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Dementia Medication Prescribing Guidance

Kent and Medway Position (*in line with NICE NG97*):

- Acetylcholinesterase (AChE) inhibitors are 1st-line treatment option for mild to moderate Alzheimer's disease. (*i.e. Donepezil (1st line), galantamine, or rivastigmine*). They are also a treatment option for dementia with Lewy bodies, vascular dementia, and Parkinson's dementia.
- Before initiating patients on cognitive enhancing medication, a full assessment in line with NICE guidance should be undertaken by the Specialist.
- A patient should be established on a stable dose of medication and a minimum of one-month supply should be given to patients by the Specialist Prescriber before transferring responsibility to primary care.
- For people with an established diagnosis of Alzheimer's disease who are already taking an AChEI, if additional therapy is required, GPs may start treatment with memantine if confident to do so on the advice of a specialist/clinician (Nurse, Consultant, Community Geriatrician, KMPT specialists, GPs with a specialist knowledge) who has the necessary knowledge and skills and does not require ongoing specialist monitoring.
- Memantine is licensed for the treatment of patients with moderate to severe Alzheimer's disease and is also a treatment option for dementia with Lewy bodies, vascular dementia, and Parkinson's dementia.
- **Memantine MONOTHERAPY** should be initiated or recommended by a specialist and:
  - should be offered to patients with severe Alzheimer's disease
  - may be used in moderate disease where an AChE inhibitor is not tolerated or contraindicated
  - may be used in dementia with Lewy bodies if AChE inhibitors are not tolerated or contraindicated (**unlicensed indication, off-label use*)
  - may be used in Vascular dementia ONLY if co-morbid Alzheimer's disease, or dementia with Lewy Bodies is suspected (**unlicensed indication, off-label use*).
- **COMBINATION THERAPY** – Primary care prescribers may start treatment with memantine without taking advice from a specialist for people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor and have worsening cognitive function or other markers of deterioration.
- If prescribing an AChE inhibitor (donepezil, galantamine, or rivastigmine), treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose). However, an alternative AChE inhibitor could be prescribed if it is considered appropriate when taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions, and dosing profiles.
- **STOPPING DEMENTIA MEDICATION** –
  - Tolerability may change over time consequent upon the ageing process and the emergence of medical co-morbidities and frailty. In later stages of dementia, medications that help with memory may be less effective (1) In this situation it may appropriate to reduce the dose or discontinue treatment.
  - This should be done ideally in consultation with the specialist who initiated treatment.
  - Dementia specialists are available to provide advice on such matters without the need for a formal re-referral. The patient's family and care home staff (if in care home) should be involved in the discussions too.
  - All letters sent to the GP will have contact details of the Consultant Psychiatrist and the older adult team for any advice and support. If there is an urgent medical need, the patient can be fast-tracked back to KMPT by contacting the Duty Team in the CMHT. *See appendix 3 for contact details*.

Diagnosis		1st Choice (Specialist Initiation or advice)	2nd Choice
Alzheimer's Disease (AD)	Mild / Moderate	Donepezil (1st line), galantamine or rivastigmine as monotherapy	-
	Moderate / Severe	Memantine monotherapy (*in moderate when AChEI not tolerated or contraindicated*)	Addition of Memantine to patient already on AChEI with worsening cognitive function or other markers of deterioration. ***(Specialist advice available if required)***

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Dementia with Lewy Body (DLB)	Mild to Moderate	Donepezil* or rivastigmine*	Galantamine* (*if 1st choice not tolerated*)
	Severe	Donepezil* or rivastigmine*	Memantine
Vascular Dementia (VD)	Comorbid AD, DLB or PDD	AChE inhibitors* or memantine*	-
Parkinson's Disease Dementia (PDD)	Mild to Moderate	Donepezil*, rivastigmine, or galantamine*	Memantine* (*if 1st choice not tolerated*)
	Severe		

[* = unlicensed indication, off-label use]

Appendix 1: **Memantine prescribing guidance document for GPs**

Treatment with memantine, in addition to an AChE inhibitor, should be considered for people with moderate Alzheimer's disease, and offered to people who have Severe Alzheimer's disease.(1) Examples of when memantine should be considered: when the dementia is significantly impacting on activities of daily living; there are emerging Behavioural and Psychological Symptoms of Dementia (BPSD); or there is increased carer strain due to deterioration of the person's symptoms of dementia.

MEDICATION	DOSE	GENERAL ADVICE
Memantine	Initially 5mg once daily for 1 week, then increased in steps of 5mg every week over the first 4 weeks of treatment reaching the recommended 20mg daily maintenance dose; maximum dose of 20mg per day. i.e. Week 1: 5mg daily, Week 2: 10mg daily Week 3: 15mg daily, Week 4: 20mg daily	• Administer once a day at approximately the same time every day • The absorption of memantine is not affected by food • Usually taken in the morning but may be given at night if sedation is a problem • Do not give if patient is on amantadine

Full prescribing information is available via www.medicines.org.uk.

