

Use of Clozaril[®] in patients aged 60 years and older

The information in this document is not intended as a definitive treatment strategy, but as a suggested approach for clinicians. It is based on previous successful experience. Each case should, of course, be considered individually.

This information is provided for healthcare professionals and should not be used as a patient information leaflet.

The Summary of Product Characteristics (SPC) for Clozaril[®] (clozapine) states that Clozaril[®] is licensed for psychotic disorders occurring during the course of Parkinson's disease in cases where standard treatment has failed.^{1,2}

Clozapine has been shown to be effective in treating elderly patients with schizophrenia.^{3,4} However, patients aged 60 years and older may generally be at more risk of adverse effects from medications due to the normal effects of ageing and the fact that they may be more likely to have medical problems. One study reported, 80% of elderly patients have at least one chronic disease⁵ and drug interactions are also more likely due to concomitant use of other medications.⁵

The ageing process can affect absorption, distribution, metabolism and clearance of drugs.⁵ Drug absorption may be modified by reductions in both gastric acidity and splanchnic blood flow. Lean body mass and total body size decrease with ageing which means that there is a wider distribution of antipsychotics, and other fat-soluble drugs, which may take longer to clear.⁵ A decline in liver and kidney function due to ageing may slow the elimination of drugs.⁵

Patients aged 60 years and older are particularly susceptible to extrapyramidal symptoms and tardive dyskinesia secondary to antipsychotics.⁵ Given the low incidence of these adverse events with clozapine versus the typical antipsychotics, this is less likely to be a major issue. One small study evaluating clozapine usage in the elderly by Frankenburg *et al* (1994) demonstrated that pre-existing extrapyramidal symptoms and tardive dyskinesia improved after starting clozapine.⁶ Another study evaluating patients with Parkinson's disease demonstrated improvements in parkinsonian tremor.⁷

Key side effects of clozapine to note in patients aged 60 years and older

Orthostatic hypotension: Patients aged 60 years and older may be more susceptible to clozapine-induced orthostatic hypotension and particularly if they have compromised cardiovascular function.^{1,2} The risk of orthostatic hypotension is higher in patients who are taking other drugs which may cause this and these include antihypertensives and anti-anginal agents.⁸ Concomitant use of additional medications, including benzodiazepines which impair balance,⁹ may increase the risk of falls.

Other side effects: Patients aged 60 years and older may be particularly susceptible to the anticholinergic effects of clozapine, such as urinary retention and constipation.^{1,2} Frankenburg *et al* (1994) reviewed the use of clozapine in eight patients over 65 years with treatment-resistant psychoses. Of these patients, six showed at least moderate improvement and two stopped treatment due to confusion and excessive sedation.⁶ Clozapine should be used with caution in patients with prostatic enlargement and narrow angle glaucoma due to its anticholinergic effects.^{1,2}

Management

In patients aged 60 years and older it is particularly important to consider any concomitant medical conditions prior to starting clozapine and review other medications if appropriate.

The recommended dose for clozapine in patients aged 60 years and older is 12.5mg given once on the first day, with subsequent dose increments restricted to 25mg/day. Slow titration of clozapine dose is recommended and, if side effects occur, it may be necessary to reduce the dose and/or speed of titration. Close monitoring of elderly patients is advisable and outpatient initiation may not be suitable for patients aged 60 years and older.

Chengappa *et al* (1995) reviewed the records of 12 female patients with psychoses all over 60 years of age, who had received clozapine.⁸ Their findings confirmed the need for low dose initiation and slow titration. Patients who were titrated slowly tolerated the drug relatively well and remained on it, with clinical improvement over time whereas four of the six patients on standard titration experienced problems with postural hypotension and discontinued the drug.

In another review paper, Barak *et al* (1999) noted that elderly patients were managed on much lower maintenance doses than the average, with a mean dose in their review of 134mg/day and that most adverse events occurred in the first 90 days of treatment.⁴

In patients with Parkinson's disease monitoring of standing and supine blood pressure is necessary during the first weeks of treatment.^{1,2}

As the dose of clozapine is increased, consideration should be given to the fact that patients aged 60 years and older, especially female ones, may have higher plasma levels than younger ones.¹⁰

In summary

Treatment with clozapine has been shown to be effective in patients aged 60 years and older in treatment resistant schizophrenia and psychosis occurring in Parkinson's disease. For each patient it is important to undertake a risk-benefit analysis to assess suitability. Careful management of dose and titration rates with monitoring for adverse effects, particularly in the early stages of treatment, may reduce the incidence and severity of side-effects.

