

No Surat : 109/PM Jupiter/MKT/MD/VII/2026
Kepada Yth : Finance Dept
Cc : Matthew Yap – Vice President; Thomas D. – MD; Bambang S – DMD; Marketing Support; File
Dari : Farah S. – PE Jupiter; Yohana M. – PM Jupiter; Ferdinand D. – HoD Jupiter
Perihal : **MIMS Skizofrenia dan Ansietas 2026**
Hari/Tanggal : Selasa, 11 Agustus 2026

Bersamaan dengan proposal ini, kami mengajukan permohonan dana untuk beberapa produk PT Mersifarma TM dalam **MIMS Skizofrenia dan Ansietas 2026** dengan rincian sebagai berikut :

No	PROGRAM	JUMLAH PRODUK	TOTAL
1	MIMS Skizofrenia dan Ansietas 2026, terdiri dari: 64 halaman (dengan cover), ukuran A5	1000 pcs	Rp135.420.000 (sudah termasuk VAT 11%)
TOTAL YANG DIBAYARKAN		IDR	Rp135.420.000

Tujuan kami dalam pembuatan MIMS Skizofrenia dan Ansietas 2026 yaitu:

1. Pengembangan dan branding existing product PT. Mersifarma secara nasional, khususnya produk-produk yang diindikasikan untuk Skizofrenia dan Ansietas, melalui MIMS sebagai platform referensi obat terbesar di Asia-Pasifik, khususnya di Indonesia. Hal ini bertujuan untuk meningkatkan awareness terhadap produk PT. Mersifarma sekaligus memperkuat eksistensi dan kredibilitas produk sebagai pilihan terapi yang tercantum dalam referensi dan guideline terkait tata laksana Skizofrenia dan Ansietas.
2. Menjadikan materi MIMS sebagai supporting material pada berbagai event ilmiah untuk memberikan informasi tambahan kepada dokter dan tenaga kesehatan terkait produk PT. Mersifarma serta referensi penggunaannya dalam tata laksana Skizofrenia dan Ansietas.
3. Meningkatkan sales produk-produk PT Mersifarma TM dengan pengembangan sales & outlet sebagai berikut :

Avg Sales 3 Bulan	Estimasi Sales	Growth
15,699,855,873	16,485,522,000	5.00%

Mohon untuk dana sebesar **Rp135.420.000** agar dapat di transfer ke Bank UOB dengan nomor rekening 486-300-835-7 Atas Nama PT. Medidata Indonesia. **Paling telat, Rabu, 19 Agustus 2026**

Dengan support ini, diharapkan sales produk-produk PT Mersifarma TM dapat meningkat secara Nasional. Atas perhatian dan persetujuan yang bapak berikan, kami ucapkan terima kasih.

Biaya untuk Listing Product di MIMS 2026 menggunakan budget:

- MKTJUP26-MA039 - JUPITER 1 (Rp15,000,000)
- MKTJUP26-MA040 - JUPITER 2 (Rp15,000,000)
- MKTJUP26-MA041 - MEET THE EXPERT SERIES 1 (Rp15,000,000)
- MKTJUP26-MA042 - MEET THE EXPERT SERIES 2 (Rp15,000,000)
- MKTJUP26-MA043 - MEET THE EXPERT SERIES 3 (Rp15,000,000) ✓
- MKTJUP26-MA044 - SCIENTIFIC MEETING / WEBINAR - 1 (Rp15,000,000)
- MKTJUP26-MA045 - SCIENTIFIC MEETING / WEBINAR - 2 (Rp15,000,000)
- MKTJUP26-MA046 - CLINICAL UPDATE PSYCHIATRIC - 1 (Rp15,000,000)
- MKTJUP26-MA047 - CLINICAL UPDATE PSYCHIATRIC - 2 (Rp15,000,000) ✓
- MKTJUP26-MA048 - EDUCATIONAL FORUM (Rp15,000,000) → *Sporella MD 022 Mercury*

Hormat kami,

Mengetahui,

Menyetujui,

[Handwritten signature]

Farah S.
PE Jupiter

for: *Jan*

Yohana M.
PM Jupiter

✓
157824

Ferdinand D
Sales Manager

11/28/20

Thomas Dewo
Marketing Director

Theresa

Bambang S.
Sales Director

11/8/26

Matthew Yap
Vice President


F. Tirtokoesnadi 12/3/83



LAMPIRAN KEGIATAN MARKETING

No. : MA202608-40
 Tgl Ajuan : 10 Aug 2026
 Jenis Kegiatan : OTHERS
 Nama Kegiatan : MIMS Skizofrenia dan Ansietas
 Tgl Kegiatan : 28 Aug 2026 s/d 28 Aug 2026
 Estimasi Biaya : Rp 135,420,000
 Target Sales : Rp 16,485,522,000

Divisi : JUPITER
 Regional : NASIONAL
 Area : All Area
 Rayon : • All Rayon

TARGET SALES :

NO	KODE	NAMA PRODUK	AVG SALES	QTY	HNA	TARGET SALES	GROWTH
1	ATA0101001	ATARAX 0.5	912,411,863	4750	202,000	959,500,000	5%
2	ATA0901002	ATARAX 1	7,525,012,731	22000	359,000	7,898,000,000	5%
3	MER0101015	MERLOPAM 0.5	205,470,239	1422	151,000	214,722,000	5%
4	MER0101016	MERLOPAM 2	3,400,671,673	8000	448,000	3,584,000,000	5%
5	VAL0101023	VALDIMEX 5	591,983,124	5050	123,000	621,150,000	5%
6	VAL0101024	VALDIMEX INJ	49,911,199	780	67,000	52,260,000	5%
7	CLO0301002	CLOFRITIS 10	610,412,557	3800	168,000	638,400,000	5%
8	LEX0101010	LEXZEPAM 3	133,788,078	610	231,000	140,910,000	5%
9	SIA0101001	SIABY ORAL SOLUTION	55,823,274	185	316,000	58,460,000	5%
10	SIA0101002	SIABY ORADIS	96,838,328	450	225,000	101,250,000	5%
11	CEP0101004	CEPEZET 100	227,269,161	4100	58,000	237,800,000	5%
12	CEP0101003	CEPEZET INJ	6,402,606	77	88,000	6,776,000	6%
13	SIK0101027	SIKZONATE INJ	309,192,658	688	470,000	323,360,000	5%
14	PER0101017	PERSIDAL 1	14,320,020	158	95,000	15,010,000	5%
15	PER0101018	PERSIDAL 2	277,681,004	2002	145,000	290,290,000	5%
16	CLO0101004	CLORILEX 100	211,929,532	287	772,000	221,564,000	5%
17	CLO0101005	CLORILEX 25	274,123,521	1280	224,000	286,720,000	5%
18	STE0101022	STELOSI 5	275,880,110	4450	65,000	289,250,000	5%
19	LOD0101011	LODOMER 2	109,828,137	945	122,000	115,290,000	5%
20	LOD0101012	LODOMER 5	301,178,118	1580	200,000	316,000,000	5%
21	LOD0101014	LODOMER INJ	83,344,013	570	153,000	87,210,000	5%
22	LOD0101013	LODOMER DROPS	26,383,927	690	40,000	27,600,000	5%
			15,699,855,873			16,485,522,000	

MONITORING APOTIK :

NO	NAMA OUTLET	ALAMAT OUTLET
1	ALL OUTLET	ALL OUTLET

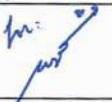
ANALISA KEGIATAN :

Estimasi Biaya : Rp 135,420,000
 Ratio Biaya Terhadap Sales : 0.86%
 Avg Sales 3 Bulan Terakhir : Rp 15,699,855,873
 Target Sales Setelah Event : Rp 16,485,522,000
 Growth : 5.00%

Proposed by

PE	 Ditandatangani secara elektronik : 2026-08-10 18:05:52
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Approved by

PM	
MM	

PT MEDIDATA INDONESIA

Ventura Building
Jl. R.A. Kartini No.26 3rd floor, West Cilandak,
Cilandak, South Jakarta City, Jakarta 12430
Tel: (6221) - 7292662 Fax : (6221) - 7293539
Email to : enquiry.id@mims.com

Client:
Ordered by:
Address:
Country (ies):

PT. Mersifarma Tirmaku Mercusana
Mr. Thomas Koencoro
Wisma Tiara 4th FL, Jl. Raya Pasar Minggu KM 18 No 17, RT.1/RW.1, West Pejaten, Pasar
Jakarta, Indonesia

Tel / Fax:
From:
Ref. No.
Date:

Service Order MIMS Reprint 2026

Please return to:
Email: ruth.meilisha@mims.com

021 - 3500487

Ruth Meilisha

Ref. No.

July 31st, 2026

PUBLICATION	COUNTRY	PROGRAM	Qty.	PRICE (Rp)	TOTAL (Rp)
MIMS Reprint MNPG 2026	ID	Reprint Book - MNPG Topic: Anxiety, Schizophrenia Total pages: 64 pages (include cover) Publication Specifications Size: A5 (14.8 × 21 cm), portrait, closed size Total Pages: 64 pages (including 4-pages cover, 1-page masthead) Cover: Art Paper 150 gsm, Full Color (4/4), UV finishing Content: HVS 80 gsm, Full Color (4/4) Binding: Perfect Binding	1000 Copies	Rp122.000.000	Rp 122.000.000
				Sub Total	Rp 122.000.000
				*VAT 11%	Rp 13.420.000
Grand Total (Rp)				Rp	135.420.000

Terms & Conditions reflected on Page 2 of 2

SPECIAL INSTRUCTION:

The above contract price is exclusive of withholding tax and any other similar taxes associated with this Service Order. All such taxes are to be borne by Client and all payments by Client hereunder shall be paid in full without any setoff, counterclaim, deduction or withholding (or similar in kind).

Issued by:

Ruth Meilisha

Date:

July 31st, 2026

Confirmed by:

Date:

CF/dd

For Internal Use Only:	Copy:
Inv by	Client
Date	Sales
Order No.	IO File
By	Prodn

Trap 10 2026

Terms & Conditions:

1. Client agrees to purchase the described Services on this Insertion Order subject to MIMS' General Terms and Conditions ("GTCs"), a copy which is available upon request or at <https://policy.mims.com/resource>, and the Special Conditions hereunder.

Special Conditions:

General

1. Client shall not place or affix any stickers, posters, notice or the like on any part of the print publication without MIMS' prior written consent, or in any way deface the print publication.
2. MIMS reserves the right to withhold listing, advertisement and/or material of a product should a third-party file claim of patent ownership notwithstanding it is yet to be determined by a court judgement.
3. MIMS treats all the user personal data held with the utmost care and security and complies strictly with the personal data protection regulation of the applicable jurisdiction. In accordance with this compliance, all user engagement or traffic data reports provided will only be made available in the form of aggregate data, personally identifiable information of MIMS audience will not be made available.
4. All accounts are payable within 30 days of invoice date. A late payment charge of 2% per month will be imposed on any account outstanding for more than 30 days from date of invoice. Agency commission, if any, will also be withdrawn.
5. Copyright and sponsorship: copyright on all content generated by MIMS belong to MIMS unless otherwise agreed between the parties.
6. All prices stated are exclusive of all applicable taxes. All payments shall be made net of any taxes and costs, without offset or deduction.

Listing Service

1. MIMS endeavours to update and maintain each product's content ("Revised Work") upon Client's timely provision of product monograph and any updates thereof. Client shall confirm in writing within 14 working days if the Revised Work is approved by Client. Failure to do so shall constitute implied/non-express acceptance of the Revised Work.
2. MIMS retains the copyright of all content assets including product monographs and images created and processed by MIMS Editorial Team. No part of the content processed by MIMS Editorial Team can be reproduced in any language; stored in or reproduced in any manner or any form be it in print or electronic without prior written consent and permission from MIMS.
3. Listing Service Fee ("Listing Fee") upon billed, shall be paid in full by the Client, in accordance with the payment terms stipulated in Clause 4 – General Section above. All fees are to be billed within the same year of listing. In case of any special arrangements for payment terms, it has to be agreed by the parties and written clearly under "Special Arrangements" on the applicable service order.

