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ADMINISTRATIVE BULLETIN TRANSMITTAL MEMORANDUM

DATE ISSUED: April 23, 2009 **REVISED:** December 1, 2011

SUBJECT: **Administrative Bulletin 3:35**
Prescribing Psychotropic Medication in State Psychiatric Hospitals

The attached **revised** Administrative Bulletin is being forwarded for your review, action if necessary, and distribution to staff as appropriate. Please be advised that each recipient of this order is responsible for being familiar with the content and ensuring that all affected personnel adhere to it.

Lynn A. Kovich
Assistant Commissioner

LAK:pjt

DIVISION OF MENTAL HEALTH & ADDICTION SERVICES
ADMINISTRATIVE BULLETIN 3:35

Effective Date: May 1, 2009
Revised Date: December 1, 2011

SUBJECT: Prescribing Psychotropic Medication in State Psychiatric Hospitals

I. Purpose

This Bulletin describes requirements ensuring the safe and appropriate prescribing of psychotropic medications in the state psychiatric hospitals. While some patients may require high dose or complex medication regimens for effective treatment, use of multiple psychotropic medications increases the risk of adverse drug effects, drug-drug interactions and medication errors, and evidence suggests that such complex regimens are unlikely to improve outcomes, even in challenging patients.

Such medication regimens are also costly, time-consuming for nurses to administer in the hospital, difficult for patients to understand, and hard for them to adhere to or maintain in the community. Frequent dispensing of medication during the day also interferes with a patient's participation in psychiatric rehabilitation programming. Further, the ongoing ordering of psychotropic agents as PRNs is an indication that patients' standing medication orders are not optimal and may subject patients to potentially unsafe levels of medication.

Therefore, in order to ensure the quality of care, this bulletin has provisions requiring detailed documentation of the rationale and/or risk/benefit when more complex or potentially high risk medication regimens are being ordered. All changes on medication, along with the rationale and target symptoms/behaviors, must be documented in a standardized weekly/monthly Psychiatric Progress Note. Certain higher risk practices shall also require a prior authorization from a managing psychiatrist before the drug regimen can be prescribed to the patient. State psychiatric hospital Managing Physicians, with the assistance of consultant pharmacists and the contracted pharmacy vendor, shall ensure that these procedures are followed.

II. Authority

N.J.S.A. 30:4-24.2
Administrative Order 2:13, Guidelines for Psychotropic Medications
Administrative Bulletin 3:36, Prevention and Management of Metabolic Syndrome State Psychiatric Hospital Patients
Administrative Bulletin 5:04, Administration of Psychotropic Medication to Adult Voluntary and Involuntary Patients

III. **Definitions**

Polypharmacy can be either 1.) Intra-class polypharmacy - the simultaneous use of more than one medication from a single class of psychotropic medications, or 2.) Inter-class polypharmacy - the use of multiple agents from different medication classes but for similar purposes

Psychotropic medications are drugs that have a direct effect on the central nervous system and which can modify emotion, cognition and behavior. These include antipsychotics, antidepressants, mood stabilizers, anxiolytics, sedative-hypnotics, and stimulants. This does not include any medications used to address side effects of psychotropics (e.g., benztropine for extrapyramidal symptoms).

IV. **Procedures**

A. The rationale for a patient's diagnosis must be based on ICD and DSM-IV criteria and shall initially be documented in the Psychiatric Assessment; any subsequent changes in diagnosis shall be documented in the standardized weekly/monthly Psychiatric Progress Note (attachment A contains instructions for this documentation), as well as in the demographics section of the physician orders.

B. Prescribing practices in the state psychiatric hospitals shall be consistent with established practice guidelines and other accepted practice standards (e.g., *DMHS Pharmacological Practice Guidelines for the Treatment of Schizophrenia*, American Psychiatric Association clinical practice guidelines) and any protocols that are promulgated by DMHAS.

C. This shall require use of generic agents, when available, and avoid the longer-term use of concentrates and other more costly dosage forms without a clear clinical indication. Dosage regimens shall be simplified and medications ordered to be dispensed once or twice daily in order to reduce nursing time and drug costs, and to allow patients to remain off the ward to participate in treatment malls and programming.

D. Every patient shall be monitored closely for medication side effects, including metabolic syndrome. In accordance with A.B. 3:36, physicians shall monitor metabolic indices, complete the Metabolic Tracking form, switch antipsychotics to those with lower relative metabolic risk when necessary, and document all interventions to screen for and manage the adverse effects of medication.

