Guidelines for Monitoring Clients on Atypical Antipsychotics and Management of Metabolic Effects

These Guidelines are promulgated by Sentara Healthcare (SHC) as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these Guidelines. The SHC Guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment.
Key Points

✓ Individuals with major mental illness are more likely than the general population to exhibit individual cardiovascular risk factors including obesity, dyslipidemia, diabetes mellitus, cigarette smoking, and hypercortisolemia.

✓ The association between atypical antipsychotics and metabolic adverse effects is well established. Over time, these effects can lead to metabolic syndrome, poor cardiovascular outcome, and type 2 diabetes mellitus.

✓ All atypical antipsychotics carry a risk of metabolic disturbances and newer atypical antipsychotics may carry less metabolic side effects but long term data is currently insufficient. Metabolic data for newer atypical antipsychotics is limited as most have not been studied long term.

✓ Obtain baseline measurements of fasting plasma glucose and lipid profile as well as weight (BMI), waist circumference and blood pressure. Obtain personal and family history related to risk factors.

✓ Waist circumference and BMI affect your risk for Diabetes, high blood pressure and cardiovascular disease. Men should aim for a waist circumference less than 40 inches and women should aim for a waist circumference less than 35 inches.

✓ Obesity is recognized as a major independent risk factor for heart disease.

✓ Routine monitoring of metabolic side effects is recommended for all atypical antipsychotics regardless of risk profile. Monitor above parameters per evidence-based recommendations.

✓ Patients taking atypical antipsychotics may experience an elevation in glucose, serum triglyceride and LDL levels and a decrease in HDL levels without an increase in BMI.

✓ Increases or abnormalities in plasma glucose or lipids should be communicated to the appropriate health professional. Management should be coordinated between the Primary Care Physician (PCP) and Behavioral Health Physician. (Clinical guidelines on Diabetes Management and Lipid Screening and Management are available on optimahealth.com).

✓ Evidence of weight gain should initiate meaningful dietary intervention and recommendations to increase physical activity level.

✓ When switching atypical antipsychotic agents, cross titrate to avoid abrupt discontinuation.

✓ Metabolic effects may not be dose-dependent; children and adolescents should be monitored.

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Figure 1. FDA-Approved Pediatric Age Ranges and Indications for Atypical Antipsychotics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Age Range (Years)</th>
</tr>
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<tbody>
<tr>
<td>aripiprazole[3]</td>
<td>5 - 17</td>
</tr>
<tr>
<td>olanzapine[4]</td>
<td>6 - 17</td>
</tr>
<tr>
<td>paliperidone[5]</td>
<td>8 - 17</td>
</tr>
<tr>
<td>quetiapine[6]</td>
<td>9 - 17</td>
</tr>
<tr>
<td>risperidone[7]*</td>
<td>10 - 17</td>
</tr>
</tbody>
</table>

- **schizophrenia**
- **bipolar I disorder: manic or mixed**
- **irritability with autistic disorder**

*Risperidone should not be used by patients older than age 16 who have been diagnosed with irritability with autistic disorder.

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## Metabolic Tracking Sheet for Patients on Atypical Antipsychotics (Second Generation Antipsychotics)

### Attachment 1

<table>
<thead>
<tr>
<th>Metabolic Effects at Baseline?</th>
<th>Baseline</th>
<th>4 Weeks</th>
<th>8 Weeks</th>
<th>12 Weeks</th>
<th>6 Months</th>
<th>Annual</th>
<th>Quarterly</th>
<th>Quarterly</th>
<th>Quarterly</th>
<th>Annual</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Date</td>
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</tbody>
</table>

- **Height**
- **Weight** (Baseline & Every 6 months after initiating medication)
- **BMI** (Body Mass Index)
- **Waist Circumference** (Measure @ umbilicus)
- **Blood Pressure**
- **Lipid Panel**
  - Total Cholesterol
  - HDL
  - LDL
- **Triglycerides**

### 3 Criteria for identification of Metabolic Syndrome

- **Weight/BMI**
  - BMI > 30
- **Abdominal Circumference**
  - Men: > 40 in
  - Women: > 35 in
- **Blood Pressure (BP)**
  - ≥ 130/≥85 mmHg
- **Fasting Blood Glucose**
  - ≥ 100 mg/dl
- **High Density Lipoprotein (HDL)**
  - Men: < 40
  - Women: < 50
- **Triglycerides**
  - ≥ 150 mg/dl

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**Sentara Lab Client Services**

Sentara Lab Client Services-A lab services client portal for Sentara.com that provides information about services provided in the Hampton Roads and Charlottesville, VA. Areas. [http://www.sentaralab.com/](http://www.sentaralab.com/)
OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is NOT complete, correct, or legible, the authorization can be delayed**

Atypical Antipsychotics

<table>
<thead>
<tr>
<th>Drug Requested (select one below):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Fanapt® (iloperidone)</td>
</tr>
<tr>
<td>☐ Invega® (paliperidone)</td>
</tr>
<tr>
<td>☐ Saphris® (asenapine)</td>
</tr>
<tr>
<td>☐ Vraylar™ (cariprazine)</td>
</tr>
</tbody>
</table>

**DRUG INFORMATION:** Complete information below or authorization will be delayed.

Drug Name/Form/Strength: __________________________________________

Dosing Schedule: __________________________________ Length of Therapy: ____________

Diagnosis: ___________________________________ ICD Code, if applicable: ____________

• If diagnosis is any type of depressive disorder, please list current antidepressant therapy:

__________________________________________________________________________________

__________________________________________________________________________________

**CLINICAL CRITERIA:** Check below **ALL** that apply. **ALL** criteria must be met for approval. **ALL** documentation, including labs or chart notes (if required), must be submitted or request will be denied.

☐ Patient has tried and failed at least 30 days of therapy with two (2) of the following:

☐ risperidone
☐ quetiapine/ER
☐ ziprasidone
☐ olanzapine
☐ aripiprazole

**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.** **

*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: ________________________________________________________________

Member Optima #: ___________________________ Date of Birth: ________________

Prescriber Name: _____________________________________________________________

Prescriber Signature: ___________________________________ Date: _______________

Office Contact Name: __________________________________________________________

Phone Number: ___________________________ Fax Number: _______________________

DEA OR NPI #: ______________________________________________________________

*Approved by Pharmacy and Therapeutics Committee: 4/15/2010
References


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