A titration pack is available containing the appropriate strength tablets for the first 4 weeks of treatment. Alternatively, the 10mg tablets can be halved to allow 5mg increments.

Renal impairment: In patients with moderate renal impairment (CrCl 30 – 49 mL/min) the daily dose should be 10 mg per day. If tolerated well after at least 7 days of treatment, the dose could be increased up to 20 mg/day according to the standard titration scheme. In patients with severe renal impairment (CrCl 5 – 29 mL/min) the daily dose should be 10 mg per day.

Hepatic impairment: No adjustment is required for mild or moderate hepatic impairment. Seek specialist advice for prescribing for people with severe impairment.

Information sources: The manufacturer's information leaflet is available via www.medicines.org.uk. Additional information for people taking memantine is available via the Choice and Medication website. This website offers information in different formats and languages. (https://www.choiceandmedication.org/kmpt/medication/memantine/)

Formulations of memantine other than standard tablets

These formulations are significantly more expensive than the standard tablets.

There is a licensed liquid memantine product available. This is presented either as a pump mechanism; each pumped dose contains 5mg, or an oral solution to be measured in mLs. Orodispersible and soluble tablets are also licensed in 10mg and 20mg strengths. Alternatively, it is acceptable to crush the tablets well and disperse in water for administration. This would however be "off-label" administration.

Monitoring of treatment: Cognitive, functional, and behavioural symptoms can be monitored as part of routine clinical care. It is not necessary to repeat cognitive tests, routinely monitor blood pressure or arrange any haematological monitoring. Refer back those with BPSD symptoms not being managed in primary care. It is appropriate to continue memantine (and acetylcholinesterase inhibitors) into the severe stages of the illness - at the time of end-of-life care planning or difficulties with swallowing etc. it would be appropriate to rationalise and stop these drugs.

(1) Dementia: assessment, management and support for people living with dementia and their carers, NICE guidelines June 2018 (NG97)

Appendix 2: **Guidance on prescribing Acetylcholinesterase Inhibitors (AChEIs)**

General advice

- The AChEIs (Donepezil, Rivastigmine, and Galantamine) are recommended as options for managing mild to moderate Alzheimer's disease.
- AChEIs are not recommended for initiation in severe Alzheimer's disease however they should not be stopped because of disease severity alone.
- For people with an established diagnosis of Alzheimer's disease who are already taking an AChEI, GPs may start treatment with memantine without taking advice from a specialist clinician.
- Secondary care can be contacted for advice if required and patients can be referred back to memory services when clinically appropriate. The treatments are not disease modifying.

Dosing and general administration advice

MEDICATION	DOSE	GENERAL ADVICE
Donepezil	Initially 5 mg once daily for one month, then increased up to 10 mg once daily if tolerated.	• Doses to be given at bedtime to minimise gastrointestinal (GI) symptoms • If sleep disturbance is noted (particularly vivid nightmares) morning dosing may resolve
Galantamine	**Immediate-release formulations** Initially 4 mg twice daily for 4 weeks, increased to 8 mg twice daily for at least 4 weeks; maintenance 8–12 mg twice daily. **Modified-release formulations** - Initially 8 mg once daily for 4 weeks, increased to 16 mg once daily for at least 4 weeks; usual maintenance 16–24 mg daily.	• If dose is not tolerated, reduce to maximum tolerated • Oral solution is only approved for short-term use in the management of hospital patients who are unable to swallow tablets/capsules. Not for use in patients who can no longer swallow tablets due to severe dementia
Rivastigmine	**By mouth** –initially 1.5 mg twice daily, increased in steps of 1.5 mg twice daily, dose to be increased at intervals of at least 2 weeks according to response and tolerance; usual dose 3–6 mg twice daily (max. per dose 6 mg twice daily), if treatment interrupted for more than several days, re-titrate from 1.5 mg twice daily. **By transdermal application using patches – a**pply 4.6 mg/24 hours daily for at least 4 weeks, increased if tolerated to 9.5 mg/24 hours daily for a further 6 months, then increased if necessary to 13.3 mg/24 hours daily, increase to 13.3 mg/24 hours patch if well tolerated and cognitive deterioration or functional decline demonstrated.	• Use with caution in patients with body-weight less than 50 kg • If treatment interrupted for more than 3 days, re-titrate from 4.6mg/24 hours patch • Rivastigmine patches are formulary approved for patients: ○ unable to tolerate treatment with oral rivastigmine due to nausea and vomiting and ○ requiring treatment with an AChE who are unable to take oral medication (e.g. swallowing difficulties or 'nil by mouth' prior to surgery

- Consult the latest edition of the British National Formulary: https://bnf.nice.org.uk/ or Summary of Product Characteristics (SPC) https://www.medicines.org.uk/emc for full details of dosing

advice for the individual acetylcholinesterase inhibitors and the necessary dose adjustments that may be required in hepatic and renal impairment.