E. Every patient or legal guardian shall be offered the opportunity for informed consent for medications being provided, and they must receive medication fact sheets and be informed about any individual risks particularly relevant their treatment by having these enumerated on the DMHAS Psychotropic Informed Consent form (Attachment B). When patients' informed consent is not available or provided, this must strictly adhere to procedures in A.B. 5:04.

F. The informed consent process shall utilize the DMHAS Psychotropic Medication Manual that has fact sheets available in English and Spanish (http://www.nj.gov/humanservices/dmhs/news/publications/med_manual_nov2008.pdf..

G. Every patient's record shall contain adequate clinical documentation for all prescribed medications, including the indications and target symptoms/behaviors, the rationale prescribing higher than maximum doses (see Attachment C), of polypharmacy, higher risk uses (e.g., antipsychotics in patients with psychotic dementia), and any other non-routine prescribing practices, as is required by this Bulletin. Note that once the rationale is documented in a weekly/monthly Psychiatric Progress Note written after the order, this does not have to be repeated in subsequent notes, as the weekly/monthly Psychiatric Progress Note shall remain in the patient record and not be purged.

H. In order to address inter-class polypharmacy, the total number of psychotropic medications that shall be written for each patient as standing orders shall not exceed five (5) medications, unless a Psychotropic Polypharmacy Prior Authorization form (see Attachment D) approved by the hospital's Managing Physician/Psychiatry accompanies the order for the additional medication. Vendor pharmacies shall not dispense the medication without such prior authorization.

I. In order to address intra-class polypharmacy, standing orders for psychotropic medications shall require the initial use of a single agent from each class of medications (e.g., monotherapy) in a dose that is within the usual therapeutic range. If regimens do not meet this definition, the rationale for this shall be documented in the weekly/monthly Psychiatric Progress Note and/or Prior Authorization in accordance with the following:.

1. Patients shall be treated with one antipsychotic agent, unless they demonstrate an inadequate response to three or more documented trials of monotherapy, which shall include an attempted trial of clozapine.

    a. Orders for use of higher than maximum dose of an antipsychotic, or for other off-label use (e.g., for non-indicated conditions, such for treatment of personality disorders), or other higher risk practices (e.g., use of atypicals in the elderly with psychotic symptoms and dementia) shall require documentation of a risk-benefit analysis in the weekly/monthly Psychiatric Progress Note.

    b. Concurrent prescribing of two atypical antipsychotic medications is discouraged and shall only occur with the specific documentation of the rationale and a risk-benefit analysis for such use in the weekly/monthly Psychiatric Progress Note.

    c. **Orders for three antipsychotics shall not be allowed, except during a period of cross titration;** the standing order for a third antipsychotic shall only be allowed once, and the order shall be written only for a maximum of up to 25 days (to allow for cross-titration).Orders must include a hard stop

date,. Orders for a third antipsychotic past 25 days will only be allowed when the pharmacy receives an approved Psychotropic Prior Authorization form from the Managing Physician/Psychiatry accompanies the order.

2. Monotherapy trials are required for all other psychotropic medications. When two or more agents in the same class are ordered, the rationale must be accompanied by a documented in the weekly/monthly Psychiatric Progress Note. In addition, the following shall be in effect:

   a. Mood Stabilizers can consist of lithium and various anticonvulsants, but off-label use of anticonvulsants must be accompanied by a rationale and the identification of specific target symptoms/behaviors

   b. Antidepressants: Every drug must have specific target symptoms/behaviors listed. Note that the concomitant use of Trazodone as a hypnotic medication will not count as an additional antidepressant.

   c. Benzodiazepines: Use in patients with a history of substance use, or any long-term benzodiazepine use (more than 60 days of continuous treatment) of these agents, shall be avoided, unless a rationale is documented in the weekly/monthly Psychiatric Progress Note.

J. Long-Acting/Depot Antipsychotics

1. In accordance with DHS Administrative Order 2:13, patients shall not be required to take a long-acting (depot) agent if they consent to take one available orally. Other use of depot antipsychotics must demonstrate positive benefits to risks and be approved by the Managing Physician/Psychiatry or designee, who shall document his/her case review using the Supplemental Page of the weekly/monthly Psychiatric Progress Notes.

2. In general, long-acting/depot medications should primarily be used with patients who have a demonstrated history of non-adherence with oral medication and who have a history of stabilization on the oral antipsychotic and are receiving monotherapy. Although use of long-acting agents may be beneficial in other situations, the rationale must be clearly documented and benefits demonstrated for continued use.

