

### Typical Anti-psychotic (FGA)

Haldol/Haliperidal  
 Thorazome/chloropromazine  
 Serentil/mesoridazine  
 Mellaril/Thoridazine  
 Permitil/Fluphenazine  
 Trilafon/Perphenazine  
 Stelazine/Trifluoperazine  
 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	psychosis
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
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### 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 increase the serotonin levels. There is an unknown relationship between dopamine and serotonin in symptom relief of psychosis. The agonism 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 increase the serotonin levels. There is an unknown relationship between dopamine and serotonin in symptom relief of psychosis. The agonism 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/- aripiprazole 4-8 Schizo; D2 partial  
Initio lauroxil (pro weeks agonist, 5HT  
drug) Glut Inj

Risperidal risperidone 2-4 weeks Glut  
Consta

Invega/Su paliperidone 1-3 months Glut  
stenna (component of  
Trinza Risperidal)

Geodon ziprasidone 2-4 weeks Glut

Zyprexa olanzapine 2-4 weeks

Vivitrol naltrexone 30 days Opioid and ETOH  
Glut addiction; in combination  
of Therapy

Maintena aripiprazole 30 days Schizo, BP1 in Adults  
(abilify) Delt or  
Glut

### 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

- decrease in weight gain with increase in EPS symptoms  
Piprazole

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

