

# Calif. Implements Psychologist Admitting Privileges

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California psychiatrists are wondering whether prescribing will be next, now that newly issued state regulations allow psychologists in the state to have admitting privileges for psychiatric patients.

“This would be a prelude to that, if you want to think about it from the psychologists’ perspective,” said Randall Hagar, di-

rector of government affairs at the California Psychiatric Association in Sacramento. “Getting this kind of privilege would be ‘physiciandom’ [so now they will say], ‘In order to better treat our patients, we need to be able to handle the medication aspect of it. We’re prevented from taking good care of our patients until we get this privilege.’ ”

Psychology groups, however, reject the notion that getting these regulations into place is a stepping-stone to prescribing.

“The big difference between prescribing and the hospital practices at issue with these laws is that the activities being envisioned by these regulations are already within the scope of the psychologist’s license,” said Russ Newman, Ph.D., executive director for professional practice at the American Psychological Association in Washington. “Prescribing is not; it would require a psychology licensure change.”

The regulations, which apply to patients at psychiatric hospitals as well as those in

psychiatric wards of acute-care facilities, permit psychologists to admit patients, order therapy, ask for consultations, and approve ground and weekend privileges, said Charles Faltz, Ph.D., director of professional affairs at the California Psychological Association in Sacramento.

Dr. Faltz added that although such privileges may be very new to some psychologists, others have already been doing much of the admitting work themselves anyway. He said that before he began working for the association, he was on the full medical staff of a hospital and was admitting and managing patients. “The way it’s done is in collaboration with a physician—usually with both the primary care physician and the psychiatrist who prescribes medications,” he said.

One of the issues in dispute with the California regulations—which were first promulgated in 1978 and finally issued in April—is the way in which they were approved. Instead of going through the usual regulatory process, which require public hearings, these regulations ended up going through the courts—with little public input.

“These particular regulations were made using Rule 100, which [means that] if the courts interpret a particular law and say ‘This is what the law means,’ the regulatory agencies have no particular ability to change it,” Dr. Faltz said. “So they can simply put those regulations through, and they don’t have public hearings, because it isn’t possible for the public to change the court’s interpretation.”

But Mr. Hagar said the regulations were the result of three attempts by the psychologists to get the regulations put out without public notice or input. “This attempt succeeded, and we’re having a hard time figuring that there’s anything else but politics involved,” he said.

Earlier attempts involved getting the psychologists privileges to order and release seclusion and restraint treatments, Mr. Hagar continued. “This time, they got the seclusion and restraint orders and also got the ability to put someone in a hospital and release them, and also to transfer them.”

Mr. Hagar said psychologists should be forewarned that their liability rates might increase now that they have these additional privileges. But Dr. Faltz said psychologists were not concerned about such a possibility, because their experience to date with collaborative practice has proved otherwise.

“There have never been any instances where it was shown that ... psychologists practicing in hospitals in this way have had increased liability for psychologists or hospitals,” he said. “In fact, when something goes wrong, all the practitioners involved with the patient are sued. So if a psychiatrist is managing the patient and has a psychologist consulting or doing testing, all involved are sued. It’s equal opportunity.”

So far, 17 other states and the District of Columbia have these hospital privileging laws in addition to California, but psychologists are not expecting many more of them to be passed, Dr. Newman said.



**Rx Only**  
**Brief Summary of Prescribing Information.**  
For complete details, please see full Prescribing Information for Namenda.

**INDICATIONS AND USAGE**  
Namenda (memantine hydrochloride) is indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

**CONTRAINDICATIONS**  
Namenda (memantine hydrochloride) is contraindicated in patients with known hypersensitivity to memantine hydrochloride or to any excipients used in the formulation.

**PRECAUTIONS**  
**Information for Patients and Caregivers:** Caregivers should be instructed in the recommended administration (twice per day for doses above 5 mg) and dose escalation (minimum interval of one week between dose increases).

**Neurological Conditions**  
Seizures: Namenda has not been systematically evaluated in patients with a seizure disorder. In clinical trials of Namenda, seizures occurred in 0.2% of patients treated with Namenda and 0.5% of patients treated with placebo.

**Genitourinary Conditions**  
Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine.

**Special Populations**  
**Hepatic Impairment**  
Namenda undergoes partial hepatic metabolism, but the major fraction of a dose (57-82%) is excreted unchanged in urine. The pharmacokinetics of memantine in patients with hepatic impairment have not been investigated, but would be expected to be only modestly affected.

**Renal Impairment**  
There are inadequate data available in patients with mild, moderate, and severe renal impairment but it is likely that patients with moderate renal impairment will have higher exposure than normal subjects. Dose reduction in these patients should be considered. The use of Namenda in patients with severe renal impairment is not recommended.

**Drug-Drug Interactions**  
**N-methyl-D-aspartate (NMDA) antagonists:** The combined use of Namenda with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution.

**Effects of Namenda on substrates of microsomal enzymes:** *In vitro* studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected.

**Effects of inhibitors and/or substrates of microsomal enzymes on Namenda:** Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the metabolism of memantine.