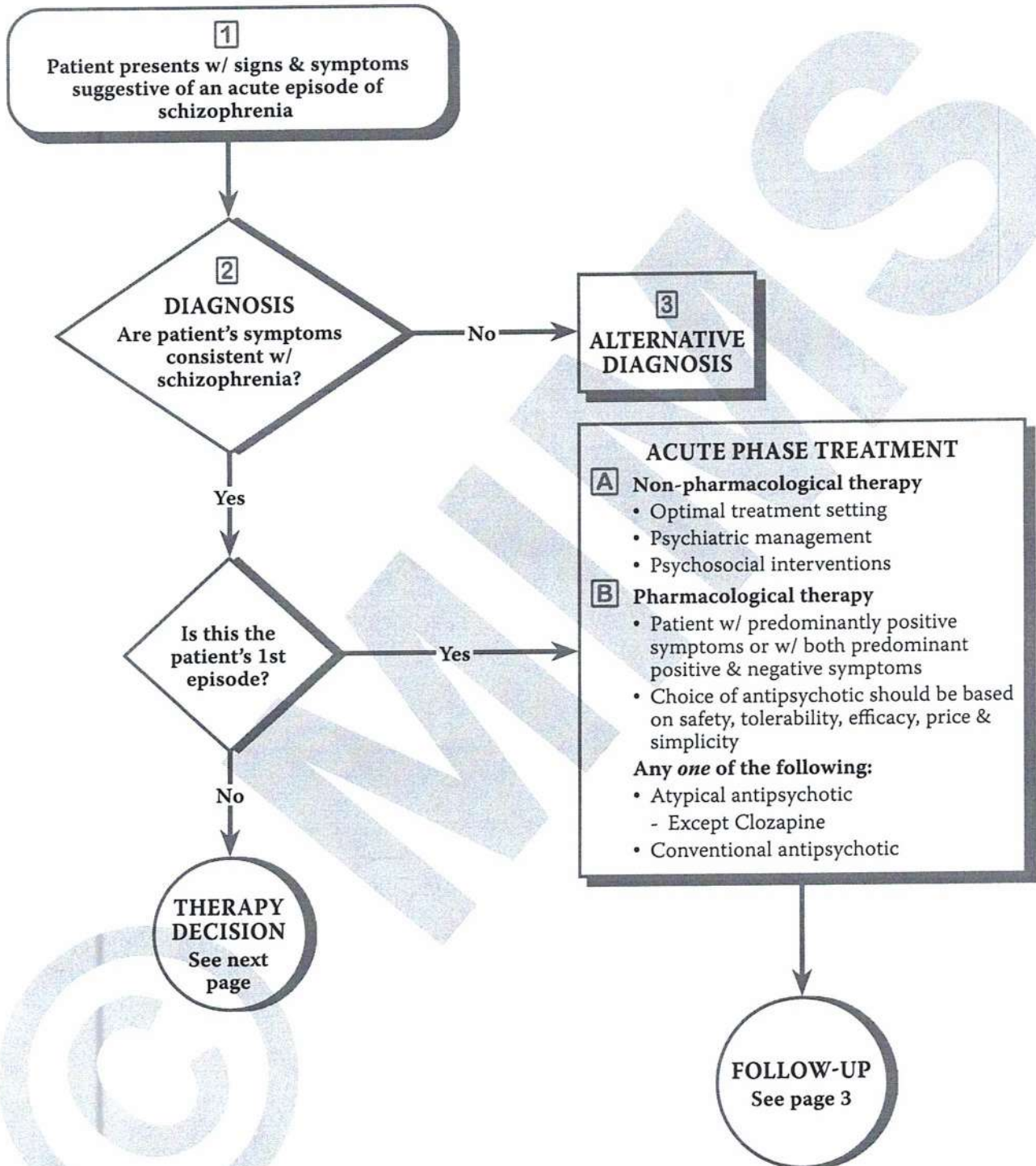
Print, Digital Advertisement Service and/or Brand Resources

1. Client is responsible for ensuring that all advertisements and materials (collectively "Materials") submitted for publication comply with relevant statutory requirements. The Materials furnished to MIMS shall not defame or violate any rights (including privacy rights) of any third party or infringe any copyright, trademark, patent, or any other property right. Client also assumes liability for all contents in the Materials including text, representation and illustration of advertisements printed and for all claims arising therefrom. Client will fully indemnify MIMS from and against all actions, proceedings, claims, demands and all related losses, damages, liability and expenses suffered or incurred by MIMS directly or indirectly as a result of any claim made against MIMS with regards to Client's Materials furnished.
2. MIMS reserves the right to reject or discontinue any advertisement making exaggerated claims or deemed objectionable as word or appearance or violating statutory requirements. MIMS likewise reserves the right to add the word 'Advertorial' or 'Paid Advertisement' to any copy, which in its opinion, simulates editorial matter and which might be misleading to the reader.
3. MIMS will not be responsible for unsatisfactory reproduction if Materials supplied are not made according to MIMS' stipulated requirements.
4. From time to time, MIMS may, at its sole discretion, update, upgrade, enhance or add features, functionalities and design updates to its channels and portals, inclusive of MIMS.com, Brand Resources feature, MIMS CPD online, and mobile applications that MIMS create from time to time.
5. Scheduled and emergency maintenance may be required from time to time. MIMS shall not be responsible or liable for any problems arising from scheduled and unscheduled downtime caused by application updates, integration, migration or modifications on MIMS digital channels.
6. Browser and operating system/platform compatibility will be based on current and/or most popular release versions. Future version upgrades of browsers and operating systems may result in unknown incompatibilities for which MIMS shall not be liable for.
7. Client acknowledges that the design and layout of the Materials submitted will conform to MIMS channels and portals' design user interface and schema.
8. MIMS shall have the right to remove the Materials without notice to the Client, if Client downgrade the listing package from Essential Plus/Advanced to Essential.
9. For Print Advertisement, requested advertisement positions will be guaranteed only within the section, not to the exact page.
10. For Print Advertisement, 4 months' advance notice from the month prior to publication month is required for cancellation of all advertising placements. Covers and premium positions are non-cancellable, and rescheduling is not allowed.
11. Fees applicable for advertisement services ("Advertisement Service Fee") upon billed, shall be paid in full by the Client, in accordance with the payment terms stipulated in Clause 4 – General Section above. All fees are to be billed within the same year of advertisement service. In case of any special arrangements for payment terms, it has to be agreed by the parties and written clearly under "Special Arrangements" on the applicable service order.

Specialty Edition

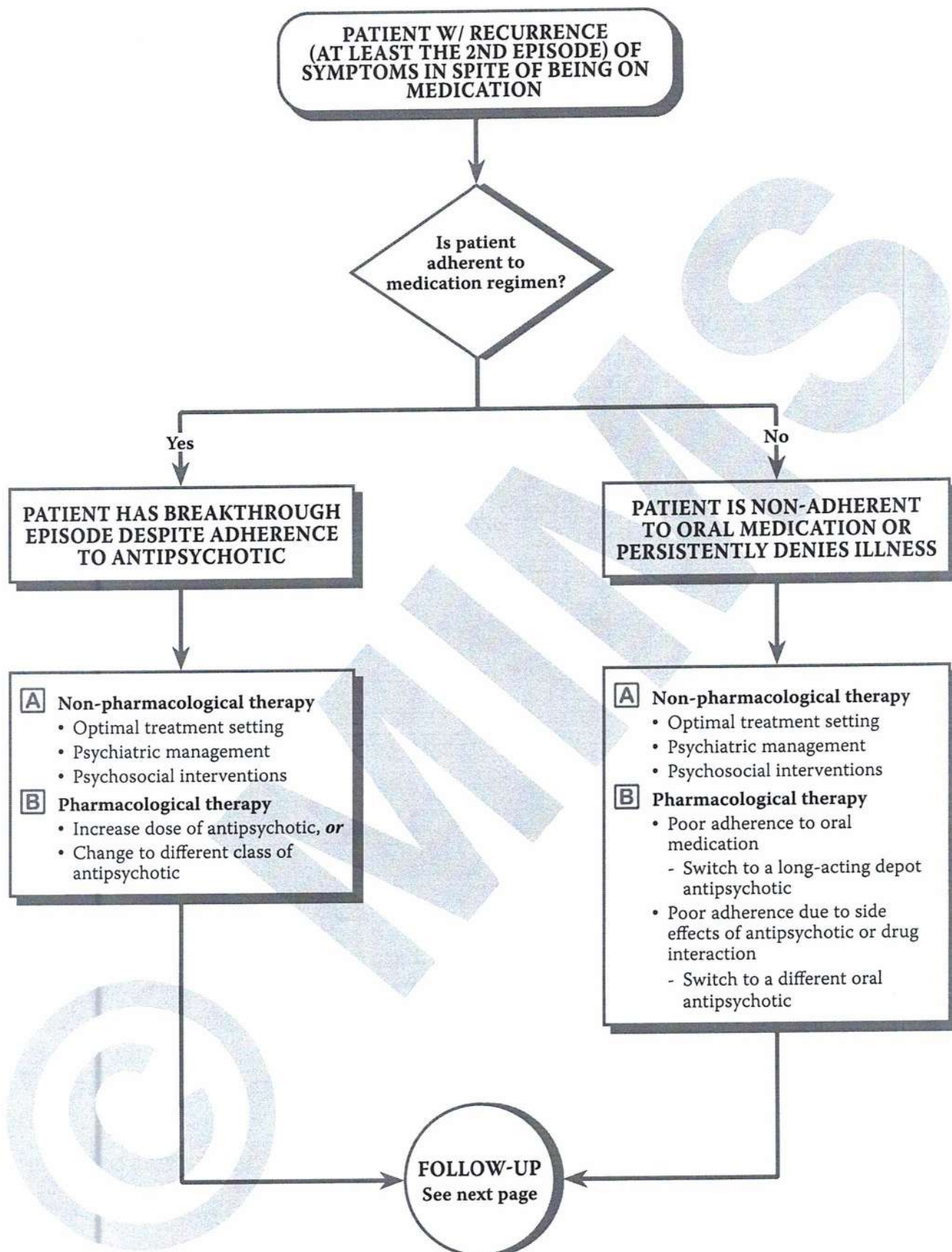
1. Sponsorship of Specialty Edition (Reprint) is for one-time distribution only. Extra printing is not included in the order and is subjected to additional costs.
2. Copyright belongs to MIMS and no part of the editorial content of the Specialty Edition can be reproduced in any language; stored in or reproduced in any manner or any form be it in print or electronic without prior written consent and permission from MIMS.
3. MIMS reserves the right to publish Specialty Edition content in other Specialty Edition publications.
4. Materials provided to Client for internal approval purposes and/or for similar references, must be secured and all applicable pages will bear the MIMS watermark.

Schizophrenia (1 of 26)



Reference: Keepers GA, Fochtmann LJ, Anzia JM et al. The American Psychiatric Association practice guideline for the treatment of patients with schizophrenia. Am J Psychiatry. 2020 Sep 1;177(9):868-872.

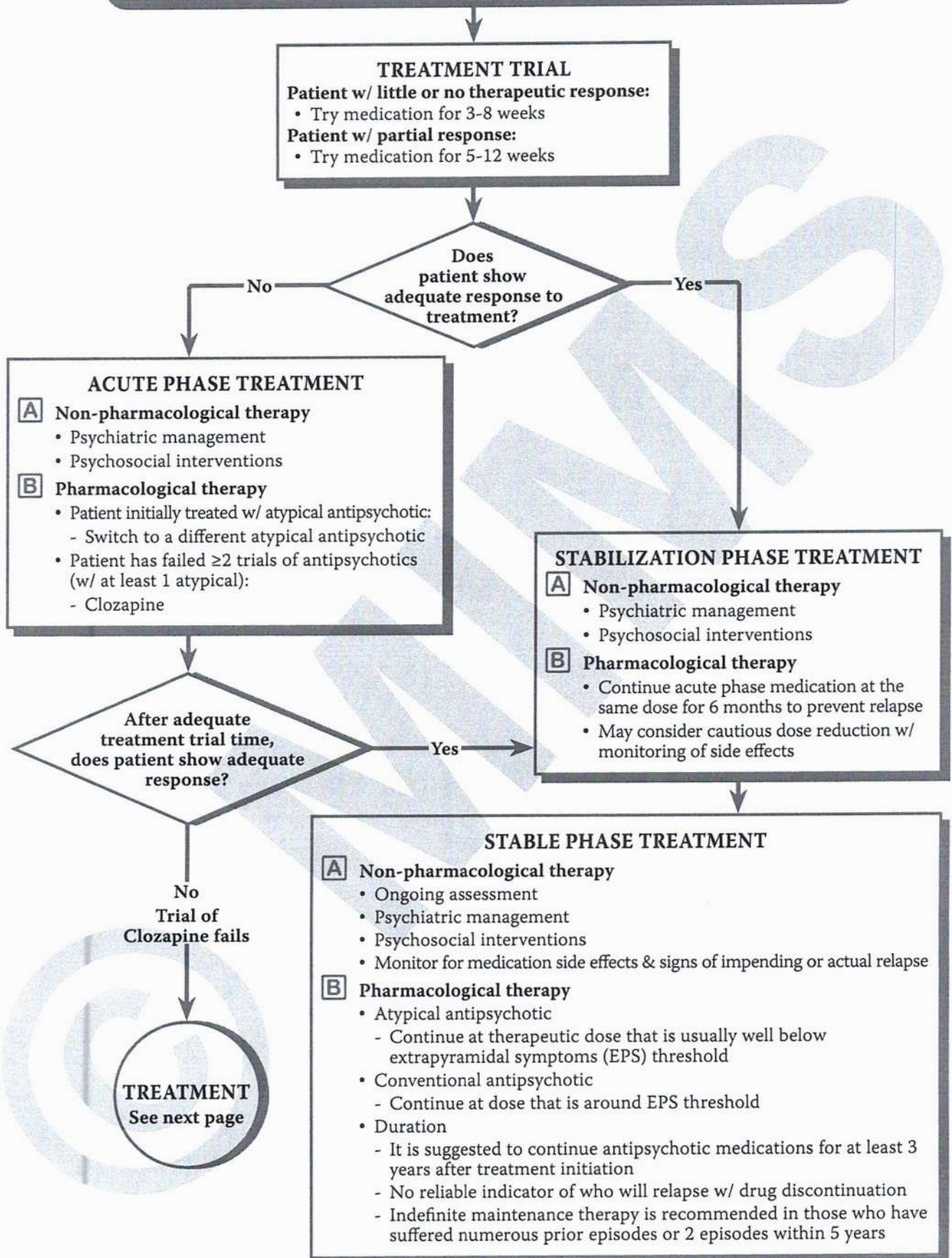
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Specific prescribing information may be found in the latest MIMS.*



References: Keepers GA, Fochtmann LJ, Anzia JM et al. The American Psychiatric Association practice guideline for the treatment of patients with schizophrenia. Am J Psychiatry. 2020 Sep 1;177(9):868-872; Galletly C, Castle D, Dark F, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Aust N Z J Psychiatry. 2016 May;50(5):410-472.

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FOLLOW-UP (NEWLY DIAGNOSED PATIENT STARTED ON TREATMENT)



References: Keepers GA, Fochtmann LJ, Anzia JM et al. The American Psychiatric Association practice guideline for the treatment of patients with schizophrenia. Am J Psychiatry. 2020 Sep 1;177(9):868-872; Galletly C, Castle D, Dark F, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Aust N Z J Psychiatry. 2016 May;50(5):410-472.