References

1. Clozaril (clozapine) Summary of Product Characteristics (online). Mylan Products Ltd. <http://www.medicines.org.uk/emc/> (Accessed on 08/04/2020).
2. Clozaril (clozapine) Summary of Product Characteristics (online). Mylan IRE Healthcare Limited. <http://www.medicines.ie/> (Accessed on 08/04/2020).
3. Howanitz E *et al*. The Efficacy and Safety of Clozapine Versus Chlorpromazine in Geriatric Schizophrenia. *J Clin Psychiatry* 1999; **60**: 41-4.
4. Barak Y *et al*. Clozapine in Elderly Psychiatric Patients: Tolerability, Safety and Efficacy. *Compr Psychiatry* 1999; **40**: 320-5.
5. Maixner SM *et al*. The Efficacy, Safety and Tolerability of Antipsychotics in the Elderly. *J Clin Psychiatry* 1999; **60**(8): 29-41.
6. Frankenburg FR and Kalunian D. Clozapine in the Elderly. *Journal of Geriatric Psychiatry and Neurology* 1994; **7**: 129-132.
7. Fischer PA *et al*. Treatment of Parkinsonian Tremor with Clozapine. *J Neural Transm* 1990; **2**: 233-238.
8. Chengappa KNR *et al*. Clozapine Use in Female Geriatric Patients with Psychoses. *Journal of Geriatric Psychiatry and Neurology* 1995; **8**: 12-15.
9. National Institute for Health and Care Excellence (NICE) (online): BMJ Group and Pharmaceutical Press <http://www.bnf.nice.org.uk/> (Accessed on 15/06/2018).
10. Rostami-Hodjegan A, *et al*. Influence of Dose, Cigarette Smoking, Age, Sex, and Metabolic Activity on Plasma Clozapine Concentrations: A Predictive Model and Nomograms to Aid Clozapine Dose Adjustment and to Assess Compliance in Individual Patients. *J Clinical Psychopharmacology* 2004; **24**: 70-78.

PRESCRIBING INFORMATION**CLOZARIL 25 mg Tablets****CLOZARIL 100 mg Tablets**

Please see Summary of Product Characteristics (SmPC) for full information before prescribing Clozaril.

The use of Clozaril is restricted to patients, physicians and nominated pharmacists registered with the Clozaril Patient Monitoring Service (CPMS).

In the UK a white cell count with differential count must be monitored:

- At least weekly for the first 18 weeks of treatment
- At least at 2-week intervals between weeks 18 and 52
- After 1 year of treatment with stable neutrophil counts, patients may be monitored at least at 4 week intervals

Monitoring must continue throughout treatment and for at least 4 weeks after discontinuation.

Blood clozapine level monitoring is advised in situations such as a patient ceases smoking or switches to e-cigarettes, when concomitant medicines may interact to increase clozapine blood levels, where poor clozapine metabolism is suspected, when a patient has pneumonia or other serious infection and in the event of onset of symptoms suggestive of toxicity.

Clozaril is associated with an increased risk of myocarditis and cardiomyopathy. If suspected Clozaril must be stopped immediately and the patient referred to a cardiologist and not re-exposed to Clozaril.

Presentations

Clozaril 25 mg Tablets containing 25 mg clozapine. Clozaril 100 mg Tablets containing 100 mg clozapine.

Indications

Treatment-resistant schizophrenic patients and in schizophrenia patients with severe, untreatable neurological adverse reactions to other antipsychotic agents, including an atypical antipsychotic agent prescribed for adequate duration. Psychotic disorders occurring during the course of Parkinson's disease, where standard treatment has failed.

Dosage and AdministrationTreatment-resistant schizophrenic patients

12.5 mg once or twice on the first day, followed by 25 mg tablets once or twice on the second day. Increase dose slowly, by increments (see SmPC). In most patients, antipsychotic efficacy can be expected with 200 to 450 mg/day given in divided doses. If dose does not exceed 200 mg/day, it can be given as a single administration in the evening. Once control is achieved, a lower maintenance dose may be effective. Treatment should be maintained for at least 6 months. Doses up to 900 mg/day can be used but the possibility of increased adverse reactions (especially seizures) occurring at doses over 450 mg/day must be considered.

See SmPC for details on re-starting therapy, ending treatment or switching from another antipsychotic.

Psychotic disorders occurring during the course of Parkinson's disease in cases where standard treatment has failed

The starting dose must not exceed 12.5 mg/day taken in the evening. Increase dose by 12.5 mg increments, with a maximum of two increments a week up to a maximum of 50 mg, preferably given as a single dose in the evening. The mean effective dose is usually between 25 and 37.5 mg/day.

