above windows):	**Do not give a double or higher dose because that could lead to toxic levels 3-5 weeks later.**		
	• Administer dose as soon as possible after the missed dose and carried on every two weeks from that point. • Oral supplementation may be needed.	• Administer the missed dose as soon as possible and carry on from that point every two weeks • Oral supplementation might be needed.	• Administer the missed dose as soon as possible and carry on from that point every two weeks • Oral supplementation may be needed for 3 – 4 weeks.

Click here for guidance on appropriate use of tolerance windows.

RISPERIDONE (TWO-weekly) 9 of 9

Amber Shared Care

Clinical Tips

- Risperidone is the parent drug of paliperidone. Some patients respond to or tolerate paliperidone better than risperidone.
- New patients should be initiated on paliperidone in preference to risperidone; do not initiate in new patients unless all other depot options have been exhausted or are contraindicated.
- If risperidone is appropriately initiated, there is an initial 3-week lag period, oral or IM medication will need to be continued to continue therapeutic cover.
- Injection requires refrigeration and reconstitution.
- Testing tolerability with oral risperidone (e.g. 2 mg/day titrated up if necessary) for at least 3 days is desirable.
- If stopping the depot, plasma levels start to drop below the steady state about five weeks after the last dose of depot is given and fall to near baseline after 7-8 weeks.
- Dose changes take time to have effect, allow 6 - 8 weeks for a new steady state to be reached before changing the dose again.

Return to Risperidone Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Switch protocol: Risperidone LAI (Consta®) to Paliperidone LAI (monthly)

1. Identify patients currently prescribed Risperidone LAI (Risperdal Consta®) and arrange to discuss their current prescribed antipsychotic medication.

2. Provide the patient with a suitable patient information leaflet from Choice and Medication site: Paliperidone (monthly LAI) and discuss with patient and/or carer the benefits of moving to monthly paliperidone LAI injections (e.g. 12 injections per year instead of 26)

3. If the patient agrees to switch a single application form is not required – discontinue the prescription for Risperidone LAI and complete a new prescription & administration chart for Paliperidone LAI, selecting an appropriate dose based on the following information:

Current Risperidone LAI 2-weekly dose	Recommended Paliperidone LAI MONTHLY dose
25 mg	50 mg
37.5 mg	75 mg
50 mg	100 mg

4. Give the first dose of Paliperidone monthly LAI on the date their next dose of Risperidone 2-weekly LAI is due (no loading doses are required) then monthly thereafter.

5. Monitor the patient for any loss of control of symptoms or new/worsened side-effects

Return to Risperidone Menu

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Adjustment of dose frequency: First generation antipsychotic depots (FLUpentixol, Haloperidol, ZUCLOpenthixol)

Increasing dose interval of First-generation depot:	From WEEKLY to every TWO weeks:	Add 25% to the final WEEKLY dose, miss a week then give double the previous weekly dose every TWO weeks
	From every TWO weeks to every THREE weeks:	Add up to 20-25% to the last TWO weekly injection, then move to injections every THREE weeks at 1.5 times the previous dose.
	From every THREE weeks to every FOUR weeks:	Leave FOUR weeks since the last dose, then start with the previous dose plus 33% every FOUR weeks
If extending dose interval, it may not be necessary to increase dose, due to long-acting nature, the depot may work for up to 4 weeks. Intervals can be increased and dose increased with clinical need. For further guidance on deprescribing and dose reduction click here.		
Reducing dose interval of First-generation depot:	From every FOUR weeks to every THREE weeks:	THREE weeks after the last dose was given, start THREE weekly injection at 75% of previous dose
	From every FOUR weeks to every TWO weeks:	TWO weeks after the last dose was given, start TWO weekly injection at 50% previous dose
	From every THREE weeks to every TWO weeks:	TWO weeks after the last dose was given, start TWO weekly injection at around 66% previous dose.
	From every TWO weeks to weekly:	Give the last TWO weekly dose as usual, miss a week, then start weekly at 50% of the previous fortnightly dose. Plasma levels may take 4-6 weeks to stabilise, no other dose adjustment seems necessary

Dose changes take time to have effect, allow 8 – 12 weeks for a new steady state to be reached before changing the dose again.

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Pre-administration Self-Check Checklist

- ❑ Correct **patient**
- ❑ Correct **drug**
- ❑ Correct **strength**
- ❑ Correct **volume** (using >1 ampoule of the same strength if necessary)
- ❑ Correct **frequency** – e.g. for two-weekly injections, check the last dose was administered 14 days previously (see Appendix D for acceptable tolerances).
- ❑ **Site of last injection** to enable site rotation, e.g. alternating between L/R side, and ensure that the site for this injection is licensed for the medication being administered or that an agreement for unlicensed use has been discussed with the prescriber and patient and is clearly documented prior to administration.

- ❑ Appropriate **needle/syringe** for administration is selected (recommendations based on site and sometimes BMI).
- ❑ **Check expiry date** of medication and any consumables.
- ❑ Any drug specific **reconstitution recommendations** detailed within the package insert.
- ❑ No known **allergies** to drug or any product excipients.
- ❑ Any new or worsening **side effects**.
- ❑ Obtain **consent** for administration.