Contraindications and Cautions

- Cholinesterase inhibitors should be prescribed with caution where there is a history of asthma or obstructive pulmonary disease.
- AChEIs have a vagotonic effect that can produce bradycardia.
- Caution is advised in patients with sick sinus syndrome and other supraventricular cardiac conditions.
- Caution advised in patients with or at risk of gastrointestinal/peptic ulcer or concurrent nonsteroidal anti-inflammatory drugs (NSAIDs). These patients should be monitored for symptoms.

Commonly reported adverse effects

- Diarrhoea, muscle cramps, fatigue, nausea and vomiting, insomnia, agitation, decreased appetite
- For a full list of possible adverse effects, please refer to the Summary of Product Characteristics (SPC) https://www.medicines.org.uk/emc for the specific medication being prescribed
- Additional information on AChEIs is available via the Choice and Medication website. This website offers information for the individual medicines in different formats and languages (https://www.choiceandmedication.org/kmpt/). The manufacturer's information leaflet is also available via www.medicines.org.uk

Physical Health Monitoring of Treatment

- **Baseline monitoring should be carried out by the initiating prescriber prior to commencement of treatment.**
- **On-going monitoring will be the responsibility of the GP**

PARAMETER AND RELATED ADVICE	BASELINE	ONGOING
Adverse events (related to individual medicines)	x	x
Weight/BMI • Weight loss is associated with Alzheimer's disease but AChEs may also cause weight loss. • Patients weighing <50kg may experience more adverse effects and are more likely to discontinue treatment.	x	x
Prescribed/Over the Counter/herbal medicines • Medication should be reviewed during each consultation in order to identify potential drug interactions.	x	x
Cardiovascular health • Acetylcholinesterase inhibitors may have vagotonic effects so baseline cardiovascular function must be monitored before starting treatment and repeated when indicated, for example, when additional drugs with vagotonic effects are added or in the event of emerging cardiovascular problems	x	When clinically indicated
Renal and hepatic function	x	Annual eGFR (memantine) When clinically indicated (AChEI)

Appendix 3: **Contact phone number and email address for advice**

For Primary Care colleagues who need advice and guidance regarding their older patients' mental health-related medication, please find a list of useful email addresses and contact numbers below. The lines are open from Monday to Friday from 9am to 5pm and you will be directed to the best member of the team to assist with your query.

If your call is unanswered:

- Please state details of your enquiry
- Provide a mobile contact number
- Confirm the best time for a member of the CMHT to call you back
- Your message will be dealt with and **you should expect a call back within 72 hours**.

Emails are monitored throughout the working day and responses will be sent out within 24 hours.

KMPT Community Mental Health Service for Older People (CMHSOP) – aged 65+

CMHSOP Location	CMHSOP Contact details
Ashford	01233 658125 KAMNASCPT.ashfordOPMH@nhs.net
Canterbury & Coastal	01227 812054 01227 812083 kmpt.canterbury.olderpeople@nhs.net
Dartford, Gravesham, & Swanley	01322 421289 01322 622208 KAMNASCPT.dgscmhsopadmin@nhs.net
Dover & Deal	01304 213364 kmpt.doveranddealcmhtop@nhs.net
Maidstone	01622 726899 kmpt.maidstonecmhsopadmin@nhs.net
Medway	0300 303 3189 KAMNASCPT.medwayCMHSOP@nhs.net
Shepway	01303 228838 kmpt.shepwaycmhsopadmin@nhs.net
South West Kent	01732 228242 01732 228270 kmpt.southwestkentcmhsopadmin@nhs.net
Swale	01795 438446 KAMNASCPT.swalecmhsop@nhs.net
Thanet	01843 267071 KAMNASCPT.thanetcmhtop@nhs.net

KMPT operates a Community Mental Health Service both for older people with mental health needs, which are complicated by age-related needs, and for people of all ages, who have needs related to dementia. The service provides support and advice to professionals, care homes and carers. Service users receive an initial assessment after which a plan will be made in collaboration with the individual concerned as to what the next steps might be. This may involve further appointments with health care professionals, invitations to specialist groups, therapy and neuropsychological assessments. The KMPT team includes consultant psychiatrists, community psychiatric nurses, occupational therapists, psychological services and support staff, Admiral nurses and administrative staff. Further information about the KMPT Community Mental Health Service for Older People can be found here.

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