Guidelines for Care of Bipolar Disorders

These guidelines are intended as an educational reference and do not supercede the clinical judgement of the treating physician with respect to appropriate and necessary care for a particular patient.

Assessment	
Evaluation to Confirm Diagnoses Assess Severity and Risk	▪ Identify the phase. Consider use of Mood Disorder Questionnaire to help determine if Depression is Unipolar or Bipolar. *** ▪ Do lab assessment: thyroid profile, LFTs, CBC, electrolytes, fasting blood sugar, lipids, BMI, and EKG if appropriate. ▪ Screen for functional impairment. Consider using Sheehan Disability Scale. *** ▪ Evaluate severity of sleep, appetite, energy and mood deregulation as mild/moderate/severe. ▪ Screen for suicidality. Consider use of Suicide Behaviors Questionnaire-R***. Refer to appropriate level of care. ▪ Screen for Chemical Dependency. Consider using the CAGE AID*** and refer to appropriate level of care.
Non Pharmacologic Interventions	
Refer to Adjunctive Therapies Monitor Labs Check blood levels	▪ Provide psycho-education and get release of information to speak with family. ▪ Review goals for treatment and Daily Mood Chart*** for illness self-management. ▪ Discuss importance of adjunctive therapy in improving self-management, functional recovery and adherence. ▪ Refer for Cognitive Behavioral Therapy - Family Focused Therapy, Interpersonal Therapy with/ without Social Rhythm Therapy. ▪ If using Second Generation Antipsychotics, adhere to metabolic monitoring guidelines. *** ▪ For Lithium, Valproic acid, Carbamazepine to guide therapeutic response/ monitor toxicity.

Pharmacological Interventions				
Stage	Depressed Phase	Euphoric Mania/Hypomania Phase	Mixed or Dysphoric Mania Phase	Follow -Up
Acute	Goal: Eliminate psychosis, reduce agitation, and normalize sleep, appetite, energy and mood. Optimize Dosing and/or blood levels **			
Step 1	1. Lithium or Lamotrigine or Symbax 2. Use SGA* if psychosis present 3. May use Benzodiazepine short term for agitation/insomnia	1. Lithium or Divalproex or SGA* 2. Add SGA if psychosis present or if severe 3. May use Benzodiazepine short term for agitation/insomnia	1. Divalproex or SGA* 2. Add SGA* if psychosis present or if severe 3. May use Benzodiazepine short term for agitation/insomnia	1-2 weeks
	Note: An Antidepressant should NEVER be used without a mood stabilizer			
Step 2	1. Change Mood Stabilizer or add SGA* or + Non Tricyclic Antidepressant 2. Use SGA if psychosis present	1. Add 2nd Mood Stabilizer (may include Carbemazepine) or add SGA* to single mood stabilizer if not present	1. Add 2nd Mood Stabilizer (may use Carbemazepine, avoid use of Lithium or Lamotrigine) or Change SGA if present	
Step 3	1. Use 2 Mood Stabilizer +/- SGA *+/- Non Tricyclic Antidepressant 2. Change Mood Stabilizer combo or SGA*	1. 2 Mood Stabilizer + SGA* 2. Change Mood Stabilizer combo or SGA	1. 2 Mood Stabilizers (not Lithium or Lamotrigine) + SGA* 2. Change Mood Stabilizer combo or SGA	
Continuation	Goal: Minimize polypharmacy; normalize sleep, appetite, energy & mood, restore level of function. Optimize Dosing and/or blood levels **			2-4 weeks
	Begin Antidepressant and Benzodiazepine withdrawal if stable, over 2-4 wks			
Maintenance	Goal: Prevent relapse, minimize polypharmacy, and maximize function. Optimize Dosing and or blood levels **			1-3 months
	1. Lithium or Lamotrigine alone or in combo 2. Eliminate Antidepressant, SGA*, if possible	1. Mood Stabilizer alone or 2nd Mood Stabilizer, or Risperidone, Olanzapine or Abilify 2. Eliminate SGA*, if possible	1. Mood Stabilizer alone or 2 Mood Stabilizers, or Risperidone, Olanzapine or Abilify 2. Eliminate SGA* if possible	

* *SGA = 2nd Generation Antipsychotic; ECT is a viable option for severe presentations and can be used in maintenance. The following are FDA approved for acute mania -all SGA as well as Lithium, Divalproex and Carbemazepoine; for acute depression only Olanzapine + Fluoxetine; for maintenance: Lithium, Lamotrigine (only depression), Abilify and Olanzapine.*

** *See Adequate Dose of Mood Stabilizing Agents on backside of this guide.*

*** *In attached tool kit or download tools at: http://apps.cignabehavioral.com/web/basicsite/provider/treatingBehavioralConditions/treatingBehavioralConditions.jsp*
STABLE tools are obtained from Center for Quality Assessment and Improvement in Mental Health at www.cqaimh.org/stable.html.
Sources for these guidelines include: Management of Bipolar Disorder: APA Practice Guidelines, Expert Consensus Guideline Series, and the Texas Medication Algorithm Project (TMAP).

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Adequate Dosing Guide for the Treatment of Bipolar Disorder						
Medication (Doses are in mg/day)	Acute				Maintenance	
	Average Start dose	Average Target Dose/Level		Usual highest final dose	Average Target Dose/Level	
		Low	High		Low	High
Carbemazepine	400					
Carbemazepine level, ug/mL		7	12	11	6	11
Divalproex	1250					
Valproic acid level, ug/mL		60	116	105	60	106
Lamotrigine*	25	100	400	200	150	300
Lithium	900					
Lithium level, mEq/L		0.7 l	1.2	1.1	0.6	1
Oxcarbazepine	600	900	2100	1800	900	1800
Aripirazole	15	15	30	30	15	30
Clozapine	75	200	600	500	200	500
Olanzapine	15	10	30	25	10	20
Quietepine	150	300	800	700	250	600
Risperidone	2.5	2.5	6	7	1.5	4.5
Ziprasadone	80	80	180	160	80	160

From the Expert Consensus Guideline Series on the Treatment of Bipolar Disorder, 2004, pages 27 and 39.

* *Lamotrigine was not included in the Expert Consensus Guideline tables, and was added for this publication.*

Consult a standardized informational resource for a complete review of relevant drug interactions and potential side/adverse effects.

Note: *Divalproic acid has been associated with Polycystic Ovaries in young females; lithium is excreted unchanged through the kidney; carbemazepine reduces the blood level of oral contraceptives.*