Name(s)

- **Generic:** aripiprazole (ay ri PIP ray zole) | **Brand:** Abilify, Abilify Maintena, Abilify MyCite

Therapeutic Category

- Atypical or Second-Generation Antipsychotic Agent | Quinolinone Derivative

Indication(s)

1. **Schizophrenia:** American Psychiatric Association (APA) generally considers atypical antipsychotics a first line agent when treating schizophrenia. Pediatric use for ages between 13 and 17 years of age.
2. **Manic/Mixed Bipolar I Disorder:** Can be used w/ or w/o lithium or valproate to treat manic/mixed bipolar I disorders in patients. Pediatric approved for 10 to 17 years of age.
3. **Major Depressive Disorder:** Add on therapy for adults when an antidepressant alone is not effective.
4. **Irritability Associated w/ Autistic Disorder:** Approved for patients between 6 to 17 years of age when treating irritability associated w/ autistic disorder.
5. **Tourette's Syndrome**: Treating pediatric patients between ages of 6 to 18 years of age.

- OFF LABEL: (Not covered, refer to most current literature) Delusional Disorder; Huntington Disease-Associated Chorea, Obsessive-Compulsive Disorder

Dosage Form / Strength / Dosing

- **Dosage Form(s)**
  - Prefilled Syringe, IM: Abilify Maintena (300 mg; 400 mg)
  - Solution, PO: 1 mg/mL
  - Suspension, Reconstituted ER: Abilify Maintena (300 mg; 400 mg)
  - Tablet, PO: 2 mg, 5 mg, 10 mg, 15 mg, 30 mg
  - Tablet, Disintegrating, PO: 10 mg, 15 mg
- **Dosing Adults for Schizophrenia**
  - PO: Initiate 10 – 15 mg po once daily. May increase by 5 mg increments every 1 week up to a max dose of 30 mg/day.
  - IM; ER injectable: Initiate 400 mg every month. Pt tolerability should be established PO over at least 2 week prior to IM initiation.
- **Dosing Adults for Bipolar Disorder**
  - PO: Maintenance adjunctive or monotherapy therapy: Initiate 10 – 15 mg po qd. Can increase in 5 – 10 mg per day dose increments approximately every week up to max of 30/day dose based on patient response/tolerability
  - IM; ER injectable: Maintenance dose is initiated at 400 mg IM once monthly. Determine pt tolerability on PO for at least 2 weeks to assess prior to IM initiation.
- **Dosing Adults for Major Depressive Disorder (Adjunctive, Unipolar)**
  - PO: Initiate 2 – 5 mg po qd. May increase in 5 mg increases every 1 week up to max of 15 mg/day based on patient response. Select patients may need 20 mg/day
- **Dosing Pediatrics with irritability due to Autism (6 to 17 years)**
  - PO: Initiate 2 mg po x7 days, then 5 mg daily for ≥7 days. 5 mg dose increases up to max 30 mg/day

- **Dosing Pediatrics with Bipolar I disorder (manic/mixed) (10 to 17 years)**
  - PO: Initiate 2 mg qd x2 days, then 5 mg qd for 2 days. Increase to target dose of 10 mg/day in 5 mg increments. Max dose 30 mg/day.
- **Dosing Pediatrics with Tourette's syndrome (≥6 years to Adolescents)**
  - **<50 kg:** Initiate 2 mg po qd for 2 days, then increase to 5 mg/day. May titrate up to 10 mg/day if desired pt response not achieved at 5 mg/day
  - **≥50 kg:** Initiate 2 mg po qd for 2 days, then increase to 5 mg/day for 5 days. Titrate to 10 mg/day by day 8 of therapy. If desired effect not achieved by 10mg/day then titrate up by 5 mg/day increments weekly up to 20 mg/day

Special Populations / Considerations

- **Dosing General Considerations:**
  - Monitor for worsening depression, suicidality, changes in behavior. Especially prevalent in the beginning of therapy or during dose adjustments.
    - If pt on ER IM responding but experiencing too many adverse effects can decrease dose to 300 mg IM
  - When d/c gradual dose reduction over weeks/months (~10% increments)
  - Cross titrations recommended when switching antipsychotics
- **If IM dose missed:**
  - Second or third dose missed
    - If >4 weeks but <5 weeks administer next dose ASAP
    - If >5 weeks admin PO for 14 days w/ next injection and adjust PO prn
  - Fourth or longer doses missed
    - If >4 weeks but <6 weeks admin ASAP
    - IF >6 weeks admin PO for 14 days w/ next injection and adjust PO prn
- **Dosing Conversions:**
  - ODT to PO is a direct mg to mg basis
  - SLN to PO is direct mg to mg up to 25 mg. IF 30 mg tab then 25 mg sln
- **CYP2D6 metabolizer status:**
  - IF poor 2D6 metabolizer
    - PO: Dose decreased by 50%
    - IM, ER, injectable: Reduce dose to 300 mg
- Dose adjust if patient has **Renal** or **Hepatic** Impairment
- **Pregnancy Concern(s):** Crosses placental and detected in cord blood at delivery. Use agent other than aripiprazole if needed.

Mechanism of Action & Pharmacology

- **MOA:** An quinolinone antipsychotic agent with affinity to dopamine and serotonin receptors. It is a partial agonist at the D2 and 5-HT1A receptor. It acts as an antagonist at the 5-HT2A receptor. Level of affinity is as follows:
  - **High affinity** for D2, D3, 5-HT1A, and 5-HT2A receptors.