**Acetylcholinesterase (AChE) inhibitors:** Coadministration of Namenda with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine and donepezil was similar to that of donepezil alone.

**Drugs eliminated via renal mechanisms:** Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system, including hydrochlorothiazide (HCTZ), triamterene (TA), cimetidine, ranitidine, quinidine, and nicotine, could potentially result in altered plasma levels of both agents. However, coadministration of Namenda and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%.

**Drugs that make the urine alkaline:** The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate) and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions.

**Carcinogenesis, Mutagenesis and Impairment of Fertility**  
There was no evidence of carcinogenicity in a 113-week oral study in mice at doses up to 40 mg/kg/day (10 times the maximum recommended human dose [MRHD] on a mg/m<sup>2</sup> basis). There was also no evidence of carcinogenicity in rats orally dosed at up to 40 mg/kg/day for 71 weeks followed by 20 mg/kg/day (20 and 10 times the MRHD on a mg/m<sup>2</sup> basis, respectively) through 128 weeks.

Memantine produced no evidence of genotoxic potential when evaluated in the *in vitro* S. typhimurium or E. coli reverse mutation assay, an *in vitro* chromosomal aberration test in human lymphocytes, an *in vivo* cytogenetics assay for chromosome damage in rats, and the *in vivo* mouse micronucleus assay. The results were equivalent in an *in vitro* gene mutation assay using Chinese hamster V79 cells.

No impairment of fertility or reproductive performance was seen in rats administered up to 18 mg/kg/day (9 times the MRHD on a mg/m<sup>2</sup> basis) orally from 14 days prior to mating through gestation and lactation in females, or for 60 days prior to mating in males.

**Pregnancy**  
Pregnancy Category B: Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 9 and 30 times, respectively, the maximum recommended human dose [MRHD] on a mg/m<sup>2</sup> basis). Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal

toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the postpartum period. The no-effect dose for these effects was 6 mg/kg, which is 3 times the MRHD on a mg/m<sup>2</sup> basis.

There are no adequate and well-controlled studies of memantine in pregnant women. Memantine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**  
It is not known whether memantine is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother.

**Pediatric Use**  
There are no adequate and well-controlled trials documenting the safety and efficacy of memantine in any illness occurring in children.

**ADVERSE REACTIONS**  
The experience described in this section derives from studies in patients with Alzheimer's disease and vascular dementia.

**Adverse Events Leading to Discontinuation:** In placebo-controlled trials in which dementia patients received doses of Namenda up to 20 mg/day, the likelihood of discontinuation because of an adverse event was the same in the Namenda group as in the placebo group. No individual adverse event was associated with the discontinuation of treatment in 1% or more of Namenda-treated patients and at a rate greater than placebo.

**Adverse Events Reported in Controlled Trials:** The reported adverse events in Namenda (memantine hydrochloride) trials reflect experience gained under closely monitored conditions in a highly selected patient population. In actual practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior and the types of patients treated may differ. Table 1 lists treatment-emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled dementia trials and for which the rate of occurrence was greater for patients treated with Namenda than for those treated with placebo. No adverse event occurred at a frequency of at least 5% and twice the placebo rate.

Table 1: Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving Namenda and at a Higher Frequency than Placebo-Treated Patients.

Body System Adverse Event	Placebo (N = 922) %	Namenda (N = 940) %
Body as a Whole		
Fatigue	1	2
Pain	1	3
Cardiovascular System		
Hypertension	2	4
Central and Peripheral Nervous System		
Dizziness	5	7
Headache	3	6
Gastrointestinal System		
Constipation	3	5
Vomiting	2	3
Musculoskeletal System		
Back pain	2	3
Psychiatric Disorders		
Confusion	5	6
Somnolence	2	3
Hallucination	2	3
Respiratory System		
Coughing	3	4
Dyspnea	1	2

Other adverse events occurring with an incidence of at least 2% in Namenda-treated patients but at a greater or equal rate on placebo were agitation, fall, infected injury, urinary incontinence, diarrhea, bronchitis, insomnia, urinary tract infection, influenza-like symptoms, abnormal gait, depression, upper respiratory tract infection, anxiety, peripheral edema, nausea, anorexia, and arthralgia.

The overall profile of adverse events and the incidence rates for individual adverse events in the subpopulation of patients with moderate to severe Alzheimer's disease were not different from the profile and incidence rates described above for the overall dementia population.

**Vital Sign Changes:** Namenda and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure, and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with Namenda. A comparison of supine and standing vital sign measures for Namenda and placebo in elderly normal subjects indicated that Namenda treatment is not associated with orthostatic changes.

**Laboratory Changes:** Namenda and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Namenda treatment.

**ECG Changes:** Namenda and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with Namenda treatment.

**Other Adverse Events Observed During Clinical Trials**  
Namenda has been administered to approximately 1350 patients with dementia, of whom more than 1200 received the maximum recommended dose of 20 mg/day. Patients received Namenda treatment for periods of up to 884 days, with 862 patients receiving at least 24 weeks of treatment and 387 patients receiving 48 weeks or more of treatment. Treatment emergent signs and symptoms that occurred during 8 controlled

clinical trials and 4 open-label trials were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized categories using WHO terminology, and event frequencies were calculated across all studies.

