Cheatography

PMHNP Anti-Psych Meds Cheat Sheet

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Typical Anti-psychotic (FGA)

Haldol/Haliperidal
Thorazome/chloropromazine
Serentil/mesoridazine
Mellaril/Thoridazinel
Permitil/Fluphenazine
Trilafon/Perphenazine
Stelazine/Trifluperazine
Loxitane/loxapine
Moban/Molindone
Navane/Thiothixene

Typical/First Generation Drugs (FGA) are full D2 agonist causing a dopamine blockade which increases the cascade effect increasing the incident of EPS with low dopamine.

Neuro S/E
Lower Dopamine
Efficacious
Can be more affordable for PT

Effects of Dopamine

Low dopamine = parkinson symptoms
High dopamine = psychosis symptoms

Dopamine has impact on other neurotransmitters and hormones.

EPS

Acute Dystonia	Can occur in hours
Akathisia	Can occur in days
Parkinsonism	Can occur in weeks
Tardive Dyskinesia	Can occur in years

Typical time frame for presentation of EPS symptoms in a patient taking Anti-psych meds. There are other non-psych meds that can also increase the risk of EPS.

EPS is less likely to occur with SGA, than with FGA:
--> FGA full blockade without the additional 5HT receptors, as in the SGA.
--> Partial agonism by some of the SGA at the D2 receptor site.

DOPAMINE

D	Drugs
O	psyhchOsis
P	Prolactin
A	Attention
M	Motivation
I	Involuntary Movements
N	Nausea
E	Energy

Signs for too much Dopamine leading to psychosis.

Other Important S/E by Pharmaceutical

Clozaril/clozapine	blood concerns with agranulocytosis

Atypical Anti-psych (SGA) Partial D2 Action

Abilify/aripiprizole	D2 partial agonist + 5HT targets
Rexulti/brexpiprizole	D2 partial agonist + 5HT targets
Vraylar/cariprazine	D2 and D3 partial agonist + 5HT targets

Partial dopamine agonism will lower dopamine levels, but not as much as the full agonist of FGA and some SGA. SGA agonism (partial and full) will Increases the serotonin levels. There is an unknown relationship between dopamine and serotonin in symptom relief of psychosis. The agnoism effect on the 5HT receptors varies from pharmaceutical formulary and is not consistent within the classification of SGA.

Typically, lower EPS with Neuro S/E but increase risk of Metabolic S/E.

Atypical Anti-psych (SGA) Full D2 Agonism

Fanapt/Iliperidone	D2 agonist + 5HT
Saphris/Asenapine	D2 agonist + 5HT
Latuda/lurasidone	D2 agonist + 5HT
Seroquel/quetiapine	D2 agonist + 5HT
Zyprexa/olanzapine	D2 agonist + 5HT

Atypical Anti-psych (SGA) Full D2 Agonism (cont)

Risperidal/risperidone	D2 agonist + 5HT
Clozaril/clozapine	D2 agonist + 5HT

Full dopamine agonism at D2 lowers dopamine levels SGA agonism of 5HT (partial and full) will Increases the serotonin levels. There is an unknown relationship between dopamine and serotonin in symptom relief of psychosis. The agnoism effect on the 5HT receptors varies from pharmaceutical formulary and is not consistent within the classification of SGA.

Typically, lower EPS with Neuro S/E but increase risk of Metabolic S/E. Cost can be a barrier to care with limited access.

Long Acting Injectable (LAI)

Aristada/-Initio	aripiprizole lauroxil (pro drug)	4-8 weeks Glut Inj	Schizo; D2 partial agonist, 5HT
Risperidal Consta	risperidone	2-4 weeks Glut	
Invega/Sustenna Trinza	paliperidone (component of Risperidal)	1-3 months Glut	
Geodon	ziprasidone	2-4 weeks Glut	
Zyprexa	olanzapine	2-4 weeks	
Vivitrol	naltrexone	30 days Glut	Opioid and ETOH addiction; in combination of Therapy
Maintena	aripiprazole (abilify	30 days Delt or Glut	Schizo, BP1 in Adults

SGA Drug Ending Short Cuts r/t S/E

-Apine	increase in sedation and weight gain with decrease in EPS symptoms
-Idone	decrease in sedation and weight gain with increase in EPS symptoms
-Piprazole	decrease in weight gain with increase in EPS symptoms

Known S/E with drug ending by class for the SGA.