Dementia Antipsychotic Prescribing Guide
Dosing, Special Populations

Dosing

Timing: Usually once daily at night or prior to sundowning. Beware of sedation-related adverse events if given earlier than bedtime.

	Starting Dose (mg/day)	Max Dose for Maintenance* (mg/day)	Special Dosage Forms**
Aripiprazole	2-5	10	ODT, L , IM
Haloperidol	0.25	2	L , IM
Olanzapine	2.5-5	7.5	ODT, L , IM
Quetiapine	12.5-25	150	XR
Risperidone	0.25-0.5	2	ODT, L

*per CMS regulations for long-term care facilities. Doses for acute treatment sometimes exceed maintenance doses.

**ODT = orally dissolving tablet, L = liquid, IM = short-acting intramuscular, XR = extended release.

Dosage forms:

- Regular tablets can be crushed and mixed with food if needed.
- IM antipsychotics used only in emergencies when oral is refused.
- Topical forms, e.g. compounded creams, not recommended. No evidence to guide proper dosing. Absorption is unknown and unpredictable.

Guidance for Special Populations

Frontotemporal dementia: Some evidence for trazodone. Mixed for SSRIs. See Iowa Geriatric Education Center website for details.

Parkinson's disease (PD) and Lewy body dementia (LBD):

-**Movement disorder treatments** (dopamine agonists, carbidopa-levodopa, anticholinergics) can cause **psychosis or delirium**. Prior to antipsychotic use, consider reducing the dose of these drugs to see if the psychosis or behaviors resolve or become manageable.

-People with PD and LBD are **very sensitive to adverse effects**, particularly **movement side effects and neuroleptic malignant syndrome**. If antipsychotics are used, expert guidelines recommend **quetiapine or clozapine** due to lower movement side effect risk.

Renal Impairment: Reduce risperidone dose. Titrate slowly.

Hepatic Impairment: Possibly reduce dose of olanzapine, quetiapine, risperidone. Caution with all.

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Monitoring for Response and Adverse Effects

Monitoring for Response

-Clearly document treatment target symptoms. If the drug does not help, discontinue the drug. These symptoms may also change over time, with or without drug treatment.

-Do not expect an immediate response. Sedation may explain much of any immediate effect that is seen. Response may take 2-4 weeks.

-Do not increase doses too quickly if the patient doesn't respond right away. At a stable dose, drug blood levels may rise for several days to a week or more before reaching a steady state level.

Increased doses lead to increased side effects.

Monitoring for Adverse Effects

Other possible adverse effects include: falls, constipation, urinary tract infection, urinary incontinence or retention, stroke, arrhythmias, and neuroleptic malignant syndrome.

Side Effect	Monitoring
Movement Side Effects	Observation for tremor, gait changes, difficulty swallowing, signs of parkinsonism, restlessness (akathisia), unusual movements (tardive dyskinesia).
	Abnormal Involuntary Movement Scale (AIMS) at baseline, every 6 months, or if movement side effects are suspected.
Central Nervous System	
Sedation	Observation, sedation scale if needed.
Confusion, delirium, or other cognitive worsening	Observation for mental status or behavior changes.
	Delirium screening tool, e.g. CAM (Confusion Assessment Method) if delirium is suspected.
Psychotic symptoms	Observation for worsening symptoms.
Cardiovascular / Metabolic	
Orthostatic hypotension	Observation for signs of dizziness or falls.
	Orthostatic blood pressure (if feasible). Monthly, or if signs of dizziness occur. More frequent on initiation or after dose increase.
Edema	Observation for swelling of extremities.
Weight gain	Monthly weight. Consider weekly for 1 month if overweight. Watch for increased appetite.
Hyperglycemia / Diabetes	Blood glucose at baseline, 3 & 6 months, then q6 months. Also PRN symptoms or mental status change. Monitor symptoms: increased thirst, urination, hunger, weakness.
Triglyceride ↑	Fasting blood lipid panel at baseline, 3 & 6 months, then q6 months. Especially if patient has cardiovascular risk factors: e.g. obesity, diabetes, hyperlipidemia.