CCGC APPENDIX 1: Antidepressant Classification and Dosages for Adults ■

FDA Black Box Warning
Antidepressants may increase the risk of suicidal thinking and behavior in adults and pediatric patients with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of antidepressants must balance this risk with the clinical need. **Carefully monitor patients receiving antidepressants for possible worsening of depression or suicidality, especially at the beginning of therapy or when the dose either increases or decreases.**

Remember to titrate up from STARTING DOSE after first 4-7 DAYS of treatment (except for Fluoxetine which may need to wait 3-4 weeks.)
See patient within 2-3 weeks for 1st follow-up visit. Contact within one week may be useful to assess side effects or adherence.

Adverse Side Effects ●
0 = absent or rare
4 = relatively common

Contraindications
(x = not recommended)

Category	Drug	Daily Starting Dosage ■	Usual Adult Dosage	Relative Cost (If one $ present, generic is available)	CNS: ACH (Anticholinergic)	CNS: Sedation	CNS: Insomnia/Excitation	Cardio vascular: Orthostatic Hypotension	Cardio vascular: Cardiac Arrhythmia	Other: Gastrointestinal Distress	Other: Sexual Dysfunction	Other: Weight Gain (>6kg)	Benign Prostatic Hypertrophy	Cardiac Conduction Abnormality/ Coronary Artery Disease	Glaucoma	Orthostatic Hypotension	Seizures	Eating Disorders	Suicidal Risk (overdose lethal)
SSRIs	Citalopram (**Celexa**)	10-20 mg QAM	20-60 mg	$ - $$	0	2	2	0	0	3	1	*							
	Escitalopram (**Lexapro**)	10 mg QAM	10-20 mg	$$	0	2	1	0	0	3	1	*							
	Fluoxetine (**Prozac**)	10-20 mg QAM	20-80 mg	$ - $$$	0	1	3	0	0	3	2	*							
	Fluoxetine (**Prozac weekly**)	90 Qwk	90 mg	$$$	0	1	2	0	0	3	2	*							
	Fluvoxamine (**Luvox**) ⅄	50 mg QHS	100-300 mg	$ - $$$	0	2	2	0	0	3	1	*							
	Paroxetine (**Paxil**)	10-20 mg QAM	20-50 mg	$ - $$	0	2	2	0	0	3	3	*							
	Paroxetine (**Paxil CR**)	12.5-25 mg QAM	25-62.5 mg	$$ - $$$	0	1	2	0	0	2	3	*							
	Sertraline (**Zoloft**)	25-50 mg QAM	50-200 mg	$	0	2	2	0	0	3	2	*							
SNRIs	Venlafaxine (**Effexor**)	25 mg BID-TID	150-375 mg	$	1	2	0	1	0	3	2	0						X	
	Venlafaxine (**Effexor-XR**)	37.5 mg QD	150-225 mg	$$	1	1	2	0	1	3	2	0						X	
	Duloxetine (**Cymbalta**)	20 mg BID	60 mg	$$$	1	1	0	0	0	3	2	0				X			
Other agents	Bupropion (**Wellbutrin**)	100 mg BID-TID	300-450 mg	$ - $$$	0	0	2	0	1	1	1	*					X	X	
	Bupropion (**Wellbutrin SR**)	100 mg QD to 100 mg BID	150-200 mg BID	$ - $$$	0	0	2	0	1	0	1	*					X	X	
	Bupropion (**Wellbutrin XL**)	150 mg	300-450 mg	$$$	0	0	2	1	1	1	1	*					X	X	
	Mirtazapine (**Remeron** or **Remeron Sol-Tab**)	15 mg QHS	15-45 mg	$$ - $$$	1	4	~	0	0	0	1	3							
	Nefazodone (**Serzone**) ▲	100 mg QHS	300-600 mg	$	1	2	~	0	0	0	1	*							
Tricyclics and older agents	Amitriptyline (**Elavil**)	25-75 mg QHS	100-300 mg	$	4	4	0	4	3	1	~	4	X	X	X	X	X		X
	Amoxapine (**Asendin**) X	50 mg BID	100-400 mg	$$	2	2	2	2	2	0	~	2	X	X	X	X	X		X
	Clomipramine (**Anafranil**)	25-75 mg QHS	100-250 mg	$$	4	~	~	~	~	~	~	~	X	X	X	X	X		X
	Desipramine (**Norpramin**)	25-75 mg QHS	100-300 mg	$	1	1	2	2	0	~	~	1	X			X	X		X
	Doxepin (**Adapin, Sinequan**)	25-75 mg QHS	100-300 mg	$	3	4	0	2	0	~	~	4	X	X	X	X	X		X
	Imipramine (**Tofranil**)	25-75 mg QHS	100-300 mg	$	3	3	1	4	3	1	~	4	X	X	X	X	X		X
	Maprotiline (**Ludiomil**)	25-75 mg QHS	100-225 mg	$	2	3	0	2	2	0	~	2	X	X	X	X	X		X
	Nortriptyline (**Aventyl, Pamelor**)	25-50 mg QHS	50-150 mg	$	2	2	0	1	2	0	~	1	X	X	X	X	X		X
	Protriptyline (**Vivactil**)	15 mg QAM	20-60 mg	$	2	1	1	2	3	0	~	0	X	X			X		X
	Trazodone (**Desyrel**)	50 mg QHS	150-600 mg	$$	1	4	0	3	1	1	~	2	X			X	X		X
	Trimipramine (**Surmontil**)	25-75 mg QHS	100-300 mg	$$	4	4	0	3	3	0	~	4	X	X	X	X	X		X