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TREATMENT OPTIONS FOR PATIENTS IN WHOM A TRIAL OF CLOZAPINE FAILS

ACUTE PHASE TREATMENT

B Pharmacological therapy

- Clozapine

Plus any one of the following:

- Adjunctive agent¹
- Conventional antipsychotic
- Atypical antipsychotic
- Electroconvulsive therapy (ECT)

Or

Taper Clozapine & switch to:

- ECT
- Atypical or conventional antipsychotic + ECT
- Atypical or conventional antipsychotic + adjunctive agent¹

¹Adjunctive agents: Mood stabilizers (Carbamazepine, Lithium or Valproate), Benzodiazepine.

TREATMENT OF ADVERSE REACTIONS

EXTRAPYRAMIDAL SYMPTOMS (EPS)

C Pharmacological therapy for adverse reactions to antipsychotics

- Pseudoparkinsonism
 - Anticholinergic agent (oral)
 - If possible, decrease dose of antipsychotic
 - Switch to an alternate antipsychotic
- Akathisia
 - Beta-blocker or Benzodiazepine
 - If possible, decrease dose of antipsychotic
- Dystonic reactions
 - Anticholinergic agent (IV or IM)
- Tardive dyskinesia
 - May be irreversible even w/ discontinuation of antipsychotic
 - Clozapine may be the best alternative
 - May consider reversible inhibitor of the vesicular monoamine transporter 2 (VMAT2)

METABOLIC SYNDROME-INDUCED ANTIPSYCHOTIC AGENTS

- Referral to an endocrinologist & nutrition specialist
- Lifestyle modifications
 - Gradual increase in physical activity
 - Dietary restriction
- Switch to another antipsychotic agent w/ lower metabolic side effect
- Regularly monitor patient's metabolic panels [eg weight, body mass index (BMI), serum lipids & fasting glucose levels]

References: Keepers GA, Fochtmann LJ, Anzia JM et al. The American Psychiatric Association practice guideline for the treatment of patients with schizophrenia. Am J Psychiatry. 2020 Sep 1;177(9):868-872; Galletly C, Castle D, Dark F, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Aust N Z J Psychiatry. 2016 May;50(5):410-472.

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TREATMENT OF COEXISTING SYMPTOMS

AGITATION/EXCITEMENT

ACUTE PHASE TREATMENT

C Adjunctive pharmacological therapy

Any one of the following:

- Aripiprazole (IM)
- Benzodiazepine (oral/IV) as required
- Lorazepam (IV/IM) → **MELOPAM** ✓
- Haloperidol (IM) short-acting
- Olanzapine (IM)
- Risperidone (oral in orodispersible preparation)
- Ziprasidone (IM)

The above treatments should be discontinued as soon as clinically feasible

PERSISTENT SYMPTOMS OF AGGRESSION/HOSTILITY

C Adjunctive pharmacological therapy

- Mood stabilizers (Carbamazepine, **Lithium** or Valproate) → **FRIMANIA**
- If patient does not respond to antipsychotic + mood stabilizer:
- Switch antipsychotic to Clozapine

INSOMNIA

C Adjunctive pharmacological therapy

Any one of the following:

- Trazodone, Zaleplon or Zolpidem as required ✓
- Benzodiazepine as required
- Only in patients without history of substance abuse

DEPRESSION

C Adjunctive pharmacological therapy

Any one of the following:

- Selective serotonin reuptake inhibitor (SSRI)
- Bupropion
- Mirtazapine
- Nefazodone
- Venlafaxine

References: Keepers GA, Fochtmann LJ, Anzia JM et al. The American Psychiatric Association practice guideline for the treatment of patients with schizophrenia. Am J Psychiatry. 2020 Sep 1;177(9):868-872; Galletly C, Castle D, Dark F, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Aust N Z J Psychiatry. 2016 May;50(5):410-472.

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Specific prescribing information may be found in the latest MIMS.*

mersi
Good Quality Improves Life's Quality

MERLOPAM®

Lorazepam Injection 2 mg/mL

"Rapid Calm, Reliable Control"



FOR HEALTH CARE PROFESSIONAL ONLY



MERLOPAM®

Lorazepam Injection 2 mg/mL



The First Me-too Injectable Lorazepam in Indonesia.¹

Expanding access to injectable lorazepam therapy in Indonesia.



First-Line Therapy for Status Epilepticus.²

Recommended as first-line treatment for convulsive status epilepticus.



Rapid Onset of Action for Acute Conditions.³

Rapid control of seizures, anxiety, and agitation.



Predictable Safety Profile.⁴

Proven safety with appropriate clinical monitoring.



Flexible Dosing.⁵

Flexible Route of Administration



PRODUCT INFORMATION



Composition

Each 1 mL of Merlopam Injection contains Lorazepam 2 mg.



Packaging

Box, 12 Ampoules @ 1 mL



Storage

Store at 2–8°C, protected from light. Keep out of reach of children.



NIE

MERLOPAM INJ® : DPL2633319943A1



Indication & Adult Dosage

MERLOPAM Injection is indicated for the treatment of:

- Status Epilepticus
4 mg IV (0.1 mg/kg; maximum 4 mg/dose), administered slowly at 2 mg/min.

Source:

1. Internal market data & BPOM registration.
2. National Institute for Health and Care Excellence. (2022). Epilepsies in children, young people and adults: Diagnosis and management (NG217).
3. Glauser, T., et al. (2016). Evidence-based guideline: Treatment of convulsive status epilepticus in children and adults. *Epilepsy Currents*, 16(1), 40–61.
4. Sharma, S., & Reddy, V. (2024). Lorazepam. In *StatPearls*. StatPearls Publishing.
5. DailyMed. (2024). Lorazepam Injection, USP: Prescribing information. U.S. National Library of Medicine.

*Please refer to the Product Insert for complete prescribing information

Authorized Distributors of Mersifarma:



PT. MERSI FARMA TM
Wisma Tiga 4th Floor
Jl. Raya Pasar Minggu Km. 18 No. 17 Jakarta 12510 Indonesia
Telp. +62 21 7967683 (Hunting) Fax. +62 21 7967686
e-mail: product@mersifarma.com, www.mersifarma.com

Lithium

Epilobium angustifolium "purple" resembles the "white" flowers! Many events have occurred that do not necessarily correspond to NAD.

serangan. Setelah merupakan serangan itu yang berakibat timbulnya serangan dengan gejala muntah, kejang, demam, dan sebagainya, biasanya serangan ini dapat berlangsung lama.

Amara gaudet quia non audit
Miserat in perditionem regni sine numero mercedemque sine

Penelitian ini bertujuan untuk mengetahui pengaruh dari faktor-faktor yang mempengaruhi perilaku kesehatan masyarakat di lingkungan rumah sakit.

Typische den jeweiligen Nischen zugehörige Merkmale:

bertindak sebagai masyarakat yang utuh dan mandiri, dengan cara mengembangkan kemampuan diri, sikap, dan perilaku yang bertanggung jawab.

2. **important type 3**
 Akibat terganggunya kemampuan mikulide organik, yang disebut sebagai *low Nucleoside* akibat tidak adanya kofaktor transkripsi yang dibutuhkan

A. Cystitis/nyeri
 infeksi merupakan infeksi "UTI" kandi yang lebih dari pada infeksi saluran kemih yang bersifat umum (memerlukan gangguan ginjal yang berat dan lama dan tidak dapat sembuh dengan antibiotik).¹

PENGALAMAN PENGGUNAAN LITHIUM DI 3 RSU INDONESIA
(Denny Thing, Marcellian Siregar, Gerald Marni Saman, Yungly, Santabel R, Kintanta, Betty Marga Agustina, Wungty Thiorbet)

"The unavailability of Lithium Carbonate which is still seen as a first line in therapy and prevention of manic is an essential disadvantage for Psychiatrist. That is why a study using Lithium Carbonate in five various hospitals in Indonesia conducted by Prof. Dr. Karyawati Setyaningsih, was recently conducted to establish its safety in poorer settings."

Penelitian ini dilakukan untuk memberikan gambaran awal kepada para dokter dalam menggunakan literatur, karena sangat sedikit. Literatur juga dapat sangat membantu dalam meningkatkan pengetahuan dan keahlian pengetahuan mengenai obat yang digunakan.



Abstract: This study is a 30-day diary of mothers' beliefs for monitoring their children's behavior.



FRIMANIA®
Lithium Carbonate 200 mg Tablet
Lithium Carbonate 400 mg Tablet

[illegible]

anatomical and physiological differences between subjects and the study design, and the possibility of confounding by other factors, such as the use of a single dose of the drug.

[illegible]

Penalties
 For the first time, the company has a financial officer who is responsible for the company's financial reporting. The company is also responsible for the company's financial reporting.

1. **Identify the problem.** The first step is to identify the problem. This is often the easiest step, but it is important to be clear about what the problem is.

Source: authors and ILO estimates

[illegible]

A black and white portrait of a woman with dark, shoulder-length hair. She is looking directly at the camera with a neutral expression. She is wearing a dark, high-necked garment. The background is a light, textured surface.

mersi
Good Quality Improves Life's Quality

ZOLMER®

ZOLPIDEM TARTRATE 10 MG

**Sleep better,
wake refreshed**



FOR HEALTH CARE PROFESSIONAL ONLY



ZOLMER®

ZOLPIDEM TARTRATE 10 MG



Effective
Proven to help you fall asleep faster & stay asleep longer, improving overall sleep quality.¹



Tolerable
Effective reducing Sleep Latency and increasing Total Sleep Time without significant negative effect used in elderly patient.²

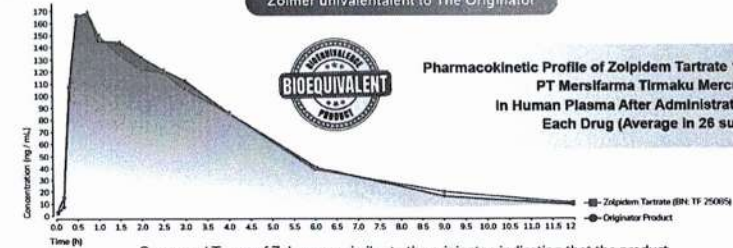


Optimal Duration
Short elimination half-life supports effective nighttime sleep while minimizing daytime carry-over effects.³



Refreshed Morning
Minimal dizziness effect for next-day functioning.⁴

Zolmer univalent to The Originator



C max and T max of Zolmer are similar to the originator, indicating that the product has a therapeutic effect equivalent to the originator

PRODUCT INFORMATION



Composition

ZOLMER® contains Zolpidem 10 mg.



Packaging

Box, 3 strips @ 10 film coated tablet



Indication & Adult Dosage

- Adults
10 mg once daily immediately before bedtime
- Elderly
recommended starting dose 5 mg before bedtime
- Prevention of recurrence in bipolar disorder
- Initial dose: 10 mg/day



NIE

ZOLMER® : DKL2633319817A1
• Use the lowest effective dose & follow physician recommendation.

Source:

1. Xiang T, et al. Efficacy and safety of zolpidem in the treatment of insomnia disorder: A meta-analysis of randomized controlled trials. Sleep. 2021;87:250-256.
2. Scharner V, et al. Efficacy and safety of Z-substances in the management of insomnia in older adults: a systematic review. BMC Geriatrics. 2022.
3. Edinoff AN, et al. Zolpidem: Efficacy and Side Effects for Insomnia. Health Psychology Research. 2021.
4. Undén M, Roth-Schlechter B. Next Day Effects After Nighttime Treatment with Zolpidem: A Review. European Psychiatry. Published online 2020.

*Please refer to the Product Insert for complete prescribing information

Authorized Distributors of Mersifarma:



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TREATMENT OF COEXISTING CONDITIONS

PREGNANCY

[B] Pharmacological therapy

- Antipsychotics
 - Haloperidol
 - Lurasidone
 - Quetiapine

SUBSTANCE USE DISORDERS

[B] Pharmacological therapy

Alcohol dependence

- Clozapine ✓

[C] Adjunctive pharmacological therapy

Tobacco use

- Bupropion
- Nicotine replacement therapy
- Varenicline

SUICIDE RISK

- Address underlying biopsychosocial factors eg suicide attempts w/ depression

[B] Pharmacological therapy

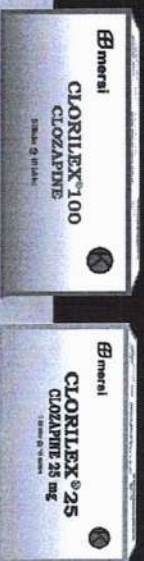
- Clozapine

Reference: Keepers GA, Fochtmann LJ, Anzia JM et al. The American Psychiatric Association practice guideline for the treatment of patients with schizophrenia. *Am J Psychiatry*. 2020 Sep 1;177(9):868-872; Galletly C, Castle D, Dark F, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Aust N Z J Psychiatry*. 2016 May;50(5):410-472.

CLORILEX®

Clozapine 25 mg & 100 mg

DECREASE SUICIDE RISK IN PATIENT WITH SCHIZOPHRENIA



- Clorilex® efektif menurunkan resiko terjadinya bunuh diri.
- Clorilex® secara konsisten menunjukkan keunggulan pada pasien yang mengalami resisten skizofrenia di bandingkan golongan antipsikotik lainnya.
- Clorilex® terbukti memperbaiki gejala positif & negatif pada penderita.
- Clorilex® terbukti meningkatkan fungsi kognitif penderita skizofrenia
- Clorilex® memiliki efek sedasi yang kuat.

