EDUCATIONAL OBJECTIVES

GOAL: To educate clinicians regarding the utilization of long-acting injectable medications for the treatment of schizophrenia

After participating in this activity, pharmacists will be able to:

> Discuss schizophrenia's unique presentation and propensity to cause internal conflict and subjective distress, which often leads to nonadherence

> Identify situations in which oral, long-acting injectable (LAI) antipsychotics, or a combination of both are ideally employed

> Compare available LAI antipsychotic agents' indications, risks, and benefits, pharmacokinetic profiles, dosing, and administration techniques in the pharmacy

> Discuss emerging opportunities for pharmacists to get involved in monitoring and administering LAI antipsychotic medication

After participating in this activity, pharmacy technicians will be able to:

> Discuss the association between schizophrenia diagnosis and adherence to therapy

> List LAI drugs used in schizophrenia, and address inventory management issues

> Recognize when to refer patients to the pharmacist for help with their schizophrenia

Addressing unique medication adherence issues for patients with schizophrenia

Megan J. Ehret, PharmD, MS, BCPP
BEHAVIORAL HEALTH CLINICAL PHARMACY SPECIALIST, DEPARTMENT OF DEFENSE, FORT BELVOIR COMMUNITY HOSPITAL, FORT BELVOIR, VA.

Abstract

Schizophrenia is a chronic, serious mental illness in which medication nonadherence is extremely problematic. Given the numerous risk factors and poor outcomes associated with nonadherence, pharmacists can play a unique role in the education of patients and increase in utilization of long-acting injectable antipsychotics. Pharmacists can help the patient and provider determine the best medication choice for a patient based on many factors, including cost, adverse effects, drug–drug interaction, efficacy, convenience, and dosing strategies. In many states, pharmacists can also administer the injection to patients in their pharmacies.
Introduction
Schizophrenia, a chronic serious mental illness, has a lifetime prevalence of 0.3% to 0.7%. Given the prodromal phase of the illness characterized by negative and cognitive symptoms, the time to diagnosis can be long and early nonadherence to treatment can result in increased hospitalizations (all cause and schizophrenia related). The many unique challenges of living with schizophrenia can be magnified by the significant stigma associated with the illness, including stigma of taking medications, hospitalizations, and frequent medical appointments. Impairment in functioning and cognitive capacity cannot only impact patients but also their families and society. Those diagnosed with schizophrenia face a number of challenges managing their lives and illness, including potential lack of insight into their illness and cognitive deficits that can interfere with treatment adherence. These types of challenges increase the risk of relapse, which can turn result in significant personal and financial costs.

Antipsychotic medications have been able to demonstrate improvement in clinical outcomes in those with schizophrenia and reduce economic burden secondary to reduced relapse and hospitalization rates and fewer emergency room visits. Even though response to treatment is often favorable for a first episode of schizophrenia, a major challenge still exists in transforming poor adherence to consistent treatment. Medication nonadherence in these patients has been reported to range from 20% to 89%.

Medication nonadherence can be extremely problematic in mental illness, particularly schizophrenia. Results from nonadherence can include: symptom exacerbation or relapse, greater risk or rates of psychiatric hospitalization and use of emergency psychiatric services, and worsening prognosis. Patients experiencing their first episode of schizophrenia who are nonadherent to medications have readmission rates 5 times higher than adherent patients in the first year. Additionally, nonadherence in the first year of diagnosis leads to worse outcomes in the subsequent 2 years. These repeated episodes of psychosis and relapse can lead to the development of chronic psychosis, longer time to symptomatic improvement, increased functional impairment and disability, and possible resistance to antipsychotic medications. Other consequences to consider in a nonadherent patient include: comorbid substance abuse, poorer cognitive functioning, reduced quality of life, increased rates of arrest, violence/aggression, or victimization, and increased risks of suicide.