■ Not intended for Seniors, Adolescents, and Children, Pregnant Women (go to *www.coloradoguidelines.com* for web links addressing these populations).
⅄ Luvox indicated for obsessive-compulsive disorder primarily and for depression secondarily only when other first line anti-depressant agents have failed.
* Emerging (not yet conclusive) evidence suggests weight gain may be associated with these medications.
● Since this list is NOT exhaustive, please refer to other references for additional side effects and drug interactions.
▲ Black box warning of hepatic failure. Brand name, Serzone, withdrawn from market. Generic still available.
X Extra pyramidal side effects (EPS) including tardive dyskinesia (TD) possible.
~ Insufficient data.

The sources used to compile these recommendations include: Drug Facts and Comparisons (2006), AHFS Drug Information (2006), AHRQ Comparative Effectiveness of Pharmacologic Treatment of Depression, FDA package inserts, peer reviewed evidence and expert clinical opinion. Comparative relative incidence rates of adverse side effects were reviewed when available.

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COLORADO CLINICAL GUIDELINES COLLABORATIVE
www.coloradoguidelines.org

Major Depression Disorder in Adults

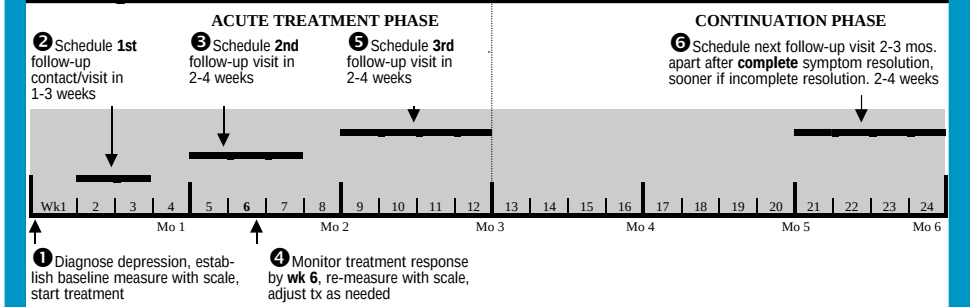
DIAGNOSIS & TREATMENT GUIDELINES

It is estimated that 10% of Americans (~26 million people) suffer from major depression and related mood disorders. Only one third to one-half of these patients are correctly diagnosed and treated initially, and up to 60% discontinue therapy before completing the recommended 6-month course. Inadequately treated depression creates a substantial social and emotional burden on both the patient and society, and costs billions of dollars per year in absenteeism and lost work productivity.

5 A's of Depression

1. **ASK all patients:**
   - In the past month, have you had little interest or pleasure in doing things?
   - In the past month, have you felt down, depressed, or hopeless?
2. **ASSESS severity of the depression using DSM-IV criteria (PHQ-9, QIDS and other** tools may be helpful for this). Assess:
   - Recent life events (Why is this an issue now?)
   - Personal history of depression or bipolar disorder
   - Family history of depression or bipolar disorder
   - Substance abuse
   - Risk of suicide (plans, attempts, recent exposure to suicide)
3. **ADVISE patient about:**
   - Treatment options
   - Possible side effects
   - Importance of compliance
4. **ASSIST patient by providing (as indicated):**
   - Patient education about depression and treatment
   - Counseling or referral to a practitioner at the appropriate level of care
   - A prescription for antidepressant medication
   - Crisis intervention
5. **ARRANGE follow-up care:**
   - Initially, within 1-3 weeks. Contact within one week may be helpful to assess side effects or compliance.
   - Then ongoing, to monitor success, failure or partial response

Depression Treatment Phases



For references, medical record tracking forms and additional color copies of the guideline, go to *www.coloradoguidelines.org* OR call 720-297-1681 OR 866-401-2092 (toll free).