3. Patients to not obtain the benefits of the long-acting antipsychotics when these are prescribed concurrently with oral antipsychotic agents. Because of the increased costs of Risperdal Consta, Invega Sustenna and Zyprexa Relprevv their use, in particular, should be limited to patients who respond to the equivalent oral agents and who do not require therapy on an ongoing basis with oral antipsychotic medication. Whenever an oral or intramuscular (IM) medication is being prescribed in addition to a long-acting agent, the rationale must be entered in the weekly/monthly Psychiatric Progress Note.

4. The oral and long-acting formulations of the same agent will be counted as two drugs in regard to the total number of antipsychotics being prescribed. If a patient is receiving three antipsychotics (e.g., the combination of quetiapine oral, risperidone oral and Risperdal Consta), the use of oral antipsychotic agents with a long-acting agent will be allowed for a period of up to sixty (60) days, at which time an approved Prior Authorization form must accompany any additional orders for this drug combination.

K. PRN Orders for Psychotropic Medication

1. PRN orders for psychotropic medication shall not exceed seven (7) days. Whenever psychotropic PRNs are re-written, the prescriber shall document in a weekly/monthly Psychiatric Progress Note both the number of PRNs given to the patient during the prior order period and the reason(s) for their continued use. As an example, for a patient on Haldol 5 mg PO q6h PRN agitation, the weekly Psychiatric Progress Note could state the following: "The had received six does of the medication in the last week with good response during periods of agitation."

2. No patient shall have PRN orders for more than two (2) psychotropic medications. The vendor pharmacist will not allow such orders to be processed. Note that medications used as back up to oral medications for patients on Three–Step/Refusing status patients are not counted as PRNs for this purpose.

3. **Orders for IM psychotropic agents as PRNs are prohibited.** If a patient otherwise requires an IM psychotropic medication, these shall be ordered as emergency (e.g., STAT) medications only.

4. When IM medications are used as back up to oral psychotropics when the latter are "refused" by patients on Refusing Status or on Emergency Certification, these shall not be considered PRN orders and so are allowed. Such patients must be receiving the IM agent in accordance with the requirements of A.B. 5:04, the patient's Three Step/Refusing or Emergency Certification Status must be stated on the 'Comments' section of the order sheet, and this back up use must be clearly indicated in the order so that the pharmacy is aware of this. An example of the order is as follows: "Give haloperidol 2 mg IM if oral risperidone is refused."

5. Nurses shall document in the progress notes each time a PRN is given to a patient, and the note shall state the reason for its use and the patient's response to it.

6. When a patient's total medication dose (standing plus PRN orders) for a psychotropic medication exceeds the maximum daily dose of the agent, then

further justification must be documented in the weekly/monthly Psychiatric Progress Note.

L. Weekly/Monthly Psychiatric Progress Note and Other Documentation

1. All psychotropic medications shall have documented target symptoms/behaviors entered into the weekly/monthly Psychiatric Progress Note. In addition, the prescriber must indicate the patient's psychiatric diagnosis for which the medication has been ordered. The target symptoms/behaviors shall be considered the focus of the treatment with the medication and subsequent notes shall document the status of the target symptoms/behaviors in response to the medication. See attachment B for Instructions on completing the weekly/monthly Psychiatric Progress Note.

2. When an order for psychotropic medication requires the documentation of a rationale (e.g., use of two or more medications in any class, prescribing dosages higher than the maximum daily dose, ongoing use of a liquid agent, etc.), the prescriber must enter a narrative note in the 'Problem-based Plan' section of the weekly/monthly Psychiatric Progress Note. This rationale shall, for example, describe the results of previous monotherapy medication trials and other information supporting use of polypharmacy. The rationale does not need to be repeated in subsequent notes, unless the patient's condition or the rationale for the medication use has changed.

3. The ongoing use of psychotropic PRNs requires the additional documentation in the weekly/monthly Psychiatric Progress Note indicating the number of PRNs actually given to the patient in the prior period and the rationale for the continued use of the PRN.

4. Certain exceptions to AB 3:35 require that the pharmacy receive the Psychotropic Polypharmacy Prior Authorization form indicating approval was given by the Managing Physician/Psychiatry before the order is accepted. These exceptions are as follows:
   a. standing orders for a third antipsychotic used for more than 25 days
   b. standing orders for more than five psychotropics

5. In order to process the above orders, the prescriber shall complete Part 1 of the Psychotropic Prior Authorization form, which shall then require that Part II be signed and sent back to the prescriber before the prescriber is allowed to write the order. <u>If no Psychotropic Polypharmacy Prior Authorization form has been received in the pharmacy and a third antipsychotic has been ordered, the pharmacy will enable a hard stop of the order at 25 days</u>.