Numerous risk factors for nonadherence can engage patients to determine their level of insight into the illness by asking why they are taking the medication and what the doctor told them it was for. Understanding a patient’s perception of the medication can help determine the potential adherence a patient is likely to have. Other risk factors for nonadherence include comorbid substance abuse, problems with continuity of care among mental health services (ie, being able to obtain medications that are prescribed), prior hospitalizations, living independently, and exhibiting a baseline level of hostility. Cultural influences and stigma can contribute to nonadherence. Tolerability and adverse effects of medications greatly contribute to a culture of nonadherence not only in schizophrenia but also in many behavioral health disorders. Pharmacists should ask at each interaction with patients how they are taking the medication and what effects they are having with it. Educating a patient on the major adverse effects and engaging a patient in discussion about those can help patients understand what to expect from their medications.

A large amount of literature describes various techniques to improve adherence to medications. Perceived effectiveness influences the continued use of medications, and appropriate medication use has been associated with a good or effective response. A patient’s perception of the ability of an antipsychotic to “cure” their illness also increases adherence. More studies on behavioral interventions are needed, including motivational interviewing, to determine their full effect on improving adherence. Long-acting injectable (LAI) antipsychotics have been studied many times over in patients who are nonadherent.

"LAs are being advocated for early episodes of schizophrenia including even after the first hospitalization."
to oral medications. It is known LAI antipsychotics are at least as effective as oral antipsychotics for treating schizophrenia.14 Additionally, a recent systematic review and meta-analysis demonstrated that second-generation LAIs were superior to first-generation LAIs for relapse prevention.15 More recently, LAIs have been studied in first-episode psychosis and for early initiation of treatment for schizophrenia.16,17 Anyone who is likely to be on long-term antipsychotic medication should be considered a candidate for an LAI. With the added benefit of addressing problems of daily adherence, LAIs are being advocated for early episodes of schizophrenia including even after the first hospitalization. Many benefits have been seen with this recommendation, including reduced rates of recurrence, rehospitalization, and comorbidities and complications of untreated/undertreated illness.18,19 LAIs are available for both typical and atypical (or second-generation) antipsychotics. All available LAIs are indicated for schizophrenia, with several of them having other unique indications (Table 1).20–27 Many differences exist between the products. They each differ in pharmacologic profile, which contributes to adverse effects; pharmacokinetic profile, which contributes to the need for oral overlap; frequency of dosing; and the ability to use a loading dose.

Many advantages exist for LAIs compared to oral antipsychotics including consistent drug delivery, adherence transparency, reduced risk of unintentional or deliberate overdose, predictable bioavailability, regular contact between the patient and healthcare team, less probability for rebound symptoms and rapidly occurring/abrupt relapses, convenience, and overcoming partial or overt nonadherence.29 Healthcare providers must weigh these risks with the potential disadvantages of using an LAI, including cost of the newer formulations, slow dose titration, longer time to reach steady state levels, less flexibility of dose adjustments, delayed disappearance of adverse effects, injection site reactions and pain, burden of potential travel to receive the injection, need for refrigeration, a patient’s perception of stigma or coercion, and decreased medication options.29

### First-generation antipsychotics

The older, typical LAIs are less expensive but are often associated with more
frequent adverse effects, including extrapyramidal symptoms, cognitive dulling, and neurologic complaints.\textsuperscript{30,31} Fluphenazine is characterized by large interpatient variability in its pharmacokinetic profile, which makes it challenging to determine the correct dose when converting from an oral antipsychotic (Table 2).\textsuperscript{30,32} As well, both fluphenazine and haloperidol must be administered using a Z-track method to reduce drug leakage and tissue irritation. In addition to this potentially painful administration technique, the volume of the injection is usually greater with the typical medications. Also, older formulations have risks of “lumps,” indurations, and abscesses with injections. The older formulations (eg, haloperidol, fluphenazine) are based in sesame oil, which is

