RubiconMD

Initiating and titrating antidepressants

In the US, most antidepressant prescriptions are written by non-psychiatric providers. Therefore it is important that PCPs understand practices for prescribing. The indications for these medications include unipolar depression, anxiety disorders, post-traumatic stress disorder, obsessive compulsive disorder, and eating disorders.

The selection of antidepressants is usually based on:

- Presenting symptom profile
- Side effects, potential drug interactions, and comorbidities
- Response to previous trials
- Patient preference
- Cost

Prescribing tips:

- **Use the medications side effects** to target specific symptoms (e.g., sedating drugs in individuals with insomnia, activating medications in hypersomnia/psychomotor retardation, appetite inducing drugs in low appetite).
- **SSRIs:** most common first line for depression (escitalopram – better tolerated, sertraline – wide dosing range from 50-200mg, citalopram - can prolong QTc, fluoxetine – more activating, paroxetine – SSRI with most side effects).
- **Patients with OCD** might need SSRIs or TCAs at doses above the maximum recommended
- **SNRIs** could treat comorbid pain (venlafaxine – migraine, duloxetine – neuropathic).
- **Bupropion:** more activating, does not impact weight and sexual drive. Can worsen insomnia and anxiety, although less likely with the XL formulation. Avoid in patients with risk of seizures.
- **Mirtazapine** can increase appetite and cause sedation.
- **TCAs** overall have more side effects and are lethal in overdose, but can help with neuropathic and chronic pain.
- **Newer agents** such as vortioxetine, vilazodone, levomilnacipran, desvenlafaxine – are not usually the first line given due to cost.
- **"Start low and go slow,"** consider starting with half of the initial dose for a week for elderly patients, patients prone to side effects, patients with prominent symptoms of anxiety, or those who are on medication with serotonergic action.
- **Set expectations with patients** in terms of side effects (most will subside with time). Remind them of the importance of adherence and the fact that a full response to the dose might take several weeks.

Examples of first line medications

Drug	Usual Starting Dose	Common titration (every 4 weeks)	Maximum dose
Sertraline*	50mg QD	25-50mg	200mg
Escitalopram*	10mg QD	2.5-5mg	20mg (10 elderly)
Bupropion XL	150 mg QD	150mg	450mg
Duloxetine*	20-30mg BID (QD*)	20-30mg	120mg
Mirtazapine	7.5 mg QHS	7.5-15mg	45mg

*"start low and go slow" is an option

Assessment at 4-week intervals

Good response reduction in PHQ-9 > 50%	Partial response PHQ-9 improvement but <50%	No response No or minimal improvement in PHQ-9
• Continue same dose • Single episode – consider discontinuation after 6 months in remission • Recurrent episodes – consider long term maintenance	• Assess adherence • Consider psychotherapy • Optimize dose (25-50% dose increase every 4 weeks) • If there are significant side effects, switch to another medication in the same or other class	• Assess adherence • Reassess diagnosis (i.e. bipolar, PTSD, grief, personality) • Consider psychotherapy • Engage behavioral health resources • Consider optimizing dose or switch to another medication in the same or other class • Upon failure of 2 adequate dose and duration antidepressant trials, consider combination therapy or specialty referral

Learn more about BHcare

www.rubiconmd.com/behavioral-health