6. The Managing Physician/Psychiatry must make every effort to review the patient's entire medical record and to see the patient in person, if needed, before

approving the request. The approved Psychotropic Polypharmacy Prior Authorization form shall go to the pharmacy, with copies to the Managing Physician/Psychiatry and patient record, where these forms shall be placed in the chart in the section with the weekly/monthly Psychiatric Progress Notes.

7. The completion of an approved Prior Authorization Form shall allow the initial use of the medication for a 90 day period only, after which another Managing Physician/Psychiatry review and prior authorization approval must be obtained in order to continue to allow the ordering of the medication to occur for an indefinite period. The hospital's pharmacy vendor shall ensure that all physician orders submitted with the required Psychotropic Polypharmacy Prior Authorization forms shall be noted in the Comments Section of the order sheet, which will serve to remind the prescribers about their orders needing such approval.

8. If the pharmacy vendor does not receive the required Psychotropic Polypharmacy Prior Authorization form and is unable to contact the prescriber or the Managing Physicians/Psychiatry, he/she shall contact the covering physician/MOD. The latter shall see the patient and determine if an emergency/STAT order or other intervention is needed until the Managing Physician/Psychiatrist is available to determine whether prior authorization can be given and the order filled.

M. Responsibilities

1. Hospital Managing Physicians/Psychiatry shall be responsible for overseeing compliance with these procedures at their facilities. They shall establish procedures for review of polypharmacy and other practices, utilizing clinical supervision and a peer review process, as well as by distribution of summary reports to psychiatrists that compare their prescribing practices with others on the staff. Case reviews of patients' medication regimens by managing psychiatrists and others shall be documented on the Supplemental Page of the weekly/monthly Psychiatric Progress Note.

2. Managing Physicians shall ensure compliance with requirements of this bulletin shall be addressed during privileging and performance evaluations (e.g., PES/PAR).

3. The hospital's pharmacy vendor shall ensure that all physician orders submitted without the required Prior Authorization form shall not be filled until this has been provided or other authorization for the order is provided. The vendor shall also assist the hospitals by providing data on polypharmacy and other practices.

4. Consultant pharmacists shall conduct monthly chart reviews during which they will review physicians' compliance with these requirements for documentation in the weekly/monthly Psychiatric Note and for prior authorization, as well as for completion of the Metabolic Tracking Form per AB 3:36. They shall provide Managing Physicians with the results of chart reviews and publish aggregated findings in monthly reports.

5. The DMHAS Medical Director will routinely monitor reports on medication use patterns and set benchmarks for such use, and data review will be a standing agenda item in monthly meetings of Managing Physicians.

N. After the effective date of this Bulletin, the contract pharmacy vendor shall ensure that newly ordered medications failing to adhere to these requirements will not be dispensed to patients. For patients who were admitted and treated prior to the effective date, medication orders and appropriate documentation of exceptions must still be made in the weekly/monthly Psychiatric Note.

Lynn A. Kovich. Assistant Commissioner
Division of Mental Health and Addiction Services

Date: December 1, 2011

LAK:pjt
Attachment

Attachment A

Instructions for Documentation of Psychotropic Medication on the Weekly/Monthly Psychiatric Note

Introduction

The Weekly /Monthly Psychiatric Note is essentially a standardized progress note that includes all generally required elements of these notes. Unlike other progress notes, the Weekly/Monthly Psychiatric Notes will not be purged from the patient's chart, thus providing a record of all medication changes during the patients' hospitalization. The purpose of these instructions is not to describe all aspects of the Weekly/Monthly Psychiatric Note, but rather to suggest how to complete the second page of the Note, since this is where psychotropic medications, their rational, their target symptoms/behaviors, and most other medication-related interventions or events are to be documented, in accordance with A.B. 3:35.

DMHAS managing physicians and staff psychiatrists from the state psychiatric hospitals, assisted in the development of the Note, one purpose of which is to improve medication-related documentation. The Note will provide a complete history of patients' psychotropic medications; this will aid physicians and pharmacists in their work, and also allow retrospective chart reviews of psychotropic medication. The Weekly/Monthly Psychiatric Note is not an additional documentation requirement; as such a note is required documentation. Furthermore, while prescribers will have to list medications and any changes in medication regimen, they do not have to write justifications for polypharmacy, high dose therapy, use of other than oral tablet formulations (e.g., liquid concentrates, long-acting injectable antipsychotics), and other exceptions every month, although this had been required previously.