B. Meris

Good Quality / Improves Life's Quality

CLORILEX®

Clozapine 25 mg & 100 mg

KOMPOSISI

Tiap tablet CLORILEX 25 mengandung Clozapine 25 mg
Tiap tablet CLORILEX 100 mengandung Clozapine 100 mg

INDIKASI

Penderita skizofrenia yang tidak memberi respon atau intoleransi terhadap neuroleptik.

POSOLOGI / DOSIS

Dosis yang diberikan disesuaikan dengan tiap individu penderita.
Tiap pasien harus menggunakan dosis efektif terendah.

Dosis pemberian secara oral sesuai dengan petunjuk :

Terapi awal : 12,5 mg (½ dari tablet 25 mg) 1 kali atau 2 kali per hari, diikuti dengan dosis sebesar 1 atau 2 kali tablet Clorilex 25 mg pada hari kedua. Jika toleransi yang dihasilkan baik, dosis per hari dapat ditingkatkan secara perlahan dengan penambahan sebesar 25-50 mg sesuai petunjuk sampai tercapai dosis sebesar 300 mg/hari dalam waktu 2-3 minggu. Kemudian, jika diperlukan, dosis per hari dapat ditingkatkan lebih lanjut dengan penambahan sebesar 50-100 mg pada setengah minggu.

Dosis terapi : pada kebanyakan pasien, khasiat antipsikotik dapat diharapkan tercapai dengan dosis sebesar 200-450 mg/hari diberikan sebagai dosis terbagi. Beberapa pasien membutuhkan dosis sampai 600 mg/hari. Dosis total perhari dapat diberikan sebagai dosis terbagi yang tidak sama rata dosis pemberiannya, dengan dosis terbesar diberikan saat tidur malam.

Dosis maksimum : untuk memperoleh efek terapi yang lebih menguntungkan, beberapa pasien membutuhkan dosis lebih besar, penambahan dosis yang bijaksana masih diperbolehkan sampai dosis 900 mg/hari. Harus dipikirkan kembali kemungkinan meningkatnya efek samping (pada serangan particular) yang dapat terjadi pada pemberian dosis sebesar > 450 mg/hari.

Dosis pemeliharaan : setelah dosis terapi maksimum tercapai, penderita dapat secara efektif menurunkan dosis pemberian. Tindakan pemeliharaan harus dilakukan selama paling sedikit 6 bulan. Jika dosis per hari tidak lebih dari 200 mg, pemberian dosis tunggal pada malam hari harus tepat.

Terapi akhir : dianjurkan untuk mengurangi dosis secara bertahap selama 1 sampai 2 minggu. Jika pemberian perlu dihentikan secara mendadak (misalnya karena leukopenia), harus diamati secara seksama timbulnya gejala psikotik pada pasien.

Terapi ulangan : pada penderita yang interval pemberian dosis akhir Clozapine lebih dari 2 hari, pemberian obat harus mulai kembali dengan dosis 12,5 mg (½ dari tablet 25 mg) yang diberikan 1 atau 2 kali pada hari pertama.

B. Meris

Good Quality / Improves Life's Quality

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1 SIGNS & SYMPTOMS

- Schizophrenia is a devastating mental illness characterized by symptoms of hallucinations, disorganized thinking, loss of goal-directed behaviors & deterioration in social role functioning
- It has approximately 0.3-0.7% lifetime prevalence but there are reported variations by race/ethnicity, across countries & by geographic origin
 - In a 2012 incidence review in England, there is a pooled incidence of 15 per 100,000 persons between 1950 & 2009 w/ rates varied according to age & gender
- It has a lifetime risk of suicide of 7%
- It is equally prevalent in men & women

Positive Symptoms

- Delusions
- Formal thought disorder
- Distorted perceptions/perceptual disturbances

Negative Symptoms

- Flat or blunted emotions
- Lack of motivation or energy
- Lack of pleasure or interest in things
- Limited speech

Disorganized Symptoms

- Confused thinking & disorganized speech
- Disorganized behavior

Cognitive Symptoms

- Impairment in verbal fluency, memory, executive functioning

2 DIAGNOSIS

- Patient should have a thorough initial work-up which may include, but is not limited to, the following:
 - Complete psychiatric & general medical histories
 - Physical & mental status exams
 - Interviews w/ family members or close contacts (especially important if patient is unable to provide a reliable history)
 - Neurologic exam
 - Urine screen to assess for alcohol or drug abuse
 - Blood levels of antipsychotic medication
 - Basic labs: Complete blood count (CBC), blood electrolytes, glucose & liver, renal & thyroid function
 - If indicated & permissible: Test for human immunodeficiency virus (HIV) status, syphilis test

Diagnostic Criteria

- Based on DSM-5-TR diagnostic criteria, diagnosis of schizophrenia can be made if the patient has experienced at least 2 of the following symptoms for a significant time during a 1-month period (or less if successfully treated):
 - Delusions
 - Hallucinations
 - Disorganized speech
 - Grossly disorganized or catatonic behavior
 - Negative symptoms like reduced emotional expression or avolition
- The above symptoms should have at least any accompanying delusions, hallucinations or disorganized speech
- DSM-5-TR also added the following criteria in diagnosing schizophrenia:
 - Continuous occurrence of the disturbance for at least 6 months w/ at least a month of active symptoms (or less if successfully treated)
 - The patient's level of functioning socially or occupationally is deteriorating over a significant amount of time
 - Other conditions such as schizoaffective disorder & depressive or bipolar disorder w/ psychotic features have been ruled out
 - Occurrence of symptoms is not related to physiological effects of a substance or another medical condition

2 DIAGNOSIS (CONT'D)**Diagnostic Criteria (Cont'd)**

- In cases of childhood onset communication disorder or a history of autism spectrum disorder an additional diagnosis of schizophrenia can only be made if together w/ the required symptoms of schizophrenia there are prominent delusions or hallucinations
- According to DSM-5-TR, after a year of having schizophrenia, the disorder can be specified as:
 - First episode, currently in acute episode where the initial manifestation of the disorder met the criteria & presenting in acute time period
 - First episode, currently in partial remission where there was improvement of symptoms in a period of time after previous episode
 - First episode, currently in full remission where there was improvement of symptoms in a period of time after previous episode in which no symptoms specific to schizophrenia is present
 - Multiple episodes, currently in acute episode where at least two episodes occurred
 - Multiple episodes, currently in partial remission
 - Multiple episodes, currently in full remission
 - Continuous where diagnostic symptoms remain for the majority of the course of the disorder w/ very brief threshold symptom periods
 - Unspecified
- Specify if the symptoms have catatonia
- Specify also the current severity (Note: Diagnosis of schizophrenia can be made without using this specifier)
 - Primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior & negative symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from zero (not present) to four (present & severe)

3 ALTERNATIVE DIAGNOSIS**Psychiatric**

- Schizophreniform disorder
- Schizoaffective disorder
- Bipolar disorder
- Major depression w/ psychotic features
- Delusional disorder

Medical

- Psychosis due to previous cerebrovascular accident or traumatic brain injury
- Psychosis associated w/ a major neurocognitive disorder (eg Alzheimer's disease, Parkinson's disease)
- Psychosis due to metabolic errors or infection (eg Wilson's disease, porphyria, syphilis or HIV infection)
- Psychosis due to known genetic disorders

A NON-PHARMACOLOGICAL TREATMENT**Acute Phase Treatment****Treatment Settings**

- Outpatient versus inpatient treatment will depend on assessment of patient's safety, safety of others & the patient's level of functioning
- Inpatient treatment is indicated if the patient has a serious threat of harm to self or others, unable to care for self or needs constant supervision

Psychiatric Management

- Goals: Prevent harm, control disturbed behavior, suppress symptoms & return to the best level of functioning
- Build a therapeutic alliance w/ the patient & the patient's family
- Educate the patient (to the best of their level of understanding) & the patient's family/caregiver about the illness
- Establish short- & long-term treatment plans

Psychosocial Interventions

- Goals: Reduce overstimulating or stressful environments, relationships or life events
- Promote reduced disease arousal by giving simple, clear communications & expectations
- Help provide a structured & predictable environment which includes low performance requirements
- Help to establish non-demanding, supportive relationships between the patients & their treatment team

Repetitive Transcranial Magnetic Stimulation (rTMS)

- May be used in patients w/ principally auditory hallucinations
 - Effective in reducing frequency & intensity of auditory hallucinations, & improved quality of life

Stabilization Phase**Psychiatric Management**

- Goals: Minimize stress on the patient & provide support to minimize chances of relapse
- Assist in the patient's adaptation to life in the community
- Help in maintaining the continued reduction of symptoms & consolidation of remissions
- Continue to educate the patient about the course & outcome of the illness
- Promote adherence to treatment regimen by educating the patients & their families about the chances of relapse w/ discontinuation of medication

Psychosocial Interventions

- Psychoeducation to promote compliance & address causes of non-adherence to medications
- Start on social & community interventions
 - Therapeutic community interventions
 - Rehabilitation eg social skills training, vocational training, cognitive-behavioral therapy (CBT), cognitive remediation therapy (CRT)
 - Self-help groups formed by patients, self-treatment organizations & relative organizations (formed mostly by patients' parents)
- Individual therapy
 - Supportive & insight-oriented
 - Individualized approach based on clinical condition, coping capabilities & preferences
- Family interventions
 - Involve the family in treatment planning, goal setting & service delivery
 - Provide education, support, guidance & training to assist family members fulfill their role as caregivers
 - Support groups for families should be suggested
 - 10 sessions for a period of 3 months should be considered as the minimum effective dose
- Group therapy
 - Group psychotherapy & support groups help enhance problem solving, goal planning, social interactions & medication side effects

B PHARMACOLOGICAL THERAPY**General Treatment Principles**

- Choice of agent will be based on STEPS principle which means Safety, Tolerability, Efficacy, Price, Simplicity
 - Will also consider side-effect profile, prior response history of patient or family member, patient preference, & intended route of administration
- Maximize benefits of pharmacological therapy & minimize side effects
- Monotherapy is preferred & polypharmacy should be avoided
- For patients in the first episode of schizophrenia, aim for the lower end of the therapeutic effective dose range of antipsychotics then titrate according to efficacy & tolerability
- Antipsychotics remain the primary treatment for schizophrenia
 - Goal of resumption to baseline & maximal functioning, good quality of life, prevention of recurrence, integration back into the society
 - Use w/ caution in the elderly because of increased risk of mortality from sudden cardiac death & cardiovascular accidents
 - Older, first-generation antipsychotics are generally considered to have minimal risk of teratogenicity

Atypical Antipsychotics

- Also called second generation antipsychotics
- Atypical antipsychotics are now generally preferred over the conventional antipsychotics
- **Effects:** Have been found to be equivalent or superior to conventional antipsychotics for the treatment of psychotic symptoms & thought disorganization
 - Some may have superior effect on negative symptoms than conventional antipsychotic drugs
 - Most atypical antipsychotics have decreased likelihood of causing extrapyramidal symptoms (EPS) as in conventional antipsychotics w/ lower-potency dopamine D₂ neuroreceptor blockade (eg Chlorpromazine, Thioridazine, Perphenazine)
- All patients are recommended to have regular monitoring of weight, BMI, serum lipids & fasting glucose levels
 - Atypical antipsychotics have been shown to cause weight gain & metabolic side effects

Amisulpride

- Appears to have benefits against negative symptoms at lower doses & at higher doses tends to be more effective against positive symptoms
- Has favorable side effects profile, but can cause hyperprolactinemia & higher doses increase risk for extrapyramidal symptoms occurrence

Aripiprazole → SIABY

- Appears to be as effective as Haloperidol in the treatment of schizophrenia
 - May also be used for treatment of acute aggression in schizophrenia
- Extrapyramidal symptoms-related adverse effects have been shown to be comparable to placebo
- May have a higher risk of insomnia compared to conventional antipsychotics, but less risk of raised prolactin & prolongation of the QTc interval than other atypical antipsychotics

Brexipiprazole

- Has been shown to be effective as conventional antipsychotics w/ acceptable clinical profile & adverse effects
- Has lower risk for cardiac events than other atypical antipsychotics

Cariprazine

- A study has shown it to be effective in reducing negative symptoms of schizophrenia compared w/ Risperidone
- Associated w/ minimal effects on plasma prolactin level & weight gain

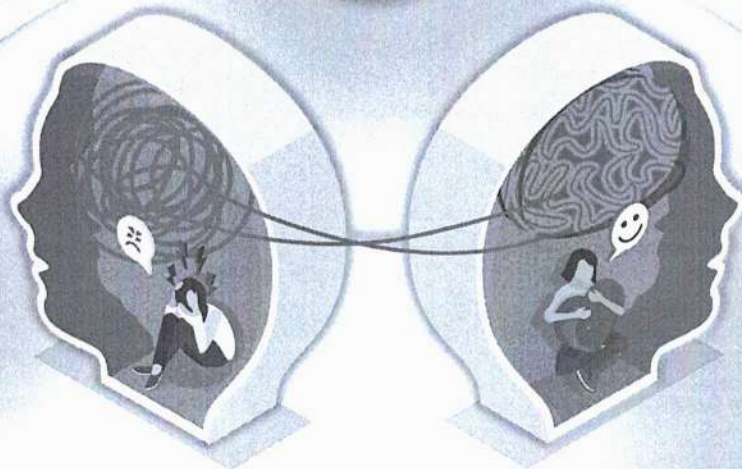
Clozapine → CLORILEX

- Has been shown to be useful in patients who do not respond to conventional antipsychotics
 - Superior to conventional antipsychotics in terms of symptom reduction & risk of relapse
- Drug of choice in the treatment of chronic & severe aggression in schizophrenia
 - Studies have shown that patients maintained on Clozapine had fewer aggressive episodes & less suicide attempts compared w/ other antipsychotics
 - Should be considered if there is significant & continuously increased risk of suicide
- May be used as an alternative treatment in patients who develop tardive dyskinesia from other antipsychotics
- In patients who were diagnosed to have both schizophrenia & alcohol use disorder, Clozapine seems to be effective in reducing craving & substance intake
- Avoid use in patients w/ history of seizure as it may lower seizure threshold
- Licensed for use only in treatment of refractory schizophrenia due to life-threatening side effect
 - Clozapine causes agranulocytosis in approximately 1% of patients
 - Regular & careful monitoring of white blood cell (WBC) count is necessary
- Recommended for use in treatment-resistant schizophrenia patients

