TEAM DANIEL©

Rev. 2/2/2022

Team Daniel Clozapine Regimen Initiation Summary

		Clozapine	Initial PRN's	Colace (Constipation)	Metformin ER (Weight Control)	Lamotrigine ER (Seizure Prophylaxis)	Other Anti-psychotics	Substance Use	Smoking
MONTH 1	Week 1	12.5 mg PM	Zofran (nausea) 4 - 8 mg, up to 2X daily 1% Atropine drops sublingual (salivation) 1 - 3 drops at bedtime Up to 3 drops 3x daily Famotidine -H2 blocker (acid reflux) 20 mg 2X daily and/or omeprazole** once daily Beta Blocker i.e. propranolol (tachycardia) 10 mg up to 3X per day Use 10-20 mg PRN for anxiety Consider PRN clozapine 12.5 - 25 mg for daytime psychosis/anxiety Desmopressin (nocturnal enuresis/urinary urgency) 0.1 mg at bedtime to start Klonopin 0.5 mg 2X daily for catatonia that has not responded to therapeutic clozapine serum levels. **PPI's decrease clozapine level		Start within first month of treatment to prevent metabolic syndrome and weight gain.	Prophylactic seizure prevention for patients with seizure history, mood disorder, or clozapine serum level over 500 ng/mL. This is especially critical to establish if a patient may need fluvoxamine in the future.	Acute psychosis: temporarily consider Zyprexa, Abilify or risperidone; to be discontinued after a therapeutic clozapine level is reached.	No changes first 2-4 weeks; keep it level. Discuss dangers of marijuana/THC. Consider 50 mg naltrexone (PM) for SUD.	Smoking decreases serum levels on average 50%
	Week 2	25 mg PM							
	Week 3	50 mg PM (Start TDM)		100 mg PM					
	Week 4	75 mg PM		Customize bowel regimen per patient symptoms: - Colace up to 400 mg - Senna-S - Dulcolax - Miralax - Linzess if needed (no fiber supplements) Use Bristol Stool chart and communicate often - patients may not be forthcoming.	500 mg PM				Discuss transition to vape or ideally NRT which is preferred.
MONTH 2	Week 5	100 mg PM*			500 mg PM	25 mg AM		As clozapine becomes effective discuss life goals and how to transition from harmful substances. Consider drug counseling, DBT, possibly 12-step programs. DO NOT PUSH. Avoid short-acting benzodiazepines like Xanax. PRN Ativan or klonopin (low dose) for acute symptoms only during initial clozapine titration; discontinue after acute symptoms subside.	
	Week 6	125 mg PM*			500 AM/500 PM	25 mg AM	Slowly down-taper and discontinue sleeping pills, stimulants, ADHD medications, and all other antipsychotics: clozapine is most effective as a mono-therapy antipsychotic. Smokers will require higher doses of clozapine and a longer transition from previous medications.		
	Week 7	150 mg PM*			500 AM/500 PM	50 mg AM			
	Week 8	175 mg PM*			500 AM/1000 PM	50 mg AM			Consider Chantix or bupropion and other means of reducing dependence on nicotine. Continue to explain the value of non-smoked forms.
MONTH 3	Week 9	Increase 25 mg weekly or every two weeks per symptoms and Therapeutic Drug Monitoring (TDM). Therapeutic range begins when clozapine serum level reaches 350-500 ng/mL. Some patients need to go higher for adequate symptom control. Consider splitting dose for strong positive symptoms with 2:1 ratio bedtime to morning dose.			500 AM/1000 PM	Continue increasing lamotrigine 50 mg every two weeks up to 200 mg. If lamotrigine is not tolerated consult Dr. Laitman for the next best option: - Gabapentin - Keppra - Trileptal (check for Asian ancestry) - Topamax Depakote is NOT recommended due to increased risks / side effects. **Watch carefully for Stevens-Johnson rash.**			
	Week 10				1000 AM/1000 PM				
	Week 11				Consider Farxiga/Xigduo and Trulicity (or similar) in patients with continuing weight or metabolic concerns. Metformin depletes B12 - add 1000 mcg daily.				
	Week 12								
MONTH 4	Week 13								
	Week 14								
	Week 15								
	Week 16								

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*** Note: Slow clozapine titration reduces incidence of myocarditis, seizure, cardiomyopathy and pneumonia. Start TDM at 50 mg to confirm patient adherence.**

Cautions:

- **Consult Dr. Laitman for instructions on how to handle medications in previous regimen that are anticholinergic or antihistaminergic, or that may lower blood pressure, increase clozapine levels or increase seizure risk.**
- **For mild neutropenia (ANC < 1500 ug/mL or ANC < 500 ug/mL for a BEN patient) start 450mg of lithium ER (PM dose). Increase as needed to 1.2 mmol/L serum level until resolved.**
- **Indigenous/Asian/Native American descent are slow metabolizers and on average need 1/3 the dosage of European descent. Slower titration with frequent TDM is recommended.**
- **Baseline tests prior to initiating clozapine: EKG, metabolic panel, A1C, ANC, HSCRP lipid panel and where financially feasible EEG/Brain MRI.**