Documentation entered into the Weekly/Monthly Psychiatric Notes shall summarize changes to the medication regimen that were made within the week or month period in which psychotropic medications are ordered or medication-related events have occurred. The first note is written after admission orders are first written upon a patient's admission and then every time there is a new medication, discontinuation of a medication or a significant change in a medication dose or formulation during a patient's hospitalization. No repeat of prior documentation is required when standing medications are routinely re-ordered, or when a medication dose is changed, unless the dose change increases the dose above the maximum recommended dose (examples of this will follow).

The documentation of orders for psychotropic PRNs are to be handled differently than standing orders for medication. Psychotropic PRNs must be re-ordered every 7 days, and a regular progress note must be written with each new order. In these notes in the regular progress note section of the chart, prescribers shall write the frequency, proportion, or number of PRN doses actually given to patients during that time period. Meanwhile, the Weekly/Monthly Psychiatric Note documentation is a summary note for the PRN use and so only needs to describe the rationale and/or the continued need for the PRN orders.

Specific Instructions for Completing Second Page of the form:

Status: Check the appropriate box as to whether the ordered drug is a new, changed, continued, or discontinued order.

Medication (Dosage and daily administration schedule/duration)
Write the generic or trade name of each psychotropic drug, including PRNs (no abbreviations) along with the dosage, formulation (e.g., liquid, IM) and how often taken or duration prescribed. if shorter than 30 days.

Target Symptoms/Behaviors and Diagnosis (If PRN, indicate frequency of use)
The initial note for a new medication shall list the diagnosis and at least two target symptoms or behaviors that are the focus of the medication treatment. Every New or Changed psychotropic medication order shall require listing of Target Symptoms/Behaviors, and some new or changed orders will also require that a rationale also be documented. In addition, if a PRN psychotropic has been ordered, the number of times the PRN medication was given to the patient in the intervening week or month period should be recorded here.

Target Symptoms/Behaviors shall be those are the most prominent and/or disabling for the patient, or that are the focus of treatment. For example, patients treated with an antipsychotic may be treated for a variety of positive and negative symptoms/behaviors, including delusions, paranoid ideation, hallucinations, disorganized thinking, poverty of speech and apathy. For other psychotropics, such as antidepressants, mood stabilizers and anxiolytics, list the co-morbid symptoms for which these are prescribed (i.e. depression, mood liability, anxiety, insomnia).

Other examples of how to document diagnosis and target symptoms are as follows:

- Ziprasidone is being prescribed for treatment of Schizophrenia, Paranoid Type. Target symptoms include: accusatory auditory hallucinations, delusions of having an electronic device in the brain, and tangential thought processes.
- Citalopram is being prescribed for treatment of Major Depressive Disorder. Target symptoms include: marked depressed mood, frequent suicidal ideation, and marked loss of energy.
- Paroxetine is being prescribed for treatment of post-traumatic stress disorder (PTSD). Target symptoms include: nightmares of the traumatic event and irritable/angry mood.
- Sertraline is being prescribed for treatment of obsessive-compulsive disorder (OCD). Target symptoms include: frequent obsessions of contamination with germs and compulsive hand washing.
- Valproic Acid is being prescribed for treatment of Bipolar Disorder, Manic Episode. Target symptoms include: little need for sleep, verbosity, and markedly pressured speech.
- Lorazepam is being prescribed for treatment of Generalized Anxiety Disorder. Target symptoms include: persistent tremor, unable to fall or stay asleep, and irritable/anxious mood.

EXAMPLE #1 - Patient is a just admitted 45 y.o. single, male with diagnosis of paranoid schizophrenia. Upon admission on 12/1/2010, he was very agitated and displaying hallucinations and paranoid delusions with episodes of agitation. Below are his initial Psychiatric Note and subsequent notes illustrating several medication changes during his hospitalization.

Psychotropic Medication/dosage (Including PRN's ordered since last update)	Target symptoms If PRN, indicate frequency of use
✠ new ☐ change ☐ cont. ☐ D/C quetiapine 300 mg at 8am and 8pm	For Dx. Schizoaffective Disorder. Target symptoms; accusatory auditory hallucinations and delusions of having an electronic device in the brain
✠new ☐ change ☐ cont. ☐ D/C Lithium 300 mg po t.i.d. Haloperidol concentrate	Agressive behavior and agitation
✠new ☐ change ☐ cont. ☐ D/C Fluoxetine 20 mg daily	Depression and irritable mood
☐ new ☐ change ☐ cont. ☐ D/C Haloperidol concentrate 5 mg po q4h PRN agitation.	Admission order- PRN drug not yet given.