*Not all products are available or approved for above use in all countries.
Specific prescribing information may be found in the latest MIMS.*

SIABY®

Aripiprazole Orally Disintegrating Tablet 10mg
Aripiprazole Oral Solution 1 mg/mL



RELIABLE ANTIPSYCHOTIC
for Sustained Mental Health Support

- Second generation antipsychotic.³
- Effective in the treatment of schizophrenia and as an adjunctive treatment for depression.^{1,2}
- Helps improve positive, negative symptoms, mood and overall quality of life.¹
- Ensures reliable treatment with lower risk of extrapyramidal, metabolic burden and prolactin elevation.³



INFORMASI PRODUK**

Komposisi	: Siaby Oral Solution	: Aripiprazole 1mg/ mL
	: Siaby Oradis	: Aripiprazole 10mg
Indikasi	: Skizofrenia, bIpolar mania, Terapi tambahan pada gangguan depresi mayor.	
Dosis Rekomendasi	: Skizofrenia - Dewasa	: 10 - 15 mg/ hari
	: Skizofrenia - Remaja	: 2 - 10 mg/ hari
	: Bipolar Mania - Dewasa	: 10 - 15 mg/ hari
	: Bipolar Mania - Pediatri	: 2 - 10 mg/ hari
	: Gangguan Depresi Mayor	: 2 - 5 mg/ hari
Kemasan	: Siaby Oral Solution	: Box, 1 Botol 150mL, Rasa Jeruk
	: Siaby Oradis	: Box, 1 Strip @ 10 Tablet Oral Terdisintegrasi

Nomor Izin Edar

Siaby Oral Solution	: DKL2433318435A1
Siaby Oradis	: DKL2433318681A1



Source:

- Mao Z, Dong F, Li A, Li F, Zhu J, Du X, Wu G, Deng H, Yu X, Liu J, Xie S, Tang X, Wang B. Effectiveness and safety of aripiprazole oral solution in the acute treatment of schizophrenia in Chinese patients. *BMC Psychiatry*. 2024 Dec 30;24(1):958. doi: 10.1186/s12988-024-06456-y. PMID: 39734272; PMCID: PMC11884757.
- Berman RM, Fava M, Thase ME, Trivedi MH, Swanink R, McQuade RD, Carson WH, Adson D, Taylor L, Harel J, Marcus RN. Aripiprazole augmentation in major depressive disorder: a double-blind, placebo-controlled study in patients with inadequate response to antidepressants. *CNS Spectr*. 2009 Apr;14(4):197-208. doi: 10.1017/S1092852900030246. PMID: 19407731.
- Keppers G, A, Fochtmann L, J., Anzili J, M., Benjamin S, Lyness J, M., ... Halibozel R. (2020). The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia. *American Journal of Psychiatry*. 177(8), 888-922. <https://doi.org/10.1176/appi.ajp.2020.177081>

**Untuk informasi lebih lengkap, mohon untuk dapat membaca insert produk

*for medical prescription only

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B PHARMACOLOGICAL THERAPY (CONT'D)**Atypical Antipsychotics (Cont'd)****Iloperidone**

- Studies have shown it to be effective in the acute & maintenance phase of therapy for schizophrenia
- It delays the time to relapse of symptoms of schizophrenia

Lumateperone

- Studies have shown that it appears to improve negative, positive & cognitive symptoms without causing significant metabolic derangements

Lurasidone

- A randomized, double-blind study revealed that Lurasidone is as effective as Olanzapine in improving positive & negative syndrome scale (PANSS) scores in acute psychotic schizophrenic patients
- Long-term treatment w/ Lurasidone has shown reduced risk of relapse in patients w/ schizophrenia
- Appears to be associated w/ minimal effects on body weight & low risk for clinically significant alterations in glucose, lipids or electrocardiogram parameters

Olanzapine → OLAPIN

- At least as effective as conventional antipsychotics
 - May also be used for treatment of acute or chronic aggression in schizophrenia
 - Improves negative symptoms, social functioning & depression
 - In a clinical trial, the combination of Olanzapine & Amisulpride has shown to be more effective in improving negative symptoms compared to monotherapy of either drug
- Generally well tolerated & has a lower risk of causing extrapyramidal symptoms
 - Major side effects are weight gain, hyperlipidemia as part of metabolic syndrome & hyperglycemia

Paliperidone

- Indicated for acute & maintenance treatment of schizophrenia in adults & adolescents (12-17 years of age) & adults w/ schizoaffective disorder
- It is not extensively metabolized in the liver
- Compared w/ other atypical antipsychotics, studies showed similar efficacy & lower odds of weight gain & undesirable metabolic side effects
- Major active metabolite of Risperidone

Quetiapine

- At least as effective as conventional antipsychotics in the treatment of schizophrenia
- One of the drugs that causes the fewest extrapyramidal symptoms
 - Orthostatic hypotension may occur during the initial titration period & at high doses
- May be used for the treatment of acute agitation

Risperidone → RISIDAL

- At least as effective as conventional antipsychotics
 - Used as maintenance treatment following acute episode of schizophrenia
 - May also be used for treatment of acute aggression in schizophrenia
- Caution is advised in the use in pregnancy due to the increased risk for fetal toxicity
- When used at recommended doses (<6 mg/day), it has very low rate of extrapyramidal symptoms
 - Higher doses increase risk of extrapyramidal symptoms
 - Hyperprolactinemia & postural hypotension may also occur

Ziprasidone

- At least as effective as conventional antipsychotics
 - May also be used for treatment of acute aggression in schizophrenia
 - Has been shown to have beneficial effects on symptoms of depression
- Has been associated w/ prolongation of the QT_c interval; dose needs to be adjusted based on therapeutic & side effects

*Not all products are available or approved for above use in all countries.
Specific prescribing information may be found in the latest MIMS.*

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Good Quality Improves Life's Quality

OLAPIN®

Olanzapine Tablet 5 mg & 10 mg

**Balance The Mind
Restore The Life**

OLAPIN® 5
Olanzapine
Film coated tablet 5 mg

OLAPIN® 10
Olanzapine
Film coated tablet 10 mg

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SIFA
BADAN POM

HALAL

GMP

PT MERSIFARMA TM

OLAPIN®

Olanzapine Tablet 5 mg & 10 mg



Fast Onset of Action

Provides rapid symptom relief, helping patients feel better sooner.¹



Minimal Drug Interactions

Lower potential for drug interactions for greater flexibility in treatment.^{1,2,3}



Provides Calming Effect

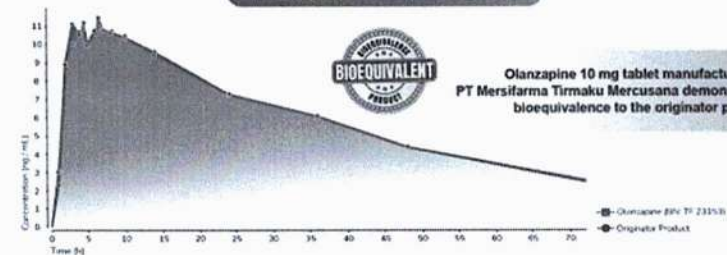
Induces a sense of calm & reduces anxiety, supporting emotional stability.⁴



Low Risk of EPS

Lower risk of extrapyramidal symptoms for better tolerability & adherence.¹

Olapin Bioequivalent to The Originator



C max and T max of Olapin are similar to the originator, indicating that the product has a therapeutic effect equivalent to the originator

PRODUCT INFORMATION



Composition

OLAPIN® 5 contains Olanzapine 5 mg
OLAPIN® 10 contains Olanzapine 10 mg



Indication & Adult Dosage

- Schizophrenia and related disorders
 - Initial dose: 10 mg/day
- Manic episode
 - Initial dose: 15 mg/day for monotherapy, 10 mg/day in combination therapy
- Prevention of recurrence in bipolar disorder
 - Initial dose: 10 mg/day
- Daily dose adjustment should be based on the individual patient's clinical status within the range of 5-20 mg/day.
- Dosage in other patient conditions may refer to the insert.



Packaging

Box, 3 strips @ 10 film coated tablet



NIE

OLAPIN® 5 : DKL2533319717B1
OLAPIN® 10 : DKL2533319717A1

Source:

1. Ashraf, R. A., Ashraf, E. S., Ashraf, A. M., Ashraf, D. P., Ashraf, A. M., Ashraf, A. T., Hakeem, B. M., Ashraf, A. R., Alwadi, F. H., Alwadi, M. H. (2024). Efficacy of Olanzapine in Enhancing Cognitive Functions in Psychiatric Disorders: A Systematic Review and Meta-analysis. *Journal of Advanced Trends in Medical Research*, 1(2), p. 205-208. DOI: 10.4732/ATMR.18124
2. Pevsner, J., Marder, C., Gerner, T., Gilman, B., & Van Vleet, B. (2006). Open study evaluating the onset of antipsychotic action of olanzapine in the treatment of patients with schizophrenia, schizophreniform or schizo-affective disorder. *International Journal of Psychiatry in Clinical Practice*, 11(6), 199-204. <https://doi.org/10.1080/13651560600600687>
3. Wiegman, P., Meehan, A., Bakker, M., Davis, S. A., Taylor, C. C., Morris, P., & Bressi, A. (2002). Smooth and safe transition from intramuscular to oral olanzapine. *European Psychiatry*, 17(5), 346-348. doi:10.1016/S0924-6460(02)00048-6

*Please refer to the Product Insert for complete prescribing information

FOR HEALTH CARE PROFESSIONAL ONLY

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B PHARMACOLOGICAL THERAPY (CONT'D)**Conventional/Typical Antipsychotics**

- Eg Haloperidol, Perphenazine, Molindone
- Also called conventional or first generation antipsychotics
- All antipsychotics in this class vary in potency & overall side effects profile, but have similar overall efficacy
- **Effects:** Patients demonstrate a decrease in positive symptoms, thought disorder, blunted affect, withdrawal retardation & autistic behavior
 - 60% of patients treated for 6 weeks w/ conventional antipsychotics achieve complete remission or experience only mild symptoms
 - All conventional antipsychotics can cause a broad range of side effects due to their effects on receptors other than the target therapeutic site including extrapyramidal symptoms & tardive dyskinesia

Chlorpromazine → CEPEZET

- Is a prototype antipsychotic
- Studies have shown its usefulness in prevention of relapse as well as part of maintenance therapy
- May be used in patients w/ concomitant psychosis & insomnia

Fluphenazine → SIKZONDATE

- Long-acting preparation used for maintenance therapy
- Has minimal sedative, anticholinergic & weight gain effects

Haloperidol → LODMER

- Has been shown to be useful in the management of acute aggression in schizophrenia
 - Most commonly used conventional antipsychotic in the emergency room setting
 - May be first-line agent in acute aggression especially if affordability is an issue
 - Cheaper compared w/ atypical antipsychotics
- Benzodiazepine may also be administered w/ Haloperidol to enhance the sedative effect

Loxapine

- Has been shown to be useful in the management of psychotic agitation in schizophrenia
- Has an aerosol formulation that is capable of reaching deep lung tissues

Molindone

- Studies have suggested that Molindone may be equally effective as atypical agents
 - A clinical trial, comparing Molindone w/ Risperidone & Olanzapine in pediatric patients w/ early-onset schizophrenia & schizoaffective disorder, showed no significant difference in terms of reduction of symptom severity

Perphenazine

- Studies have suggested that Perphenazine may be equally effective as atypical agents
 - A clinical trial, comparing Perphenazine w/ Risperidone, Olanzapine, Quetiapine & Ziprasidone in adult patients, showed Olanzapine was most effective in terms of rates of discontinuation, but overall efficacy was similar among the drugs; extrapyramidal symptoms were uncommon & metabolic side effects were mostly seen in Olanzapine use
- For some patients, conventional agents such as Perphenazine may be an appropriate first-line treatment

Route of Administration**Oral**

- Typically used for acute & maintenance treatment
- Reaches peak concentration in 2-3 hours which gives a calming effect
 - May take several days-weeks to see the true antipsychotic effects

Short-Acting IM

- Quick onset of action is an advantage when calming effects are needed to treat agitation
- Peak concentration is reached in 30-60 minutes after administration

Depot Formulations (Long-acting Injectable)

- Recommended for patients who have trouble taking oral medications reliably, who deny illness or who have poor insight or for those who prefer depot
- Limited number of conventional & atypical antipsychotics are available in this form
- Require 2-4 months to reach steady-state therefore seldom used alone during acute treatment when the dose needs to be adjusted based on therapeutic & side effects

*Not all products are available or approved for above use in all countries.
Specific prescribing information may be found in the latest MIMS.*

25. *Journal of the American Medical Association*, 277, 1996, 1211-1212.

Long Acting ANTISCHIZOPHRENIC to Improve Patient's Compliance



- ✓ Improve patient's comfort as well as decrease cumulative antipsychotic exposure, without increasing relapse rates or symptoms.
- ✓ Once injection for a month or longer.
- ✓ Cost effective.

mersi
Good Quality Improves Life's Quality

KOMPOSISI

Tiap mL mengandung :
Fluphenazine Decanoate BP 25 mg

INDIKASI

Fluphenazine Decanoate digunakan untuk penggunaan jangka panjang pada gangguan psikotik (misalnya, penderita skizofrenia kronis). Fluphenazine Decanoate belum terbukti efektif pada penggunaan untuk perilaku yang kompleks pada pasien dengan keterbelakangan mental.