  - **Moderate affinity** for D4, 5-HT2C, 5-HT7, alpha1 adrenergic and H1 receptors.
  - **Moderate affinity** for serotonin reuptake transporter
- **Absorption**: IM, ER absorption is slow and prolonged and PO is well absorbed | **Metabolism**: Hepatically metabolized via CYP2D6 and CYP3A4. | **Excretion**: 55% of drug is fecally excreted; 25% of drug is excreted through urine. | **Onset of Action**: 1 – 3 weeks | **Time to Peak**: When IM 4 days if admin in deltoid and 5- 7 days if gluteal administration | **Half-Life Elimination**: 75 – 94 hours if PO and 30 – 47 days if IM administration. | **Protein Binding**: ≥99%

Side Effects

- **Dizziness, lightheadedness, drowsines**s, nausea, vomiting, orthostatic hypotension, tachycardia
- **Weight gain**, constipation, headache, trouble sleeping
- Rare but serious concern are **tardive dyskinesia** (unusual uncontrolled movements (face, mouth, tongue, arms, legs) and **neuroleptic malignant syndrom**e (fever, muscle stiffness/pain/weakness, dark urine)

BLACK BOX WARNING: Increased mortality in elderly pts w/ dementia-related psychosis – increased risk of death and not approved for treat of dementia-related psychosis. **Suicidality and antidepressant drugs –** increased risk of suicidal throughts and behaviors in children, adolescents and young adults. Closely monitor patients for clinical worsening or emergence of suicidal thoughts and behaviors.

Drug Interactions

- Alcohol (Ethyl) and cannabis effects may be enhanced by CNS Depressants
- Amphetamine effects may be diminished by antipsychotic agents
- Blood pressure lowering agents may increase hypotensive effects of antipsychotic agents
- CYP2D6 inhibitors/inducers: Inhibitors increase serum concentrations of aripiprazole. Inducers decrease serum concentrations of aripiprazole.
- CYP3A4 inhibitors/inducers

Monitoring Parameters

- Mental status, suicidal thoughts and behaviors
- Extrapyramidal symptoms (EPS) such as unusual uncontrolled movements.
- Blood sugars if on IM administration

Patient Counseling Information

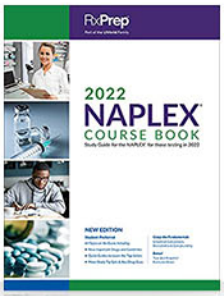
- Used to treat mood disorders such as schizophrenia, bipolar disorders, depression.
- May cause fatigue, agitation, anxiety, headache.
- Consult MD immediately if EPS, mental status change, or irregular muscle cramps/stiffness.

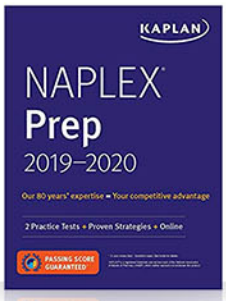
Reference(s)

- https://www.drugs.com/ppa/aripiprazole.html
- https://www.abilify.com/
- https://www.webmd.com/drugs/2/drug-64437-4274/aripiprazole-oral/aripiprazole-oral/details

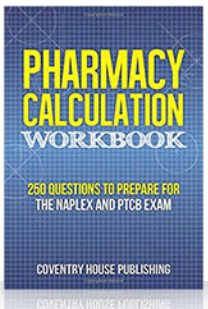
PREPARE FOR SUCCESS!

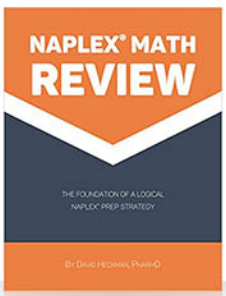
Comprehensive (NAPLEX)

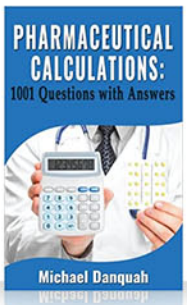


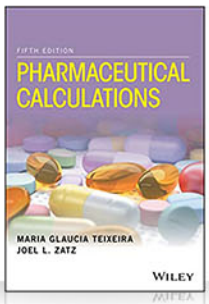


Calculations (NAPLEX)

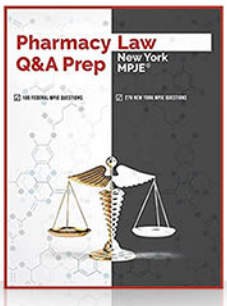


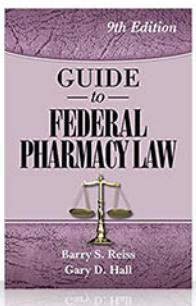




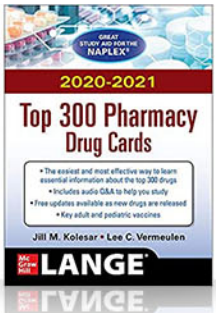


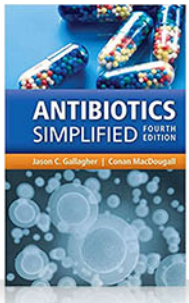
Pharmacy Law (MPJE)

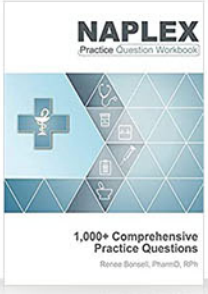


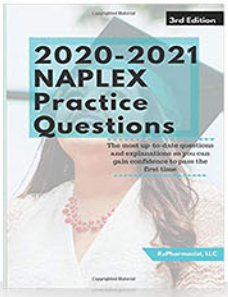


Supplemental









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DRUG CARDS DAILY

Monday at 7 am EST
(6 am CST, 4 am PST)

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