Problem Based Plan/Psychotropic Regimen Rationale: Provide clinical summary of events and interventions, updates to the Master Treatment Plan, and the rationale for use of medications, including, details of failed monotherapy trials and risk/benefit of antipsychotics for dementia.

Patient admitted to unit after three week STCF admission in which he was treated with the above medications. He remains paranoid and suspicious of others, but is generally cooperative with staff and following the unit routine. He has been pacing in the hallway, but overall he appears to be less agitated and aggressive currently when compared to the description of his behavior when he was at the STCF. PRNs have only been needed once this week when he became angry because he could not leave the unit with other patients. Will continue current medications but will increase quetiapine slowly to address paranoid thinking and restlessness. He has not displayed any side effects, other than mild sedation and is willing to take the increased dose of quetiapine.

Example 2: Patient who has not responded to antipsychotic monotherapy and so will have a second antipsychotic added.

2/11/11 Psychiatric Note

Psychotropic Medication/dosage (Including PRN's ordered since last update)	Target symptoms If PRN, indicate frequency of use
☐ new☐ change ☐cont. ☐ D/C risperidone 3 mg po B.I.D	For derogatory auditory hallucinations and paranoid delusions
❑ new ❑ change ❑ cont.❑ D/C olanzapine 20 mg po od	For derogatory auditory hallucinations and paranoid delusions
☐ new ☐ change☐ cont.☐ D/C	

Patient has had trial of risperidone at maximum dose for over 2 months and this has been ineffective, as delusional thinking and periods of agitation continue. His delusions involve others wishing that he was dead, and the voices tell him that he is not a good person. Review of patient's past records suggest that antipsychotics have only been partially effective in eliminating these symptoms, and that he mainly has had monotherapy trials, although he also was on two antipsychotics at times, with no documented good response to any medication regimen. Not known if he has had a trial of clozapine from a review of records or talking to the patient and his family. However, he is refusing to consent to taking clozapine because he does not like to get blood tests. As patient's medication history suggests that he had partial response to olanzapine in the past, will add this to the risperidone and see if a better response occurs. Patient is healthy and not obese, so increased risks of metabolic effects are not a major risk, although this will need to be monitored closely.

4/1/11 Psychiatric Note

Psychotropic Medication/dosage (Including PRN's ordered since last update)	Target symptoms If PRN, indicate frequency of use
❑ new ❑ change ☒cont.❑ D/C risperidone 3 mg po B.I.D.	For derogatory auditory hallucinations and paranoid delusions
☒ new❑ change ❑ cont. ❑ D/C olanzapine 20 mg po once daily	For derogatory auditory hallucinations and paranoid delusions
☐ new ☐ change ☐ cont.☐ D/C lorazepam 2 mg po q6h PRN	PRN for agitation

Patient on 20 mg olanzapine for one month but continues to exhibit delusional thinking and frequent periods of agitation (2-3 episodes daily). Since olanzapine has been added, the patient's weight has not changed and metabolic indices (blood sugar and lipids) continue to be normal. Will increase olanzapine to 30 mg daily (maximum dose) to see if patient shows better response.

Patient has had periods of agitation, for which lorazepam was recently ordered. Patient was given doses of the PRN almost daily last week, so have re-ordered this. He will need to remain on PRN lorazepam for agitation awhile, at least until the effectiveness of the added olanzapine can be assessed.

5/1/11 Psychiatric Note

Psychotropic Medication/dosage (Including PRN's ordered since last update)	Target symptoms If PRN, indicate frequency of use
❑ new ❑ change ☒cont.❑ D/C risperidone 3 mg po B.I.D	For derogatory auditory hallucinations and paranoid delusions
☐ new ☐ change☐ cont.☐ D/C olanzapine 30 mg od	For derogatory auditory hallucinations and paranoid delusions
☒ new ❑ change ❑ cont.☒ D/C lorazepam 2 mg po q 6h PRN	PRN agitation

Patient is less agitated and not voicing any paranoid fears as he did previously. Upon assessment, however, he appears to still be having derogatory voices telling him that he is a bad person. Also, while he is still guarded, he is much less fearful and appears to be interacting more readily with peers on the unit. He is apparently responding to the increased doe of olanzapine, but this will be monitored. The Metabolic Tracking form does not show any changes in his weight, but his blood glucose is borderline high and needs to be repeated. He received only occasional doses of the PRN lorazepam and so will be discontinued next week if it appears to be no longer needed.