Catatan : Fluphenazine Decanoate tidak dimaksudkan untuk penggunaan gangguan non-psikotik atau untuk terapi jangka pendek (<3 bulan).

POSOLOGI/DOSES

Fluphenazine Decanoate dapat diberikan melalui intramuskular atau rute subkutan. Alat suntik dan jarum suntik yang digunakan harus dalam keadaan kering yang mampu menekan minimal 21 gauge. Bila menggunakan spuit atau jarum yang basah, larutan injeksi akan mengidri ketuk.

Gangguan Psikotik :

Pasien dewasa

Pasien gelisah berat :

Pasien-pasien baru memerlukan pengobatan awal yang bersifat cepat dari senyawa gugus Phenothiazine seperti Fluphenazine HCl injeksi. Ketika gejala akut telah mereda, 25 mg (1 mL) Fluphenazine Decanoate bisa diberikan, kemudian dosis disesuaikan dengan kebutuhan.

Dosis awal : Bagi sebagian besar pasien, dosis 12,5 – 25 mg (0,5 – 1 mL) dapat diberikan untuk awal terapi. Pemberian injeksi dan interval dosis berikutnya ditentukan sesuai dengan respon pasien.

Terapi pemeliharaan : Injeksi tunggal efektif dalam mengontrol gejala skizofrenia sampai 4 minggu atau lebih. Respon dosis tunggal telah diketahui berlangsung selama 6 minggu di beberapa pasien pada terapi pemeliharaan. Dosis tidak boleh melebihi 100 mg. Jika dosis lebih besar dari 50 mg sudah dianggap penuh, maka dosis berikutnya harus diturunkan secara hati-hati dengan penambahan sebesar 12,5 mg secara berturut-turut.

Pasien anak-anak

Dosis dalam rentang yang lebih rendah (1/4 – 1/2 dari orang dewasa muda) kemungkinan cukup untuk pasien lanjut usia. Disarankan kepada pasien yang tidak memiliki sejarah terhadap pengobatan Phenothiazine pada awal pengobatan harus diawasi Fluphenazine dalam short-acting (bentuk sediaan Fluphenazine HCl) sebelum pemberian Fluphenazine Decanoate untuk menentukan respon pasien terhadap Fluphenazine dan untuk menetapkan dosis yang tepat.

Konversi dari Fluphenazine short-acting : Tidak ada formula yang tepat dapat diberikan untuk mengkonversi dari short-acting obat ini menjadi pada penggunaan Fluphenazine Decanoate namun, sebuah studi multicenter terkontrol pada pasien yang menerima dosis oral 5-60 mg Fluphenazine HCl sehari, menunjukkan bahwa dosis harian 20 mg Fluphenazine HCl setara dengan 25 mg (1 mL) Fluphenazine Decanoate setiap 3 minggu. Ini merupakan perkiraan bahwa 20 mg Fluphenazine HCl setiap hari sebanding dengan 25 mg (1 mL) Fluphenazine rasio konversi 0,5 mL (12,5 mg) Fluphenazine Decanoate setiap 3 minggu untuk setiap 10 mg dari Fluphenazine HCl harian.

Pasien resiko terkecil : Untuk pasien dengan hipersensitivitas terhadap Phenothiazine, timbul tanpa hasil yang dapat dipertahankan atau dengan gangguan mempengaruhi reaksi yang tidak beres, terapi dapat dimulai dengan Fluphenazine HCl pemberian oral atau pemberian dengan hati-hati. Ketika efek farmakologis dan dosis yang diinginkan telah tercapai, dosis setara dengan Fluphenazine Decanoate bisa diberikan dengan penyelesaian dosis berikutnya dilakukan sesuai dengan respon pasien.

KONTRADIKASI

Pasien pingsan, gangguan hati, penyakit kuning, gangguan ginjal, gangguan otak, marked cerebral atresia, phaeochromocytoma, gangguan jantung, kondisi depres, keadaan disritmia darah, dan riwayat hipersensitivitas terhadap bahan-bahan sediaan tersebut.

Dua, 5 ampul @ 1 mL SIKZONATE Injeksi, No. Reg. DMD 1034100143A1

PT. MERSIFARMA TM
Wilaya Tiera 4th Floor, Jl. Raya Pasar Minggu Km. 18 No. 17
Jakarta 12560 Indonesia

LODOMER

Haloperidol Tablet 2 mg & 5 mg, Haloperidol 5mg/ml Injection
Haloperidol 2mg/ml Drops



**COVER EVERYTHING
YOU NEED**

*for medical prescription only

- **Sediaan Lengkap fleksibilitas dalam pemberian dosis.¹**
- **Dapat digunakan untuk Fase akut, kronis ataupun maintenance pada skizofrenia.^{1,2}**
- **Aman karena EPS rendah.³**



INFORMASI PRODUK**

Komposisi

- Lodomer 2 - Haloperidol 2 mg
- Lodomer 5 - Haloperidol 5 mg
- Lodomer Drops - Haloperidol 2 mg/15 ml
- Lodomer Injection - Haloperidol 5 mg/ml

Indikasi

Skizofrenia. Sebagai antipsikotik untuk mengatasi agitasi, psikomotor dan ketidaksi-tabilan perilaku.

Dosis Rekomendasi

Dosis Dewasa

Gajala Sedang	0,5-2 mg, 2-3 kali sehari
Gajala Berat	3-5 mg, 2-3 kali sehari
Pasien gerak/tentak, kondisi lemah	sekitar 0,5-2 mg, 2-3 kali sehari
Pasien kronis atau resisten	3-5 mg, 2-3 kali sehari

Jika efek terapeutik belum mencukupi, terutamanya pada pasien yang kurang responsif terhadap dosis rendah, maka dosis dapat ditingkatkan. Dalam beberapa kasus, dosis yang lebih tinggi mungkin diperlukan.

Anak-anak, usia 3-12 tahun berat badan 15-40 kg)

Dosis awal: 0,5 mg, 2-3 kali sehari, atau lebih rendah bila merangsang. Dosis dapat ditingkatkan secara bertahap sampai tercapai efek terapeutik yang diinginkan. Tidak direkomendasikan untuk anak di bawah usia 3 tahun.

Kemasan

- Lodomer 2 - Box, 10 strips @ 10 tablet LODOMER 2, No. Reg. DK.03330617A1
- Lodomer 5 - Box, 10 strips @ 10 tablet LODOMER 5, No. Reg. DK.03330617B1
- Lodomer Drops - Box, bottle @ 15 mL LODOMER DROPS, No. Reg. DK.03330503A1
- Lodomer Injection - Box, Ampul @ 12 LODOMER INJ, No. Reg. DK.03330403A1



1. Haloperidol, in: Stahl SM, Yudofsky M, eds. Textbook of Clinical Psychopharmacology, 4th ed. Washington, DC: American Psychiatric Press; 2002: 247-257.
2. Cui Y, Liu X, Wang J, et al. The efficacy and safety of haloperidol in the treatment of schizophrenia: a meta-analysis. J Clin Psychopharmacol. 2004;24(2):149-154.
3. Marder SR, Marder DR. Neuroleptic side effects: a review. J Clin Psychiatry. 1999;60(1):1-10.
4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC: American Psychiatric Association; 1994: 41-42.

**Untuk informasi lebih lengkap, mohon untuk dapat membaca brosur produk

PT. Tiara Kencana

- ☎ Surabaya (031) 31 64 4106
- ☎ Yogyakarta (0271) 24 2277
- ☎ Bandung (021) 74 74 2399
- ☎ Jakarta (021) 74 74 2399

Centrifuge dan yang lainnya akan
dijual secara terpisah.



PT. MESQUASMA TM

Wisma Tuna 4th Floor
Jl. Raya Pasar Minggu km. 18 No. 17, Jakarta 12510 Indonesia
Telp. +62 21 7987683 (Hunting) Fax. +62 21 7987688
e-mail: product@mesquasma.com, www.mesquasma.com

C ADJUNCTIVE PHARMACOLOGICAL THERAPY & PHARMACOLOGICAL THERAPY FOR ADVERSE REACTIONS TO ANTIPSYCHOTICS

Adjunctive Medications¹

- It may be necessary to use additional medications along w/ antipsychotics
 - Adjuncts (eg anticholinergic agents) may be used to treat side effects caused by antipsychotics
 - Other adjuncts may be used to treat refractory psychotic symptoms, comorbidities or nonpsychotic symptoms eg agitation, anxiety & depression

Anticholinergic Agents

- **Effect:** Effectively treat extrapyramidal symptoms due to antipsychotics
 - May be added to atypical antipsychotics to treat extrapyramidal symptoms or excessive salivation due to Clozapine

Antidepressants

- Depressive symptoms are usually treated after acute psychosis has been treated w/ antipsychotics
 - Use antidepressants w/ caution in the acute phase of illness since they may exacerbate psychotic symptoms
- **Effect:** Effectively treat residual (post-psychotic) depressive symptoms

Benzodiazepines

- Effects tend to be most useful in the acute management phase
- **Effects:** Treat agitation, insomnia, catatonia, anxiety, akathisia & other concomitants of schizophrenia

Beta-Blockers

- **Effect:** Treat akathisia due to conventional antipsychotics

Bupropion

- It has been shown to be effective in people w/ schizophrenia who also smoke tobacco, particularly when combined w/ nicotine replacement therapy
- Should be offered to schizophrenia patients who want to reduce or quit smoking
- May lower epileptic threshold

Mood Stabilizers

- **Lithium** → **PRIMANIA**
 - Used to stabilize mood & reduce excitement in patients treated w/ antipsychotics
 - **Effect:** Has been shown to augment the antipsychotic response when added to conventional antipsychotic medications
- Valproate & Carbamazepine
 - **Effects:** Stabilize mood & help reduce persistent agitation in schizophrenia

Varenicline

- May be offered to schizophrenia or psychotic patients who want to reduce or quit smoking
- Carries the risk of developing mood swings during treatment

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

- Eg Deutetrabenazine, Tetrabenazine, Valbenazine
- May be given to patients w/ disabling tardive dyskinesia secondary to effects of antipsychotic medications
- Acts effectively in lessening the motor aspect of tardive dyskinesia

¹There are many medications that can be used as adjuncts to antipsychotics. Specific prescribing information may be found in the latest MIMS.

Dosage Guidelines

ATYPICAL/2ND GENERATION ANTIPSYCHOTICS		
Drug	Dosage	Remarks
Benzamides		
Amisulpride	400-800 mg/day PO divided 12 hrly Max dose: 1200 mg/day For patients w/ predominantly negative symptoms: 50-300 mg PO 24 hrly	Adverse Reactions • Same as Chlorpromazine, see page 22 • Sleep disturbances, agitation, over stimulation, less commonly GI effects; hyperprolactinemia has occurred • CNS effects (insomnia, anxiety, agitation, acute dystonia); GI effects (N/V, dry mouth, constipation); CV effects (hypotension, QTc prolongation); Other effect (wt gain) • If EPS occurs it is generally mild; tardive dyskinesia has been reported w/ long-term therapy • Less likely to cause sedation & hypotension; antimuscarinic effects are minimal Special Instructions • Same as Chlorpromazine, see page 22
Clozapine	Initial dose: 1st day: 12.5 mg PO 12-24 hrly 2nd day: 25-50 mg/day PO Increase dose at 25- to 50-mg increments up to: 300-450 mg/day PO in divided doses within 14-21 days If necessary, further increases may be made at 50- to 100-mg increments at once- or twice-wkly intervals up to: Max dose: 900 mg/day Once a therapeutic response is reached, may gradually decrease dose to: Maintenance dose: 200-450 mg/day PO	Adverse Reactions • Granulocytopenia & agranulocytosis w/ the majority of cases occurring within the 1st 18 wk of therapy; monitoring of WBC is necessary • CV effects (tachycardia, orthostatic hypotension, ECG changes, hypertension, hypotension); GI effects (dry mouth, hypersalivation, constipation, wt gain, diarrhea, abdominal discomfort, N/V); CNS effects (drowsiness, sedation, dizziness, headache, decrease in seizure threshold, syncope); Other effect (fatigue) • EPS including tardive dyskinesia rarely occur, little effect on prolactin secretion Special Instructions • Before starting Clozapine, WBC w/ differential must be taken, only patients w/ normal WBC count $\geq 3500/\text{mm}^3$ & absolute neutrophil count (ANC) $\geq 2000/\text{mm}^3$ should receive the drug • WBC & ANC need to be monitored wkly for the 1st 18 wk of therapy, then mthly thereafter. Discontinue drug if WBC $< 3000/\text{mm}^3$ or ANC $< 1500/\text{mm}^3$ • Avoid in patients w/ uncontrolled epilepsy, alcoholic or toxic psychosis, history of circulatory collapse or drug intoxication, bone marrow suppression, myeloproliferative disorders or in any abnormalities of WBC or differential count • Avoid in patients w/ history of drug-induced neutropenia or agranulocytosis, patients w/ severe renal impairment, liver disease or severe heart failure • Use w/ caution in patients w/ mild-moderate renal impairment

All dosage recommendations are for non-pregnant & non-breastfeeding women, & non-elderly adults w/ normal renal & hepatic function unless otherwise stated.

Not all products are available or approved for above use in all countries.

Products listed in the Dosage Guidelines are based on indications stated in locally approved product monographs.

Please refer to local product monograph in the latest copy of MIMS or in www.mims.com for country-specific prescribing information.