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>INITI AL (MG)</th>
<th>AVERAGE (MG)</th>
<th>MAXIMUM (MG)</th>
<th>ORAL OVERLAP</th>
</tr>
</thead>
</table>
| Fluphenazine | 12.5–25  
(usually 1.25 X oral daily dose) | 6.25-25/2 weeks | 100 | Unknown; significant effects on symptoms typically occur in 2–4 days |
| Haloperidol | 10–20 X oral daily dose. If injection dose conversions >100 mg, second injection should be administered in 3–7 days. | 10–15 X oral daily dose/month. If dose large (>200 mg IM) or above volume limit (3 mL) for single injection, may need series of injections during week. | 450 | Yes, steady state concentrations are not obtained until after 3rd or 4th dose |
| Aripiprazole | 400  
Dose adjustment needed for CYP2D6 poor metabolizers and patients on concomitant CYP2D6 inhibitors and/or CYP3A4 inhibitors | 400/month  
Dose adjustment needed for CYP2D6 poor metabolizers and patients on concomitant CYP2D6 inhibitors and/or CYP3A4 inhibitors | 400 | In conjunction with 1st dose, take 14 consecutive days of concurrent oral aripiprazole (10–20 mg/day or current oral antipsychotic) |
| Aripiprazole lauroxil | ORAL DOSE: 10 mg/day = 441 mg/month  
ORAL DOSE: 15 mg/day = 662 mg/month  
ORAL DOSE: ≥20 mg/day = 882 mg/month  
Dose adjustment needed for CYP2D6 poor metabolizers and patients on concomitant CYP2D6 inhibitors and/or CYP3A4 inhibitors | 441–882/month or 882/6 weeks  
Dose adjustment needed for CYP2D6 poor metabolizers and patients on concomitant CYP2D6 inhibitors and/or CYP3A4 inhibitors | 882/month | In conjunction with 1st dose, take 21 consecutive days of concurrent oral aripiprazole |
| Olanzapine | ORAL DOSE: 10 mg/day = 210/2 weeks X 4 doses or 405/4 weeks X 2 doses  
ORAL DOSE: 15 mg/day = 300/2 weeks X 4 doses  
ORAL DOSE: 20 mg/day = 300/2 weeks X 4 weeks | ORAL DOSE: 10 mg/day = 150/2 weeks or 300/4 weeks  
ORAL DOSE: 15 mg/day = 210/2 weeks or 405/4 weeks  
ORAL DOSE: 20 mg/day = 300/2 weeks | 300 (if every 2 weeks) or 405 if every 4 weeks | Not required |
| Paliperidone (monthly) | 234 followed by 156 1 week later (+/- 4 days) | 39–234/month (schizophrenia)  
79–234/month (schizoaffective disorder)  
ORAL DOSE: 12 mg/day = 234/month  
ORAL DOSE: 6 mg/day = 117/month  
ORAL DOSE: 3 mg/day = 39–78/month | 234 | Not required  
Initial dosing regimen must be followed. |
| Paliperidone (every 3 months) | Depends on last dose of monthly paliperidone  
78 mg/month = 273 mg/3 months  
117 mg/month = 410 mg/3 months  
156 mg/month = 546 mg/3 months  
234 mg/month = 819 mg/3 months | 273–819 mg/3 months | 819 | Not required |
| Risperidone | 25 mg every 2 weeks | 25–50 mg every 2 weeks | 50 mg every 2 weeks | 3 weeks of oral overlap required |

Source: Refs 20,21,23–27
Z-track method.

The first of the atypicals to be formulated in an LAI, risperidone long-acting injection is unlike previous typical LAIs, as it comes as a powder that must be refrigerated. The medication should rest at room temperature for 30 minutes prior to injection. Just prior to injection, the clinician mixes the powder in the provided saline and shakes. This administration process can be more challenging and time consuming than previous LAI medications. Additionally, if the patient should decide not to receive the injection, the medication cannot be saved. Other disadvantages of the medication include its release mechanism. After the initial injection, only 1% of the medication is released. It is not until week 3 that the tiny microspheres release the medication slowly into the body. A minimum of a 3-week overlap is required with oral medications to prevent relapse. Advantages of the medication include its dissolution in saline and the injection is much less painful than typical antipsychotic LAIs.

As well, dosing is rather uncomplicated with 2 mg to 4 mg daily of risperidone orally equaling the 25-mg every 2-week injection. See Table 2 for complete dosing recommendations for LAIs. See Table 3 for common adverse reactions for the atypical antipsychotics.

Paliperidone palmitate 3-month extended-release injectable suspension. This formulation of paliperidone provides the longest interval of any approved long-acting injectable antipsychotic. It is approved for patients who have been taking the 1-month paliperidone palmitate injection for at least 4 months. Due to its low solubility in water, paliperidone palmitate dissolves slowly once injected before being hydrolyzed as paliperidone and absorbed in the bloodstream. From the time of release on day 1, it remains active for as long as 18 months. The medication carries the same risks and adverse effects as paliperidone monthly, but offers the advantage of 4-times-a-year injection.