Example 3: One of patient's antipsychotics is being switched, so he is receiving cross titration of two antipsychotics and has an interval period in which three antipsychotics were prescribed.

6/1/11 Psychiatric Note

Psychotropic Medication/dosage (Including PRN's ordered since last update)	Target symptoms If PRN, indicate frequency of use
❑ new ❑ change ☒cont.❑ D/C quetiapine 400 mg po B.I.D	For derogatory auditory hallucinations and paranoid delusions
❑ new ❑ change ☒ cont❑ D/C haloperidol 10 mg po B.I.D. mg od	For derogatory auditory hallucinations and paranoid delusions
☒ new ❑ change❑ cont☒ D/C aripiprazole 10 mg po od	For derogatory auditory hallucinations and paranoid delusions

Patient has been receiving quetiapine 800 mg along with haloperidol 20 mg for paranoid delusions and derogatory auditory hallucinations. Although he has responded clinically and is doing well o the medications, he has been gaining considerable weight (15 lbs. in last two months) and he complains of sedation. Will do a cross titration in which quetiapine will be reduced and aripiprazole started and titrated up ij the next two weeks. Plan is to discontinue quetiapine in two weeks.

NOTE : As A.B. 3:35 prohibits use of IM psychotropic medication as PRNs, these can only be ordered as STAT medications (there is no prohibition on use of IM doses for patients on the Three-Step who refuse oral medications). If STAT doses of IM lorazepam, haloperidol, or olanzapine are ordered in emergent situations, the documentation of the use of the medication should be entered as a regular progress note.

Attachment B

DMHAS PSYCHOTROPIC MEDICATION

INFORMED CONSENT FORM

Addressograph – **if unavailable please print** patients name, mr/unit#, DOA and DOB

Patient Name:_____ **Hospital:**_____

GENERAL INFORMATION

If psychotropic medication (a medicine that changes your behavior or the way you think) is considered a necessary part of your treatment program, you will be given information about how the doctor, nurse, or team believes the medication will help you, and specific information about expected changes, both good and bad, that might happen to you if you take the medication. You will also receive this information in writing in the form of a Medication Fact Sheet that describes the purpose, benefits, side effects, and risks of each medication being prescribed to you. You will then have the opportunity to sign the back of this form, indicating that you agree to take the medication.

If you are a voluntary patient, the staff may not give you ANY psychotropic medication without your consent unless there is an emergency (you are going to hurt yourself or someone else very soon) and no less drastic measures will stop the emergency. You can only be medicated in an emergency for 72 hours.

If you are committed to the hospital, you still have the right not to sign the consent, and to refuse psychotropic medication, but the hospital staff can give you medication in an emergency, and can go through a process known as the three-step process to give you the medication even though you don't consent. The three-step process requires the involvement of the person who prescribes the medication, members of your treatment team, the hospital's Rennie Advocate, and the hospital's medical director.

A **Rennie Advocate** is available to assist you if you have questions about your medication or if you want to refuse to take psychotropic medications. The Rennie Advocate at this hospital is _____ and s/he can be reached toll free at _____.

THE MEDICATIONS PRESCRIBED FOR YOU ARE:

Medication Name (Brand/Generic)	How medication(s) will be taken	Dosage Range
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional information about the above medication(s) in your treatment:

☐The dose is higher than usual dose and this is why this is necessary._____
_____

☐These are specific side effects/medical risks for you (e.g., metabolic effects, TD)_____
_____

DMHAS **Print double sided/white** **FRONT**

DMHAS Psychotropic Medication

Informed Consent Form

Addressograph–**if unavailable please print**

patients name, mr/unit#, DOB and DOA

PATIENT'S CONSENT:
Based on my understanding of the benefits and risks of these medications and the choices that are available to me, I consent to taking the medication(s) listed on the front of this document.

_____ _____
Patient's signature Date Time

_____ _____
Guardian or Mental Health Care Representative's signature Date Time

Staff witness: I affirm that the patient or an authorized representative of the patient agreed in my presence to take the medication described on the front of this document.