The maximum dose of 100 mg/day must never be exceeded. Dose increases should be limited or deferred if orthostatic hypotension, excessive sedation or confusion occurs. Blood pressure should be monitored during the first weeks of treatment. When there has been complete remission of psychotic symptoms for at least two weeks, an increase in anti-parkinsonian medication is possible on the basis of motor status. Cautious titration and a divided dosage schedule are necessary to minimise the risks of hypotension, seizure and sedation.

Method of administration Clozaril is administered orally.

Switching from a previous antipsychotic therapy to Clozaril

It is generally recommended that Clozaril should not be used in combination with other antipsychotics. When Clozaril therapy is to be initiated in a patient undergoing oral antipsychotic therapy, it is recommended that the other antipsychotic should first be discontinued by tapering the dosage downwards.

Special populations: Hepatic impairment Patients with hepatic impairment should receive Clozaril with caution along with regular monitoring of liver function tests (see section 4.4 of SmPC).

Paediatric population No paediatric studies have been performed. The safety and efficacy of Clozaril in children and adolescents under the age of 16 years have not yet been established. Clozaril should not be used in this group until further data becomes available.

Patients 60 years of age and older Initiation of treatment is recommended at a particularly low dose (12.5 mg given once on the first day), with subsequent dose increments restricted to 25 mg/day. See SmPC for information on ending therapy.

Contraindications

Hypersensitivity to the active substance or to any of the excipients. Patients unable to undergo regular blood tests. History of toxic or idiosyncratic granulocytopenia / agranulocytosis (with the exception of granulocytopenia / agranulocytosis from previous chemotherapy). History of Clozaril induced agranulocytosis. Concurrent treatment with substances known to have a substantial potential for causing agranulocytosis; concomitant use of depot antipsychotics is discouraged.

Impaired bone marrow function. Uncontrolled epilepsy. Alcoholic and other toxic psychoses, drug intoxication, comatose conditions. Circulatory collapse and/or CNS depression of any cause.

Severe renal or cardiac disorders (e.g. myocarditis). Active liver disease associated with nausea, anorexia or jaundice; progressive liver disease, hepatic failure. Paralytic ileus.

Warnings and Precautions

Agranulocytosis: Before initiating clozapine therapy, patients should have a blood test and a history and physical examination. Clozaril can cause agranulocytosis, so is restricted to patients who have initially normal leukocyte findings (White Blood Cell (WBC) count > 3.5x 10⁹/l and Absolute Neutrophil Count (ANC) > 2.0x 10⁹/l), and in whom regular WBC counts and ANC can be performed within 10 days prior to starting Clozaril, weekly for first 18 weeks, thereafter at 4 week intervals throughout treatment and for 4 weeks after complete discontinuation.

Patients with history of cardiac illness or abnormal cardiac findings on physical examination prior to treatment should be referred to a specialist for other examinations that might include an ECG, and the patient treated only if the expected benefits clearly outweigh the risks. The treating physician should consider performing a pre-treatment ECG.

QT interval prolongation: As with other antipsychotics, caution is advised in patients with known cardiovascular disease or family history of QT prolongation. As with other antipsychotics, caution should be exercised when clozapine is prescribed with medicines known to increase QTc interval.

Cerebrovascular adverse events: Clozapine should be used with caution in patients with risk factors for stroke. Risk of thromboembolism: Cases of venous thromboembolism (VTE) have been reported with antipsychotic drugs. If the diagnosis of NMS is confirmed, Clozaril should be discontinued immediately and appropriate medical measures should be administered. **Metabolic changes:** Atypical antipsychotic drugs, including Clozaril, have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. **Hyperglycaemia:** Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. **Hepatic impairment:** Patients with stable pre-existing liver disorders may receive Clozaril, but need regular liver function tests. Liver function tests should be performed in patients in whom symptoms of possible liver dysfunction, such as nausea, vomiting and/or anorexia, develop during Clozaril therapy.

Prior to treatment initiation, physicians must ensure that the patient has not experienced an adverse haematological reaction to clozapine that necessitated discontinuation.

Immediate discontinuation of Clozaril is mandatory if either the WBC count is less than 3.0x10⁹/l or the ANC is less than 1.5x10⁹/l at any time during Clozaril treatment. Patients in whom Clozaril has been discontinued as a result of either WBC or ANC deficiencies must not be re-exposed to Clozaril. Following discontinuation of Clozaril, haematological evaluation is required until haematological recovery has occurred. **If Clozaril has been withdrawn and either a further drop in the WBC count below 2.0x10⁹/l occurs or the ANC falls below 1.0x10⁹/l the management of this condition must be guided by an experienced haematologist.** The patient should be educated to contact the treating physician immediately if any kind of infection, fever, sore throat or other flu-like symptoms develop. WBC and differential blood counts must be performed immediately if any symptoms or signs of an infection occur.