Dosage Guidelines

ATYPICAL/2ND GENERATION ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Benzisoxazoles		
Iloperidone	1 mg PO 12 hrly May titrate daily in increments of 2 mg PO 12 hrly until Target dose: 6-12 mg PO 12 hrly Max dose: 24 mg/day	Adverse Reactions - CNS effects (tremor, paresthesias, EPS, restlessness, tardive dyskinesia); CV effects (orthostatic hypotension, QTc prolongation); GI effects (nausea, dry mouth, abdominal discomfort); Ophthalmologic effect (blurred vision); Hematologic effects (neutropenia, leukopenia); Other effects (wt gain, hyperprolactinemia) Special Instructions - Use w/ caution in patients w/ CV & cerebrovascular diseases, DM, Parkinson's disease, renal & hepatic impairment, history of seizure, conditions predisposing to hypotension, blood dyscrasia - Use w/ caution in patients taking strong CYP3A4 or CYP2D6 inhibitors - Monitor CBC, LFT, fasting plasma glucose level/HbA1c, fasting lipid panel - Avoid abrupt withdrawal
Paliperidone	Adolescent (12-17 yr): 3 mg PO 24 hrly Adult: 6 mg PO 24 hrly Dose range: 3-12 mg/day PO May adjust dose at increments of 3 mg for at least 5 days interval Max dose: 12 mg/day	Adverse Reactions - GI effects (increased appetite, constipation, N/V, dysphagia); CNS effects (headache, insomnia, anxiety, lightheadedness, drowsiness); CV effects (QT prolongation, orthostatic hypotension); Other effects (hyperprolactinemia, neutropenia) - Incidence of EPS & somnolence is low w/ akathisia being the most commonly reported; tardive dyskinesia is infrequent Special Instructions - Same as for Chlorpromazine, see page 22 - Use w/ caution in patients w/ cardiac disease, hemodynamic instability, prior MI or ischemic heart disease, congenital long QT syndrome, Parkinson's disease, renal impairment, risk of seizure - For patients w/ mild to moderate hepatic impairment, no dose adjustment is needed

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Dosage Guidelines

ATYPICAL/2ND GENERATION ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Benzisoxazoles (Cont'd)		
Paliperidone palmitate	1-mth inj: 150 mg IM on day 1 then 100 mg IM a wk later Mthly maintenance dose: 25-150 mg Depending on the patient's tolerability &/or efficacy 3-mth inj: After adequate 4-mth therapy of 1-mth inj dose, the last 2 doses of the 1-mth inj dose should be the same dosage strength before initiating 3-mth inj therapy Start 3-mth inj therapy when the next 1-mth inj dose is scheduled w/ the dose based on the previous 1-mth inj dose which is equivalent to 3.5-fold higher dose as follows: 1-mth inj 50 mg = 3-mth inj 175 mg 1-mth inj 75 mg = 3-mth inj 263 mg 1-mth inj 100 mg = 3-mth inj 350 mg 1-mth inj 150 mg = 3-mth inj 525 mg May be administered up to 7 days before or after the mthly time point of the next scheduled 1-mth inj dose Following the initial 3-mth inj dose, administer it every 3 mth. Adjust the dose every 3 mth, if necessary, in increments within the range of 175-525 mg	Adverse Reactions - CNS effects (insomnia, headache, agitation, dizziness, tardive dyskinesia); CV effects (QT prolongation, orthostatic hypotension); Other effects (upper resp tract infection, wt gain, inj site pain) Special Instructions - First 2 inj are administered in the deltoid muscle - Maintenance dose may be administered either in the deltoid or gluteal muscle 3-mth inj therapy should only be started once the 1-mth inj therapy has been established for 4 mth - Contraindicated in patients w/ severe renal impairment, dementia-related psychosis - Use w/ caution in patients w/ history of seizure, Parkinson's disease - Discontinue use if severe neutropenia & neuroleptic malignant syndrome occur
Risperidone	Initial dose: 2 mg PO 24 hrly or divided 12 hrly May increase to 4 mg/day PO on 2nd day Adjust dose at increments of 1-2 mg/day at wklly intervals based on patient response; some patients may need a slower titration rate Dose range: 4-6 mg/day PO Max dose: 16 mg/day Long-acting IM: 25 mg IM every 2 wk Max dose: 50 mg IM every 2 wk	Adverse Reactions - Same as Chlorpromazine, see page 22 - Lower incidence of EPS & sedation than Chlorpromazine but agitation may occur more frequently - CNS effects (headache, somnolence, anxiety, agitation, dizziness, tardive dyskinesia); GI effects (dyspepsia, nausea, abdominal pain); CV effects (hypertension, orthostatic hypotension, tachycardia); Other effects (fatigue, restlessness) Special Instructions - Same as Chlorpromazine, see page 22

All dosage recommendations are for non-pregnant & non-breastfeeding women, & non-elderly adults w/ normal renal & hepatic function unless otherwise stated.

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Dosage Guidelines

ATYPICAL/2ND GENERATION ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Diazepines, Oxazepines, Thiazepines & Oxepines		
Asenapine	Acute treatment Initial dose: 5 mg sublingual 12 hrly Maintenance treatment Initial dose: 5 mg sublingual 12 hrly May increase to 10 mg sublingual 12 hrly after a week, based on tolerability	Adverse Reactions - CNS effects (somnolence, insomnia, headache, extrapyramidal symptoms, akathisia, dizziness, oral hypoesthesia, tardive dyskinesia); Endocrine effects (hypertriglyceridemia, hyperglycemia, hyperprolactinemia); CV effects (hypertension, tachycardia, orthostatic hypotension); Hematologic effects (agranulocytosis, thrombocytopenia); GI effects (constipation, vomiting); Other effects (peripheral edema, wt gain) - Potentially fatal: Neuroleptic malignant syndrome Special Instructions - Avoid in patients w/ severe hepatic impairment - Use is contraindicated in the treatment of dementia-related psychosis - Use w/ caution in patients w/ cerebrovascular disease, CV disease (prior MI or ischemic heart disease), Parkinson's disease, those w/ hemodynamic instability, patients w/ history or at risk for seizures, DM - Monitor CBC, HbA1c/fasting blood sugar, fasting lipid profile, LFTs
Olanzapine	Initial dose: 10 mg PO 24 hrly May gradually increase dose by 5-mg increments based on patient response Usual dose: 5-20 mg/day Max dose: 20 mg/day Short-acting IM: Initial dose: 5-10 mg IM as a single dose Followed by 5-10 mg IM after 2 hr Max dose: 3 inj/24 hr & no more than 20 mg/day for up to 3 days Follow w/ oral dose	Adverse Reactions - Same as Chlorpromazine, see page 22 - Low incidence of EPS, sedation, mild transient antimuscarinic effects may occur - CNS effects (somnolence, dizziness); GI effects (increased appetite, wt gain); CV effects (orthostatic hypotension); Other effects (hyperprolactinemia, elevation of plasma glucose, triglyceride, & liver enzymes, edema) Special Instructions - Same as Chlorpromazine, see page 22 - Patients receiving IM inj should be monitored closely for hypotension, bradyarrhythmia & hypoventilation for 2-4 hr after administration

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Dosage Guidelines

ATYPICAL/2ND GENERATION ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Diazepines, Oxazepines, Thiazepines & Oxepines (Cont'd)		
Quetiapine	Immediate-release tab: Day 1: 50 mg/day PO divided 12 hrly Day 2: 100 mg/day PO divided 12 hrly Day 3: 200 mg/day PO divided 12 hrly Day 4: 300 mg/day PO divided 12 hrly Followed by an increase in dose based on patient response to: Maintenance dose: 300-450 mg/day PO divided 12 hrly Max dose: 800 mg/day Extended-release tab: Day 1: 300 mg/day PO preferably at bedtime Day 2: 600 mg/day PO preferably at bedtime Dose range: 400-800 mg/day PO	Adverse Reactions - CNS effects (dizziness, somnolence, EPS, headache, sedation); GI effects (dry mouth, constipation, dyspepsia, nausea, tardive dyskinesia); CV effects (tachycardia, hypertension, syncope, orthostatic hypotension); Endocrine effects (increased cholesterol & blood glucose levels); Other effects (blurred vision, wt gain, peripheral edema, mild asthenia) Special Instructions - Use w/ caution in combination w/ centrally acting drugs & alcohol, in CV & cerebrovascular diseases, conditions predisposing to hypotension, in seizures, EPS & tardive dyskinesia, neuroleptic malignant syndrome, in patients w/ increased risk of suicidal thoughts, self-harm & suicide-related events - Monitor for suicidal ideation or clinical worsening, CBC, fasting lipid profile, fasting plasma glucose, LFT, thyroid function test - Avoid abrupt withdrawal
Zotepine	Initial dose: 25 mg PO 8 hrly May increase dose based on patient response every 4 days up to: Max dose: 300 mg/day Usual dose: 75-150 mg/day PO in divided doses	Adverse Reactions - CNS effects (agitation, anxiety, dizziness, lowered seizure threshold, headache); CV effects (prolongation of QT interval, hypotension); Other effects (asthenia, wt gain, uricosuria, blurring of vision, elevated LFT) - EPS & tardive dyskinesia w/ long-term treatment Special Instructions - Same as Chlorpromazine, see page 22 - Avoid in patients w/ known history of QT prolongation, gout or hyperuricemia - Monitor ECG, LFT & electrolytes during treatment - Use w/ caution in patients at risk of arrhythmias, those w/ history of coronary artery disease & severe hypertension - Avoid abrupt withdrawal

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Dosage Guidelines

ATYPICAL/2ND GENERATION ANTIPSYCHOTICS (CONT'D)

Drug	Dosage	Remarks
Indole Derivatives		
Lurasidone	Initial dose: 40 mg PO 24 hrly Max dose: 160 mg/day <u>For patients w/ moderate or severe hepatic or renal impairment:</u> Max dose: 40 mg/day	Adverse Reactions • Lower incidence of EPS than Chlorpromazine • Prolongation of QT interval (Lurasidone has minimal effects on QT interval) • CNS effects (insomnia, somnolence, headache, anxiety, agitation, EPS, tardive dyskinesia, akathisia, tremor); CV effect (tachycardia); GI effects (N/V, constipation, dry mouth, dyspepsia); Other effects (asthenia, fatigue, visual impairment) Special Instructions • Avoid in patients w/ known history of QT prolongation, arrhythmias, recent myocardial infarction (MI) or decompensated heart failure, elderly w/ dementia-related psychosis, Parkinson's disease, history of seizure • Use w/ caution in patients w/ electrolyte imbalances, taking other CNS depressants or alcohol, DM, renal or hepatic impairment • Monitor serum K & Mg prior to treatment & electrolytes in patients on diuretics • Patient should be instructed to report symptoms of torsade de pointes (eg dizziness, palpitations or syncope) immediately to the physician
Sertindole	Initial dose: 4 mg PO 24 hrly May increase dose at 4-mg increments every 4-5 days to reach optimal maintenance dose Maintenance dose: 12-20 mg PO 24 hrly Max dose: 24 mg/day	
Ziprasidone	Initial dose: 20-40 mg PO 12 hrly May increase dose based on patient response at ≥2-day intervals up to: Max dose: 80 mg PO 12 hrly Maintenance dose: Lowest effective dose should be given, 20 mg PO 12 hrly may be sufficient	
Phenylpiperazine		
Cariprazine	Initial dose: 1.5 mg PO 24 hrly May adjust dose based on response & tolerability to 3 mg on day 2 Further adjustments would be in increments of 1.5-3 mg Dose range: 1.5-6 mg PO 24 hrly Max dose: 6 mg/day	Adverse Reactions • CNS effects (EPS, Parkinson-like syndrome, akathisia, headache, insomnia, drowsiness, restlessness, tardive dyskinesia); GI effects (N/V, dyspepsia, abdominal pain, constipation); CV effects (hypertension, hypotension, tachycardia) Special Instructions • Patients should be monitored for treatment response & adverse effects for several wk after starting treatment • Use w/ caution in patients w/ hematologic disease, seizures, severe hepatic impairment • Monitor fasting lipid profile at baseline then periodically during treatment

All dosage recommendations are for non-pregnant & non-breastfeeding women, & non-elderly adults w/ normal renal & hepatic function unless otherwise stated.