Deprescribing: Risk/Benefit Analysis

- Is the patient symptom-free and if so for how long? (excluding any long-standing, non-distressing symptoms that have previously been non-responsive to medication)
- How severe, tolerable or disabling are the side effects?
- What is the previous pattern of illness? (consider the speed of onset, duration and severity of past relapses and any dangers or risks posed to self or others)
- Has dose reduction been attempted before? If so, what was the outcome?
- What are the patient's current social circumstances? Is it a period of relative stability, or should stressful life events be anticipated?
- What is the potential social cost of relapse? (e.g. is the patient the main income earner for a family?)
- Is the patient able to monitor their own symptoms and seek appropriate help if necessary?

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Glossary of Terms

Term	Definition
ADR	Adverse Drug Reaction
BMI	Body Mass Index
Cmax	Maximum concentration reached
CMHT	Community Mental Health Team
CNS	Central Nervous System
CPN	Community Psychiatric Nurse
Depot/LAI	Long-acting injectable antipsychotic
ECG	Electrocardiogram
EDL	Electronic Discharge Letter

Term	Definition
EPMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Records
EPSE	Extra-pyramidal Side Effects
FGA	First Generation Antipsychotic
HDAT	High Dose Antipsychotic
SGA	Second Generation Antipsychotic
SPC	Summary of Product Characteristics
VCB	Visual Control Board

Resources and Guidelines

Prescribing and Monitoring Guidelines

- Medicines Optimisation - Interactive Guide
- Medicines Optimisation - Interactive Guide – External
- Shared Decision Making (NICE NG197).
- Psychosis and schizophrenia in adults: prevention and management (NICE CG178)
- Guidelines for Prescribing and Administration of Olanzapine Long - Acting Injection (TEWV PHARM-0038-v5) – olanzapine
- Guidelines on Unlicensed and Off-Label Use of Medicines
- Guidelines for the Management of QTc Prolongation with Psychotropic Medication
- Guidance on Prescribing Psychotropic Medication for Patients of Childbearing Potential & in the Perinatal Period
- High Dose Antipsychotic Prescribing Guideline
- Trust Psychotropic Drug Monitoring Guidance
- Safe Transfer of Prescribing Guidelines
- Mental Health Medicines: Safety Guidance for Acute Hospital Teams.

Patient Information

- Treatment Choices for Psychosis Handy Chart (Choice and Medication)
- Treating Symptoms of Psychosis in Pregnancy and Breastfeeding - Handy Fact Sheet

Prescribing Advice

- Safe Transfer of Psychotropic Medication at Discharge from Inpatient Wards - Medication Safety Series 18
- Paliperidone Long-Acting Injection - Prescribing Support Series 2
- Prescribing First Generation Antipsychotic depots - Prescribing Support Series 4

Administration and Record Keeping

- Hand Hygiene procedure
- Standard (Universal) Precautions for Infection Prevention and Control policy
- Safe Handling and Disposal of Sharps
- Accidental inoculation
- Medicines – Management of Alerts, Recalls, Reporting and Shortages
- Medicines Preparation and Administration
- Patients Own Drugs Procedure
- Medicines - Ordering, Storage Security, Transporting and Disposal
- Resuscitation Policy.
- Moving records and other sensitive information procedure.
- Tips for Administration of Depot Injections (Community)
- Tips for Administration of Depot Injections (Inpatient)
- Medicines – Retention of Records Policy

Incident Form

Single Application Form

HDAT Calculator (Ready Reckoner)

Approved by	Drugs and Therapeutics Committee	Date of Approval	28th May 2026
Protocol Number	PHARM-0081-v3.0	Date of Review	31st May 2029

Return to Main Menu

Version Control

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This document replaces	PHARM-0081-v2.2
This document was approved by	Drug and Therapeutics Committee
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An equality analysis was completed on this policy on	Part of medicines overarching framework assessment
Document type	Public
FOI Clause (Private documents only)	n/a

Version	Date	Amendment details	Status
2	22 Sept 2022	New document – replacing previous documents: PHARM-0081-v1.6 Depot Injections - Community services procedure PHARM-0089-v1 Depot & Long Acting Injections – Inpatient Services Guidance on the Use of Antipsychotic Long-acting Injections in North of England (TEWV version), July 2017	Superseded
2.1	23 Nov 2023	• Section 5.1.1 – advice added about switching between depots and stopping treatment (also added to product monographs in appendix A) • Section 5.1.2 – advice added about patient-specific supplies • Section 5.5.1 – advice added about risks of administration in association with alcohol use • Section 5.5.2 – advice added about using ampoules of same strength and batch size; advice added about utilising acceptable tolerances for “monthly” depots in team clinics • Appendix A: flupentixol decanoate monograph – warning of increased suicidality in early weeks of treatment added	Superseded
2.2	23 May 2024	• Section 4 – aripiprazole 2-monthly injection added to products which are non-formulary and out of scope • Section 5.1.4 added - advice on deprescribing • Section 5.8 added – caseload standards • Section 8 – reference to standards in section 5.8 added	Superseded
3.0	28 May 2026	Full review and reformatting - key changes: • Reformatted into interactive / user-friendly format • 12-month prescriptions in community with alignment to an annual review process (as done with clozapine) • A standard e-visual control board for community teams (linked via sharepoint)	Approved