Olanzapine extended-release injectable suspension. This medication is supplied as a pre-filled syringe, which makes administration easier, but it has potentially serious adverse effects if the medication is not administered properly. Post-injection delirium/sedation syndrome occurred in 30 reported cases during clinical trials with the med-
ications due to intravascular injection of a portion of the medication, which clinically presents like an olanzapine overdose. The side effect, although rare (0.07% of injections) can be life threatening. It can occur immediately or up to 300 minutes after injection. When preparing the injection, specific instructions are provided for administration. After mixing the injection and preparing the site for injection, the needle should be inserted into the gluteal muscle only. After insertion, aspiration for several seconds should be completed to ensure that no blood appears. If blood appears in the syringe, the syringe and dose should be discarded and a new kit used. This can be costly if another kit must be used. The injection should be given with steady, continuous pressure. Additionally, the injection site should not be massaged. For this reason, the patient must be observed for at least 3 hours post injection by a healthcare professional. Additionally, to prescribe this medication, the clinician must be registered with Eli Lilly’s Patient Care Program. Note that not only does the clinician have to register but also the healthcare facility and pharmacy provider must register to dispense the product.

**Aripiprazole extended-release injectable suspension.** One of the new atypical LAIs, this medication is available as a lyophilized powder, which needs to be reconstituted with sterile water. Again, this can make administration more challenging, but the medication offers the advantage of less weight gain compared to other atypical LAIs, less hyperprolactinemia, and no QTc prolongation. Disadvantages include adverse motor effects (tremor, akathisia), which are common. Additionally, the medication has had drug–drug interactions with CYP2D6 and 3A4 inhibitors and 3A4 inducers. Patients who are CYP2D6 poor metabolizers may also require dosage adjustments (50% dose decrease), which can be difficult with an LAI. The medication also requires a 2-week oral overlap, as the maximum plasma concentration is obtained on days 5 to 7.

**Aripiprazole lauroxil extended-release injectable suspension.** This LAI contains the same active ingredient as the previous drug, but the aripiprazole lauroxil particles dissolve slowly and undergo hydrolysis resulting in extended systemic availability of aripiprazole. Due to this extended release, this particular formulation requires a 3-week oral overlap. At its highest dose of 882 mg, this medication can be administered every 6 weeks. Other advantages include pre-filled syringes and availability of the medication in 3 strengths, which can provide ease when dosing the medication. The formulation carries the same adverse effects and drug interactions as does the previous product.

**Recommending LAIs and the pharmacist’s role**

Even with the many treatment barriers that can exist when considering LAIs, healthcare professionals should not always assume patients will reject LAIs and will want an oral medication. Clinicians should discuss LAI antipsychotic treatment options with all patients and should not wait until patients are in crisis. Making patients aware of misconceptions about LAI antipsychotics can help increase adherence. Pharmacists should emphasize the benefits of treatment rather than the injection itself. Providers should use success stories of other patients and recommend LAI antipsychotics to improve patient adherence and reduce the stigma of injections.

As front-line educators, pharmacists can reduce the stigma of injections, improve patients’ attitudes toward medication, and increase adherence.

<table>
<thead>
<tr>
<th>Comparison of Adverse Effects with Second-Generation Antipsychotics</th>
<th>ARIPIPRAZOLE</th>
<th>OLANZAPINE</th>
<th>PALIPERIDONE</th>
<th>RISPERIDONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight gain</td>
<td>Low</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Low</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>QTc prolongation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CYP3A4 metabolism</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Sedation</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Extrapyramidal symptoms</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Akathisia</td>
<td>Moderate</td>
<td>Low-Moderate</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Hyperprolactinemia</td>
<td>Low</td>
<td>Low-Moderate</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Source: Refs 20-25

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“As front-line educators, pharmacists can reduce the stigma of injections, improve patients’ attitudes toward medication, and increase adherence.”
psychotics with confidence. Patients should be offered these medications at their first break to help prevent unnecessary relapses and hospitalizations.