Low WBC count/ANC: If, during Clozaril therapy, either the WBC count falls to between 3.5x10⁹/l and 3.0x10⁹/l or the ANC falls to between 2.0x10⁹/l and 1.5x10⁹/l, haematological evaluations must be performed at least twice weekly until the patient's WBC count and ANC stabilise within the range 3.0-3.5x10⁹/l and 1.5-2.0x10⁹/l respectively, or higher.

Eosinophilia: Discontinuation of Clozaril is recommended if the eosinophil count rises above $3.0 \times 10^9 / l$; therapy should be restarted only after the eosinophil count has fallen below $1.0 \times 10^9 / l$.
Discontinuation of Thrombocytopenia: Clozaril therapy is recommended if the platelet count falls below $50 \times 10^9 / l$.
Cardiovascular disorders: Orthostatic hypotension, with or without syncope, can occur during Clozaril treatment. Rarely, collapse can be profound and may be accompanied by cardiac and/or respiratory arrest which is more likely to occur with concurrent use of certain medications (See SPC for more details) and during initial titration with rapid dose escalation. Patients starting Clozaril treatment require close medical supervision. Clozaril is associated with an increased risk of myocarditis, pericarditis/pericardial effusion and cardiomyopathy; and if suspected, Clozaril treatment should be promptly stopped and the patient immediately referred to a cardiologist. Patients with clozapine-induced myocarditis or cardiomyopathy should not be re-exposed to Clozaril. In patients who are diagnosed with cardiomyopathy while on Clozaril treatment, there is potential to develop mitral valve incompetence, including mild or moderate mitral regurgitation. Myocarditis or cardiomyopathy should be suspected in patients who experience persistent tachycardia at rest, especially in the first two months of treatment, and/or palpitations, arrhythmias, chest pain and other signs and symptoms of heart failure or symptoms mimicking myocardial infarction. Flu-like symptoms may also be present.
Myocardial infarction (MI): There have been post marketing reports of MI which include fatal cases.
Epilepsy: Patients with a history of epilepsy should be closely observed during Clozaril therapy since dose related convulsions have been reported.
Hepatic impairment: Patients with stable pre-existing liver disorders or liver dysfunction need regular liver function tests. If the LFTs are elevated, discontinue Clozaril and resume only if LFTs return to normal.
Dyslipidemia: Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics, including Clozaril. Clinical monitoring, including baseline and periodic follow-up lipid evaluations in patients using clozapine, is recommended.
Anticholinergic effects: Use with care in patients with a history of colonic disease, a history of lower abdominal surgery, glaucoma, narrow angle glaucoma, prostatic enlargement and in patients receiving concomitant medications known to cause constipation, megacolon and intestinal infarction/ischaemia, paralytic ileus.
Pyrexia: High temperatures should be evaluated carefully to rule out underlying infection, agranulocytosis or Neuroleptic Malignant Syndrome (NMS). If NMS is confirmed, discontinue Clozaril immediately and administer appropriate medical measures. Patients with rare hereditary problems of galactose intolerance should not take Clozaril. Impaired glucose tolerance and/or development or exacerbation of diabetes mellitus has been reported rarely during treatment with clozapine. Falls: Clozaril may cause seizures, somnolence and other conditions that could lead to falls. Fall risk assessments should be performed on patients with exacerbating conditions.
Risk of thromboembolism: Immobilisation of patients should be avoided due to reports of thromboembolism. Increased mortality in elderly patients with dementia.
Caution when prescribing to pregnant women. Mothers receiving Clozaril should not breast-feed. Adequate contraceptive measures must be ensured in women of childbearing potential. Neonates exposed to antipsychotic drugs (including Clozaril), during the third trimester of pregnancy are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress or feeding disorder. Consequently, newborns should be monitored carefully. Activities such as driving or operating machinery should be avoided, especially during the initial weeks of treatment.

Interaction with other medicinal products and other forms of interaction

Clozaril must not be used concomitantly with substances having a well-known potential to suppress bone marrow function. (See Section 4.3 of the SmPC, Contraindications). Long-acting depot antipsychotics (with myelosuppressive potential) must not be used with Clozaril because these cannot be removed from the body in situations where they may be required e.g. neutropenia. Alcohol should not be used with Clozaril due to possible potentiation of sedation.