_____ _____
Staff/Witness signature Date Time

_____ _____
Staff/Witness signature Date Time

PHYSICIAN'S CERTIFICATION ***Please initial each section and sign below:***

___I have explained to this patient: the nature of his/her condition; the purpose, nature, dosage range and method of administration of the medication; the anticipated benefits, risks and side effects of the medication; the patients prognosis with and without medication; and whether or not there are any feasible alternative treatments. If the patient has offered to take different medications or consent to other less restrictive treatments, I have considered the patient's wishes and explained why the medication(s) that I have prescribed is a better choice.

___I have given the patient copies of the appropriate Medication Fact Sheets, explained their contents in language and a manner that I think s/he can understand, and offered to answer any questions.

___I have advised the patient that if s/he refuses medication, s/he will not be given medication until s/he is reviewed by the treatment team and the Medical Director, except in an emergency.

___I have advised the patient that s/he may contact the Rennie Advocate at any time during regular working hours if s/he has any questions about the medications.

___I have explained to the patient that even if s/he consents to medication, s/he may revoke consent at any time.

Based on my assessment of this patient, I have concluded that the patient is capable of providing consent to medication and is willing to do so.

Physician's Name (print and sign): _____ Date: _____ Time: _____

Interpreter's Name (print and sign): _____ Date: _____ Time: _____

DMHAS **Print double sided/white** **BACK**

MAXIMUM DOSAGES TABLE

MEDICATION	MAXIMUM DAILY DOSAGE **(unless noted otherwise)**
Chlorpromazine	1000 mg
Fluphenazine	40 mg
Fluphenazine Decanoate IM	100 mg **q4 weeks**
Haloperidol	100 mg
Haloperidol Decanoate IM	450 mg **q4 weeks**
Loxapine	250 mg
Molindone	225 mg
Perphenazine	64 mg
Pimozide	10 mg
Thioridazine	800 mg (absolute)
Thiothixene	60 mg
Trifluoperazine	40 mg
Aripiprazole	30 mg
Asenapine	20 mg
Clozapine	900 mg
Olanzapine	30 mg
Paliperidone (Invega Sustenna) IM	234 mg / **month**
Paliperidone	12 mg
Quetiapine	800 mg
Risperidone*	16 mg*
Risperidone Consta IM	50 mg **q2 weeks**
Ziprasidone	160 mg

*Risperidone doses above 6 mg are associated with increased risk of Extrapyrmidal symptoms.

N.J. DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

POLYPHARMACY/PRIOR AUTHORIZATION FORM

INSTRUCTIONS: PART I of this form must be completed by the Treatment Psychiatrist whenever a 3rd Antipsychotic or a 6th Psychotropic is ordered.

PART II must be completed by a Managing Psychiatrist (Chief of Psychiatry or Medical Director). After approval is given by a Managing Psychiatrist, the completed form must accompany the order before it can be filled. **PLEASE PRINT**

PART I – COMPLETED BY TREATING PSYCHIATRIST

Patient Name:_____ Hospital #:_____

Patient's Diagnosis:_____

Current Psychotropic Medications (Name, Dose, and Frequency):_____

_____

_____

New Drug(s) Requested:_____

Purpose of Request (Check one only):

☐ Initial order for 3rd Antipsychotic Trial (allows orders for 90 days) ☐Approval of 3rd Antipsychotic for Maintenance TX

☐Initial order for 6th Psychotropic Trial (allows orders for 90 days) ☐ Approval of 6th Psychotropic for maintenance TX

Explain Rationale for Request:_____

_____

_____

_____

_____

Describe Target Symptoms:_____

Clozapine Trial – Was Clozapine use ever recommended or attempted?: ☐ Yes ☐ No

If Not, Why?:_____

Describe the outcome of Clozapine trial (Include time and duration of trail):_____

_____

_____

Describe findings of most recent AIMS) and assessment of other medication side effects: _____

_____

_____

Consent: Has the patient signed an informed consent for psychotropic medication? ☐ Yes ☐ No

☐ Patient is on refusing Status ☐ patient is on Functionally Incompetent Status

Treating Psychiatrist Print Name:_____ Signature:_____ Date/Time:_____/_____

This form is to be faxed to the Chief of Psychiatry or Medical Director

PART II – MANAGING PSYCHIATRIST'S EVALUATION (Check all that applies)

☐ Chart Reviewed ☐ Patient Interviewed :

Decision: 3rd Antipsychotic Approved (Check One): ☐ Yes ☐ No 6th Psychotropic Approved: ☐ Yes ☐ No

Approval is for (Check One) ☐ Initial 90 day Trial ☐ Maintenance Therapy

Rationale for Approval:_____

_____

Managing Psychiatrist (Print name and sign):_____ Date/Time: _____/_____