Those administering the vaccine should employ good injection practices utilizing the correct injection site (deltoid versus gluteal), rotating injection sites, using proper injection technique, and addressing any injection site discomfort.

Pharmacists can expect to encounter a lot of barriers related to LAIs, including access to care. Many patients are simply unaware that these medications exist or have little knowledge about the use of these types of formulations for long-term treatment of their illness. Patients have seen LAIs as more coercive than other treatments and may prefer to have an oral formulation instead. Additionally, the cost and inconvenience of receiving the injection can also be barriers to their increased use.

Pharmacists can increase utilization of LAIs in many ways. As front-line educators, pharmacists can reduce the stigma of injections, improve patients’ attitudes toward medication, and increase adherence. Asking how a patient is taking their medication, how many doses in the last week they have missed, and how they feel on the medication can help address adherence issues. Describing the many symptoms of schizophrenia and discussing how the medication can help to address them can help create a therapeutic alliance with a patient. This alliance can help with medication adherence as well. Additionally, pharmacists can help navigate many of the insurance programs to help patients determine their coverage and copayment for injections. Pharmacists can also serve as the communication bridge between the patient and psychiatrist to discuss utilization of an LAI for appropriate patients. As well, pharmacists may be able to recognize inadequate adherence by late refills and follow up with patients and providers.

Pharmacists can also assist in the underutilization of LAIs because of the limited availability of experienced personnel to administer the injection at psychiatric office practices and community mental health centers. With pharmacists’ expanding role in the administration of immunizations, several states and collaborative practice agreements now permit pharmacists to administer nonvaccine injections. Currently, pharmacists in Texas, Washington, Maryland, and Washington, DC, are able to administer LAIs. The programs in Washington and Texas are specifically in community pharmacies. A small pharmacist-run injection clinic demonstrated financial benefit, saving the institution over $6000 in total unreimbursed inpatient charges and close to $3000 in acquisition costs for the purchase of LAIs over the course of a year.

Many models exist across the country on which pharmacists can base these innovative, community-based programs with expanded pharmacist injectable administration privileges. Not only do the clinics provide the injections but they also provide pharmacist-based medication management services associated with their administration, including adherence and adverse-effect monitoring. Pharmacists should inquire about the laws and regulations in their particular state to determine the feasibility of creating an injectable clinic. Determining the need in the area by partnering with behavioral health clinics and psychiatrists can be valuable as well. Educating the pharmacy staff on the uses of LAIs and how to engage patients in discussions about these formulations will help increase the utilization of the medication. Many of the pharmaceutical companies that manufacture the medications are happy to provide training materials on the injections.

Pharmacists should strive to practice to the highest level of their license and training by staying well-informed about the levels of service allowed by their state within a collaborative practice agreement. Additionally, pharmacists should become fully familiar with the key regulatory and liability concerns associated with the injection process (eg, sharps disposal, liability insurance coverage, and state Board of Pharmacy regulations).

How would you implement an LAI clinic into your practice setting?

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FOR PATIENTS WITH SCHIZOPHRENIA

TEST QUESTIONS

1. Which of the following can result from medication nonadherence in patients with schizophrenia?
   a. Better prognosis
   b. Decreased hospitalizations
   c. Symptom exacerbation
   d. Decreased use of emergency services

2. Which of the following is likely to occur after repeated episodes of psychosis and relapse?
   a. Shorter time to symptomatic improvement
   b. Development of chronic psychosis
   c. Increased risk of adverse effects
   d. Decreased functional impairment

3. Which of the following is a potential consequence for patients with schizophrenia who are nonadherent to their medications?
   a. Increased cognitive function
   b. Increase in quality of life
   c. Decreased risk of suicide
   d. Increased rates of arrest

4. Which of the following medications is approved for the treatment of schizoaffective disorder?
   a. Paliperidone palmitate 1-month extended-release injectable suspension
   b. Risperidone long-acting injection
   c. Aripiprazole lauroxil
   d. Aripiprazole extended-release injectable suspension

5. Which of the following is a potential disadvantage to the use of long-acting injectable medications?
   a. Slow dose titration
   b. Increase in adverse effects
   c. Increase in frequency of clinic visits
   d. Lack of benefit in first episodes