Caution is advised if Clozaril is used concomitantly with other CNS active agents such as, MAOIs, perazine, SSRIs especially fluvoxamine, caffeine, CNS depressants including narcotics, antihistamines and benzodiazepines. Caution is advised if Clozaril is used concomitantly with antihypertensive agents, highly protein bound drugs (e.g. warfarin and digoxin), phenytoin, lithium, rifampicin, valproic acid, noradrenaline [norepinephrine], adrenaline [epinephrine] or omeprazole. Cases have been reported of an interaction between citalopram and clozapine, which may increase the risk of adverse events associated with clozapine. The nature of this interaction has not been fully elucidated. Hormonal contraceptives (including combinations of estrogen and progesterone or progesterone only) are CYP 1A2, CYP 3A4 and CYP 2C19 inhibitors. Therefore initiation or discontinuation of hormonal contraceptives, may require dose adjustment of clozapine according to the individual medical need. In cases of sudden cessation of smoking, the plasma clozapine concentration may be increased, thus leading to an increase in adverse effects. See SPC for more details.

Fertility, Pregnancy and Lactation

Pregnancy: Caution should be exercised when prescribing to pregnant women. Neonates exposed to antipsychotics (including Clozaril) during the third trimester are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, or feeding disorder. Consequently, newborns should be monitored carefully.

Lactation: Animal studies suggest that clozapine is excreted in breast milk and has an effect in the nursing infant; therefore, mothers receiving Clozaril should not breast-feed.

Fertility: Limited data available on the effects of clozapine on human fertility are inconclusive.

Women of child-bearing potential: A return to normal menstruation may occur as a result of switching from other antipsychotics to Clozaril. Adequate contraceptive measures must therefore be ensured in women of childbearing potential.

Ability to Drive and Operate Machinery

Owing to the ability of Clozaril to cause sedation and lower the seizure threshold, activities such as driving or operating machinery should be avoided, especially during the initial weeks of treatment.

Undesirable effects

Adverse reactions are ranked under headings of frequency. Very common ($\geq 1/10$), common ($\geq 1/100$, $< 1/10$), uncommon ($\geq 1/1,000$, $< 1/100$), rare ($\geq 1/10,000$, $< 1/1,000$), very rare ($< 1/10,000$), including isolated reports.

The most serious adverse reactions experienced with clozapine are agranulocytosis, seizure, cardiovascular effects and fever.

Very common: Drowsiness/sedation, dizziness, tachycardia, constipation, hypersalivation.

Common: Leukopenia/decreased WBC/neutropenia, eosinophilia, leukocytosis, weight gain, blurred vision, headache, tremor, rigidity, akathisia, extrapyramidal symptoms, seizures, convulsions, myoclonic jerks, ECG changes, hypertension, postural hypotension, syncope, nausea, vomiting, anorexia, dry mouth, elevated liver enzymes, urinary incontinence, urinary retention, fatigue, fever, benign hyperthermia, disturbances in sweating/temperature regulation, dysarthria.

Uncommon: Agranulocytosis, neuroleptic malignant syndrome, dysphemia, falls.

For details of rare, very rare and not known undesirable effects please refer to SmPC."

Package Quantities and basic NHS price

28 x 25 mg tablets : £2.95 ; 84 x 25 mg tablets : £6.30; 100 x 25 mg tablets : £7.50

28 x 100 mg tablets : £11.76 ; 84 x 100 mg tablets : £25.21 ; 100 x 100 mg tablets : £30.01

Supply of Clozaril is restricted to hospital pharmacies registered with the CLOZARIL Patient Monitoring Service.

Marketing Authorisation Holder

Mylan Products Limited, 20 Station Close, Potters Bar, Herts, EN6 1TL, UK.

Product Authorisation Numbers

25 mg tablets: PL 46302/0054

100 mg tablets: PL 46302/0057

Legal Category: POM

Further information is available in the UK from: BGP Products Ltd., Building Q1, Quantum House, 60 Norden Road, Maidenhead, Berkshire, SL6 4AY, UK.

Date of last revision: May 2020

Clozaril is a registered Trademark

Reporting of adverse reactions:

Please continue to report suspected adverse drug reactions with any medicine or vaccine to the MHRA through the Yellow Card Scheme.

It is easiest and quickest to report adverse drug reactions online via the Yellow Card website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Alternatively, you can report via some clinical IT systems (EMIS/SystemOne/Vision/MiDatabank) or by calling the Commission on Human Medicines (CHM) free phone line: 0800-731-6789. Adverse reactions/events should also be reported to Viatri via cpms@viatri.com

uk-pi-clozaril-May20-v5