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Dosage Guidelines

ATYPICAL/2ND GENERATION ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Other Antipsychotics		
Aripiprazole	Oral: 10-15 mg PO 24 hrly then 10-20 mg PO 24 hrly for 14 consecutive days Dose may be increased after 2 wk Maintenance dose: 15 mg PO 24 hrly Max dose: 30 mg/day or IM: Initial & maintenance dose: 400 mg IM mthly (no sooner than 26 days after the previous inj) or May reduce dose to 300 mg IM mthly for those w/ tolerability issues Control of agitation: Initial dose: 9.75 mg IM May give additional dose after 2 hr Dose range: 5.25-15 mg IM as single dose	Adverse Reactions - Psychiatric effects (suicidal thoughts/behavior, agitation, compulsive disorders); CNS effects (insomnia, anxiety, headache, lightheadedness, drowsiness, sedation, tremor); GI effects (constipation, N/V); CV effects (tachycardia, orthostatic hypotension); Endocrine effect (hyperprolactinemia); Other effects (wt gain, dyslipidemia, blurred vision, fatigue, inj site pain/induration) - Potentially fatal: NMS, blood dyscrasias, ketoacidosis/hyperosmolar coma - Incidence of EPS is low w/ akathisia being the most commonly reported; tardive dyskinesia is infrequent Special Instructions - Aripiprazole: Prior to initiating IM treatment, the patient should have established tolerability to oral Aripiprazole - After the 1st IM treatment, administer oral Aripiprazole for 14 consecutive days to achieve therapeutic Aripiprazole concentrations during initiation of therapy - Use w/ caution in patients w/ known CV disease, cerebrovascular disease, Parkinson's disease or diseases that would predispose patients to hypotension, patients w/ a history of seizure, dementia-related psychosis - Use w/ caution in patients taking strong CYP3A4 or CYP2D6 inhibitors & inducers - CBC, fasting lipid profile & fasting blood glucose/HbA1c should be tested prior to therapy then monitored periodically - Perform annual eye examination - Monitor for suicidal ideation or clinical worsening - Avoid abrupt withdrawal
Brexpiprazole	Initial dose: Day 1-4: 1 mg PO 24 hrly Day 5-7: 2 mg PO 24 hrly May increase to 4 mg PO 24 hrly starting day 8 Target dose: 2-4 mg PO 24 hrly Max dose: 4 mg/day	

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Dosage Guidelines

CONVENTIONAL/1ST GENERATION/TYPICAL ANTIPSYCHOTICS		
Drug	Dosage	Remarks
Benzamide		
Sulpiride	Initial dose: 200-400 mg PO 6-12 hrly May increase dose based on patient response Max dose in patients w/ predominant positive symptoms: 2,400 mg/day PO Max dose in patients w/ predominant negative symptoms: 800 mg/day PO Patients w/ mixed positive & negative symptoms: 400-600 mg PO 12 hrly Short-acting IM: 200-800 mg/day IM	Adverse Reactions • Same as Chlorpromazine, see page 22 • CNS effects (insomnia, drowsiness, EPS [tardive dyskinesia]); Endocrine effects (hyperprolactinemia, amenorrhea); Other effects (wt gain, increased liver enzymes) • Sleep disturbances, agitation, over stimulation, EPS occurs as often as w/ Chlorpromazine but may be milder • Less likely to cause sedation & hypotension; antimuscarinic effects are minimal • May exacerbate mania or hypomania Special Instructions • Same as for Chlorpromazine, see page 22 • Use w/ caution in manic or hypomanic patients, patients w/ pheochromocytoma, acute porphyria, prolactin-dependent tumors, epilepsy • Avoid use in patients w/ moderate-severe renal impairment
Butyrophenones		
Bromperidol	1-15 mg/day PO Max dose: 80 mg/day Depot formula: 300 mg IM every 4 wk	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely than Chlorpromazine to cause sedation, hypotension or antimuscarinic effects • May have higher incidence of EPS Special Instructions • Same as for Chlorpromazine, see page 22
Haloperidol	0.5-5 mg PO 8-12 hrly May increase dose up to: Max dose: 100 mg/day Maintenance dose: 3-10 mg/day PO Short-acting IM/IV: 2-10 mg IM/IV 4-8 hrly up to 1 hrly or as required Max dose: 18 mg/day IM or IV Depot formula: Initial dose: 10-20x the daily oral dose given IM up to 100 mg/dose If initial dose of 100 mg is exceeded, administer the excess after 3-7 days Maintenance doses are then given every 4 wk May increase dose up to ≥300 mg/dose	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause sedation, hypotension & antimuscarinic side effects but EPS are common Special Instructions • Same as Chlorpromazine, see page 22 • Use w/ caution in childn & adolescents • May cause severe EPS in patients w/ hyperthyroidism
Lumateperone	42 mg PO 24 hrly	Adverse Reactions • CNS effects; (drowsiness, headache, sedation, tardive dyskinesia) GI effects (abdominal pain, decreased appetite, diarrhea, N/V, xerostomia); Other effects (increased serum transaminases, increased creatine phosphokinase, orthostatic hypotension) Special Instructions • Use w/ caution in patients w/ decreased GI motility, urinary retention, benign prostatic hyperplasia, xerostomia, visual problems, patients at risk of seizures

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Dosage Guidelines

CONVENTIONAL/1ST GENERATION/TYPICAL ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Diazepines, Oxazepines, Thiazepines & Oxepines		
Loxapine	Initial dose: 10 mg PO 12 hrly For severe symptoms, initial dose should be 50 mg/day May increase dose based on patient response over the next 7-10 days up to 60-100 mg/day PO divided 6-12 hrly Max dose: 250 mg/day Maintenance dose: 20-100 mg/day PO Inhalation dose: 10 mg via inhaler device 24 hrly	Adverse Reactions • Same as Chlorpromazine, see below • Anticholinergic effects (constipation, xerostomia, blurred vision, urinary retention); Resp effects (bronchospasm, dyspnea); GI effects (N/V); CNS effect (headache); Metabolic effects (wt gain or loss, polydipsia); Other effects (seborrhea, ptosis, paresthesia, flush) Special Instructions • Same as for Chlorpromazine, see below
Phenothiazines		
Chlorpromazine	10-25 mg PO 8 hrly or 75 mg PO 24 hrly at night May increase dose at 25- to 100-mg increments at daily intervals to: Usual dose range: 200-1000 mg/day PO Max dose: 1 g/day Short-acting IM: 25-75 mg IM 6-8 hrly as required	Adverse Reactions • Anticholinergic effects (dry mouth, urinary retention, blurred vision, constipation); CV effects (tachycardia, cardiac arrhythmias, orthostatic hypotension); CNS effects (EPS [eg acute dystonia, akathisia & neuroleptic malignant syndrome], tardive dyskinesia, seizures, EEG abnormalities, sedation); Endocrine effects (galactorrhea, oligomenorrhea, hyperglycemia); GI effects (hepatic dysfunction, wt gain); Hematologic effects (agranulocytosis, leukopenia); Ophthalmologic effects (pigmentary retinopathy, corneal opacities); Other effects (sexual function disturbances, allergic rashes) • Photosensitivity reactions are more common w/ Chlorpromazine than w/ other antipsychotics Special Instructions • Contraindicated in patients w/ preexisting CNS depression or coma, bone marrow suppression, pheochromocytoma, prolactin-dependent tumors • Use w/ caution in patients w/ impaired liver, kidney, CV, cerebrovascular function, chronic resp disease, angle-closure glaucoma, history of jaundice, Parkinson's disease, hypothyroidism, myasthenia gravis, paralytic ileus, prostatic hyperplasia, urinary retention, epilepsy, seizures, in the presence of acute infection or leukopenia • Sedative effects are most marked during the 1st 2 wk of administration • Regular eye exams are recommended for patients on long-term therapy • Monitor CBC in patients w/ fever or unexplained infection • Monitor LFT, fasting plasma glucose level/HbA1c, lipid profile panel • Patient should remain supine for at least 30 min after parenteral administration; monitor BP during administration • Avoid abrupt withdrawal

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Dosage Guidelines

CONVENTIONAL/1ST GENERATION/TYPICAL ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Phenothiazines (Cont'd)		
Fluphenazine	2.5-10 mg/day PO divided 6-8 hrly May increase dose based on patient response up to: Max dose: 40 mg/day Then gradually decrease dose to: Maintenance dose: 1-5 mg/day PO Short-acting IM: Initial dose: 1.25 mg IM May adjust dose based on patient response to: Usual dose: 2.5-10 mg/day IM divided 6-8 hrly or as required Depot formula: Initial dose: 6.25-25 mg IM/SC as a single dose May adjust dose based on patient response to: Usual dose: 12.5-100 mg IM every 2-6 wk Max dose: 100 mg IM/inj	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause sedation, hypotension or antimuscarinic side effects but EPS are more common Special Instructions • Same as Chlorpromazine, see page 22 • Depot inj are contraindicated in severely depressed patients since Fluphenazine can exacerbate depression
Levomepromazine (Methotrimeprazine)	25-50 mg/day PO divided into 3 doses The larger portion should be administered at night Non-ambulatory patients: 100-200 mg/day PO in divided doses Max dose: 1 g/day	Adverse Reactions • Same as Chlorpromazine, see page 22 • May be more sedating than Chlorpromazine • May cause severe postural hypotension Special Instructions • Same as Chlorpromazine, see page 22 • Patients on large initial doses or >50 yr should be recumbent when receiving medication to decrease the risk of postural hypotension
Pericyazine (Periciazine)	Initial dose: 75 mg/day PO in divided doses The larger portion should be administered at night May increase dose based on patient response by 25 mg at wkly intervals Max dose: 300 mg/day	Adverse Reactions • Same as Chlorpromazine, see page 22 • Sedation & orthostatic hypotension are common Special Instructions • Same as Chlorpromazine, see page 22
Perphenazine	Initial dose: 4-8 mg PO 8 hrly Adjust dose based on patient response up to 8-64 mg/day PO divided 6-8 hrly Max dose: 24 mg/day in outpatients & 64 mg/day in hospitalized patients	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause sedation than Chlorpromazine, but EPS are more common Special Instructions • Same as Chlorpromazine, see page 22

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Dosage Guidelines

CONVENTIONAL/1ST GENERATION/TYPICAL ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Phenothiazines (Cont'd)		
Prochlorperazine	Initial dose: 5-10 mg PO 6-8 hrly or 12.5 mg PO 12 hrly x 7 days May increase dose based on patients response up to 75-100 mg/day PO Some patients may be maintained on lower doses: 25-50 mg/day PO Short-acting IM: As Prochlorperazine mesilate: 12.5-25 mg IM 8-12 hrly as required or As Prochlorperazine edisylate: 10-20 mg IM single dose May repeat dose 2-4 hrly as required	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause sedation, antimuscarinic effects but EPS are more common Special Instructions • Same as Chlorpromazine, see page 22
Thioridazine	Maintenance dose for outpatients: 50-300 mg/day PO in divided doses Maintenance for inpatients: 100-600 mg/day PO in divided doses Max dose: 800 mg/day	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause EPS but more sedating & anticholinergic effects • Antimuscarinic effects, hypotension, cardiotoxicity, dose-related prolongation of QT interval & sexual dysfunction are more common • Life-threatening arrhythmias limit its use • Pigmentary retinopathy is observed in patients on high dose Special Instructions • Same as Chlorpromazine, see page 22 • Use in schizophrenia should be limited to patients who have failed therapy w/ other antipsychotics • Start w/ low dose & titrate upwards slowly • Avoid in patients w/ cardiac disorders, hypokalemia & electrolytes prior & during treatment - Monitor ECG before each dose increase, 1 wk after max therapeutic dose & at 6-mth intervals - Monitor serum electrolytes prior to treatment & periodically throughout therapy
Trifluoperazine	Initial dose: 2-5 mg PO 12 hrly May gradually increase dose based on patient response to 15-20 mg/day PO Max dose: 40 mg/day PO	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause sedation, hypotension, hypothermia or antimuscarinic effects but EPS are more common (especially if doses >6 mg/day) Special Instructions • Same as Chlorpromazine, see page 22

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Dosage Guidelines

CONVENTIONAL/1ST GENERATION/TYPICAL ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Thioxanthenes		
Chlorprothixene	15-50 mg PO 6-8 hrly <i>or</i> 25-100 mg IM up to 6 hrly May increase dose based on patient response up to: Maintenance dose: 100-200 mg/day PO Severe cases: ≥600 mg/day PO	Adverse Reactions • Same as Chlorpromazine, see page 22 Special Instructions • Same as Chlorpromazine, see page 22
Flupentixol (Flupenthixol)	Depot formula: Initial test dose: 20 mg IM as a single dose After ≥7 days, if well-tolerated, follow w/ 20-40 mg IM every 2-4 wk Shorter dosage intervals or larger doses may be administered to some individuals	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause sedation but EPS are more common Special Instructions • Same as Chlorpromazine, see page 22 • Not recommended in states of overactivity or excitement, including mania
Tiotixene (Thiothixene)	Initial dose: 2 mg PO 8 hrly <i>or</i> 5 mg PO 12 hrly May increase dose gradually based on patient response to 20-30 mg/day PO Max dose: 60 mg/day Short-acting IM: 4 mg IM 6-12 hrly or as required Max dose: 30 mg/day	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause sedation but EPS are more common Special Instructions • Same as Chlorpromazine, see page 22
Zuclopenthixol	10-50 mg/day PO May increase to 75 mg/day PO or more Maintenance dose: 20-50 mg/day PO Zuclopenthixol acetate: Used for the initial treatment of acute psychoses & for exacerbations of chronic psychosis Initial dose: 50-150 mg IM May repeat every 2-3 days In some patients, an additional inj may be needed 24-48 hr after 1st inj Not more than 4 doses should be given during the course of treatment Max dose: 400 mg/course of treatment For maintenance, may administer oral doses 2-3 days after last IM injection Zuclopenthixol decanoate (depot formula): Initial test dose: 100 mg deep IM Followed after at least a week by 200-500 mg IM every 1-4 wk Max dose: 600 mg/wk of treatment	Adverse Reactions • Same as Chlorpromazine, see page 22 • Less likely to cause sedation but EPS are more frequent Special Instructions • Same as Chlorpromazine, see page 22 • Avoid in patients who are in apathetic or withdrawn states

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Dosage Guidelines

CONVENTIONAL/1ST GENERATION/TYPICAL ANTIPSYCHOTICS (CONT'D)		
Drug	Dosage	Remarks
Other Antipsychotics		
Clotiapine (Clothiapine)	10-200 mg PO divided 8-12 hrly May increase up to 360 mg/day PO for severe or resistant cases Chronic schizophrenia: 20-80 mg PO 24 hrly	Adverse Reactions • Same as Chlorpromazine, see page 22 Special Instructions • Same as Chlorpromazine, see page 22
Molindone	Initial dose: 50-75 mg/day PO divided 6-8 hrly May increase to 100 mg/day PO divided 6-8 hrly after 3-4 days Maintenance dose: 15-225 mg/day PO divided 6-8 hrly Max dose: 225 mg/day	Adverse Reactions • Same as Chlorpromazine, see page 22 Special Instructions • Same as Chlorpromazine, see page 22

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Please see the end of this section for the reference list.

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