6. Which of the following adverse effects is more likely to occur with a first-generation decanoate versus a second generation?
   a. Extrapyramidal symptoms
   b. Hyperlipidemia
   c. Increased weight
   d. Hyperglycemia

FOR PHARMACY TECHNICIANS

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3. Fluphenazine injections should be given by which of the following procedures?
   a. Z-track
   b. Subcutaneously
   c. Intramuscular
   d. Intradermal

4. How many days on either side of the day 8 injection of 1-month paliperidone palmitate extended-release injectable suspension can a patient receive their day 8 injection?
   a. 1
   b. 4
   c. 7
   d. 10

5. Which of the following is a major limitation to the use of olanzapine extended-release injectable suspension?
   a. Oral overlap
   b. Z-track administration
   c. Loading dose procedure
   d. Reconstitution of the product

6. Which of the following LAIs has the highest risk of sedation?
   a. Olanzapine
   b. Risperidone
   c. Paliperidone
   d. Aripiprazole

7. Which of the following medications is approved for the treatment of schizoaffective disorder?
   a. Paliperidone palmitate 1-month extended-release injectable suspension
   b. Risperidone long-acting injection
   c. Aripiprazole lauroxil

8. A pharmacist should recommend oral overlap with risperidone long-acting injection for a minimum of how many days?
   a. 7
   b. 14
   c. 21
   d. 28

9. Which of the following is required for risperidone long-acting injection?
   a. Verification of sesame allergy
   b. Z-track administration
   c. Loading dose procedures
   d. Reconstitution of the product

10. Which of the following is a common adverse effect seen with aripiprazole extended-release injectable suspension?
    a. QTc prolongation
    b. Hyperprolactinemia
    c. Weight gain
    d. Akathisia

11. Which of the following is a potential adverse effect of Aripiprazole extended-release injectable suspension?
    a. Post injection delirium/sedation
    b. Oral overlap
    c. Z-track administration
    d. Reconstitution of the product

12. How many days on either side of day 8 injection of 1-month paliperidone palmitate extended-release injectable suspension can a patient receive their day 8 injection?
    a. 1
    b. 4
    c. 7
    d. 10

13. How many months should a patient be stabilized on 1-month paliperidone palmitate extended-release injectable suspension prior to conversion to 3-month paliperidone palmitate extended-release injectable suspension?
    a. 1
    b. 4
    c. 7
    d. 10

14. Which of the following is a major limitation to the use of olanzapine extended-release injectable suspension?
    a. Post injection delirium/sedation
    b. Oral overlap
    c. Z-track administration
    d. Reconstitution of the product

15. Which of the following items can all pharmacists provide to patients with schizophrenia?
    a. Education
    b. Administration of LAIs
    c. Laboratory monitoring for adverse effects
    d. Switching between oral and LAIs

16. Which of the following doses of aripiprazole lauroxil extended-release injectable suspension can be dosed every 6 weeks?
    a. 210 mg
    b. 441 mg
    c. 662 mg
    d. 882 mg

17. Which of the following LAIs has the highest risk of sedation?
    a. Olanzapine
    b. Risperidone
    c. Paliperidone
    d. Aripiprazole

18. Which of the following would be an appropriate dose of haloperidol decanoate for a patient maintained on 5 mg twice daily of the oral formulation?
    a. 100 mg every month
    b. 300 mg every month
    c. 200 mg every 2 weeks
    d. 400 mg every 2 weeks

19. Which of the following LAIs would be an appropriate starting dose of aripiprazole for extended-release injectable suspension for someone who is CYP2D6 poor metabolizer?
    a. 100 mg every month
    b. 200 mg every month
    c. 300 mg every month
    d. 400 mg every month

20. Which of the following items can all pharmacists provide to patients with schizophrenia?
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FOR PHARMACISTS

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   a. 7
   b. 14
   c. 21
   d. 28

9. How many months should a patient be stabilized on 1-month paliperidone palmitate extended-release injectable suspension prior to conversion to 3-month paliperidone palmitate extended-release injectable suspension?
   a. 1
   b. 4
   c. 7
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10. Which of the following is required for risperidone long-acting injection?
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REFERENCES