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COLORADO CLINICAL GUIDELINES COLLABORATIVE
www.coloradoguidelines.org

Practice Guideline: Major Depression Disorder in Adults
DIAGNOSIS & TREATMENT
(Abbreviated form, please see long form for additional information)

Common Symptoms
- Pains and aches
- Low energy
- Apathy, irritability, anxiety, sadness
- Sexual complaints
- Disrupted sleep patterns
- Vague GI symptoms
- Concentration difficulties

High Risk Conditions
- Chronic disease
- ETOH/Substance abuse
- Chronic pain
- Postpartum
- Victim of Abuse/Trauma

Attend to common symptoms of depression during routine medical screens (PHQ-9 highly recommended as screening tool)

Depression Criteria (DSM IV):
5 or more in same 2 weeks, including at least one of the first two symptoms:
- Depressed mood
- Marked diminished interest/pleasure
- Significant weight gain or loss
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or inappropriate guilt
- Diminished concentration or indecisiveness
- **Suicidal ideation** (thoughts, plans, means, intent)

If imminently suicidal, consider psych consult, emergency hold, 911, and/or psychiatric inpatient evaluation.

Confirm Diagnosis using criteria and/or depression scale
(see Appendix 2)

Consider Comorbid Medical Psychiatric Disorders
Carefully screen for Bipolar and Substance Abuse

Treatment and/or Referral Options:
- **Medications**—*especially for moderate to severe* and/or chronic symptoms.
- **Referral to Outpatient Psychotherapy**—suitable *for mild to moderate* symptoms.
- **Combined** medication and psychotherapy—for more *severe* symptoms and incomplete response to either medications or therapy.

Determine method of treatment:
- medication
- psychotherapy
- both

Medication Selection & Dosage Considerations:
- Existing medical & psychiatric conditions (see Appendix 1)
- Side effects
- Lethality for suicidal patients

Educate patient about:
- medication side effects
- importance of compliance
- not character defect/ personal weakness

- **Monitor for increased anxiety/agitation with suicidal ideation**
- **Monitor for onset of mania (see MDQ on website)**
- Monitor treatment response using depression scale (PHQ-9) and/or DSM-IV criteria
- Ongoing patient education on course of illness and compliance

Acute Treatment Phase (Wk 1 - Wk 12)
- symptom reduction expected by Wk 6 to 12
- first follow-up appt after evaluation in Wk 1- 3
- next follow-up appts/ contacts every 2 - 4 Wk
- evaluate response by Wk 6

Partial or no Improvement

Complete symptom resolution

Augment or change treatment
- increase dosage
- try different medication
- refer for therapy
- obtain consult

Complete symptom resolution

Partial or no Improvement

Continuation Phase (Mo 4 -Mo 9)
- begins after symptom resolution observed
- continue medications at full strength
- schedule appt/ contact every 2-3 Mo

Discontinue with taper over several weeks with education about discontinuance side effects and relapse awareness, or proceed with maintenance

Obtain psych consult or refer to mental health specialty care

Maintenance Phase (Mo 9 and on)
- at-risk for relapse based on history or genetic disposition
- aimed at preventing relapse
- continue medications for one to several years

Psych Consult/Referral Considerations:
- Psychotic/bipolar/severe depressive state
- Active suicidal, homicidal, self injurious behavior
- Co-existing substance abuse/dependence
- Specialized treatment for psychotic/severe depression (e.g. ECT)
- Ongoing monitoring indicates decline
- Partial or no response to one or more medication trials
- Complex psychosocial issues
- Co-administering second psychotropic medication
- Medically unstable geriatric patient
- Second opinion desired
- Guideline not suitable for patient
- Administering antidepressant in pregnant woman

This guideline is designed to assist the clinician in the management of major depression. This guideline is not intended to replace a clinician's judgement or establish a protocol for all patients with a particular condition.

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