All adverse events occurring in at least two patients are included, except for those already listed in Table 1, WHO terms too general to be informative, minor symptoms or events unlikely to be drug-caused, e.g., because they are common in the study population. Events are classified by body system and listed using the following definitions: frequent adverse events - those occurring in at least 1/100 patients; infrequent adverse events - those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to Namenda treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies.

**Body as a Whole:** *Frequent:* syncope. *Infrequent:* hypothermia, allergic reaction.

**Cardiovascular System:** *Frequent:* cardiac failure. *Infrequent:* angina pectoris, bradycardia, myocardial infarction, thrombophlebitis, atrial fibrillation, hypotension, cardiac arrest, postural hypotension, pulmonary embolism, pulmonary edema.

**Central and Peripheral Nervous System:** *Frequent:* transient ischemic attack, cerebrovascular accident, vertigo, ataxia, hypokinesia. *Infrequent:* paresthesia, convulsions, extrapyramidal disorder, hyperreflexia, tremor, aphasia, hypoesthesia, abnormal coordination, hemiplegia, hyperkinesia, involuntary muscle contractions, stupor, cerebral hemorrhage, neuralgia, ptosis, neuropathy.

**Gastrointestinal System:** *Infrequent:* gastroenteritis, diverticulitis, gastrointestinal hemorrhage, melena, esophageal ulceration.

**Hemic and Lymphatic Disorders:** *Frequent:* anemia. *Infrequent:* leukopenia.

**Metabolic and Nutritional Disorders:** *Frequent:* increased alkaline phosphatase, decreased weight. *Infrequent:* dehydration, hyponatremia, aggravated diabetes mellitus.

**Psychiatric Disorders:** *Frequent:* aggressive reaction. *Infrequent:* delusion, personality disorder, emotional lability, nervousness, sleep disorder, libido increased, psychosis, amnesia, apathy, paranoid reaction, thinking abnormal, crying abnormal, appetite increased, paroniria, delirium, depersonalization, neurosis, suicide attempt.

**Respiratory System:** *Frequent:* pneumonia. *Infrequent:* apnea, asthma, hemoptysis.

**Skin and Appendages:** *Frequent:* rash. *Infrequent:* skin ulceration, pruritus, cellulitis, eczema, dermatitis, erythematous rash, alopecia, urticaria.

**Special Senses:** *Frequent:* cataract, conjunctivitis. *Infrequent:* macula lutea degeneration, decreased visual acuity, decreased hearing, tinnitus, blepharitis, blurred vision, corneal opacity, glaucoma, conjunctival hemorrhage, eye pain, retinal hemorrhage, xerophthalmia, diplopia, abnormal lacrimation, myopia, retinal detachment.

**Urinary System:** *Frequent:* frequent micturition. *Infrequent:* dysuria, hematuria, urinary retention.

**Events Reported Subsequent to the Marketing of Namenda, both US and Ex-US**

Although no causal relationship to memantine treatment has been found, the following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in labeling: atrioventricular block, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, claudication, colitis, dyskinesia, dysphagia, gastritis, gastroesophageal reflux, grand mal convulsions, intracranial hemorrhage, hepatic failure, hyperlipidemia, hypoglycemia, ileus, impotence, malaise, neuroleptic malignant syndrome, acute pancreatitis, aspiration pneumonia, acute renal failure, prolonged QT interval, restlessness, Stevens-Johnson syndrome, sudden death, supraventricular tachycardia, tachycardia, tardive dyskinesia, and thrombocytopenia.

**ANIMAL TOXICOLOGY**  
Memantine induced neuronal lesions (vacuolation and necrosis) in the multipolar and pyramidal cells in cortical layers III and IV of the posterior cingulate and retrosplenial neocortices in rats, similar to those which are known to occur in rodents administered other NMDA receptor antagonists. Lesions were seen after a single dose of memantine. In a study in which rats were given daily oral doses of memantine for 14 days, the no-effect dose for neuronal necrosis was 6 times the maximum recommended human dose on a mg/m<sup>2</sup> basis. The potential for induction of central neuronal vacuolation and necrosis by NMDA receptor antagonists in humans is unknown.

**DRUG ABUSE AND DEPENDENCE**  
**Controlled Substance Class:** Memantine HCl is not a controlled substance.

**Physical and Psychological Dependence:** Memantine HCl is a low to moderate affinity uncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 2,504 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

**OVERDOSAGE**  
Because strategies for the management of overdose are continually evolving, it is advisable to contact a poison control center to determine the latest recommendations for the management of an overdose of any drug. As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine. In a documented case of an overdose with up to 400 mg of memantine, the patient experienced restlessness, psychosis, visual hallucinations, somnolence, stupor and loss of consciousness. The patient recovered without permanent sequelae.

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Rev. 05/05

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