Recognizing and treating tardive dyskinesia (TD)

Long-term care facilities

NEUROCRINE® BIOSCIENCES

TD is a medication-induced movement disorder

associated with prolonged use of dopamine receptor blocking agents (DRBAs), including antipsychotics[1]

For all residents receiving antipsychotics, Centers for Medicare & Medicaid Services (CMS) guidance states that **facilities must evaluate the effectiveness of the medications as well as look for potential adverse consequences.**[2]

TD is an adverse consequence requiring monitoring.[2]

MEDICATIONS THAT MAY REQUIRE MONITORING FOR TD

FIRST-GENERATION ANTIPSYCHOTICS[3]

- Chlorpromazine *(Thorazine)*
- Molindone *(Moban)*[4]
- Fluphenazine *(Prolixin)*
- Loxapine *(Loxitane)*
- Haloperidol *(Haldol)*
- Perphenazine *(Trilafon)*
- Thioridazine *(Mellaril)*
- Thiothixene *(Navane)*
- Trifluoperazine *(Stelazine)*

SECOND-GENERATION ANTIPSYCHOTICS[3]

- Aripiprazole *(Abilify)*
- Asenapine *(Saphris)*
- Brexpiprazole *(Rexulti)*
- Cariprazine *(Vraylar)*
- Clozapine *(Clozaril)*
- Iloperidone *(Fanapt)*
- Loxapine *(Loxitane)*
- Lumateperone *(Caplyta)*
- Lurasidone *(Latuda)*
- Olanzapine *(Zyprexa)*
- Paliperidone *(Invega)*
- Pimavanserin *(Nuplazid)*
- Quetiapine *(Seroquel, Seroquel XR)*
- Risperidone *(Risperdal)*
- Ziprasidone *(Geodon)*

OTHER DRBAs[1]

- Prochlorperazine *(Compazine, Compro)*
- Promethazine *(Phenergan, Promethegan, Phenadoz)*
- Trimethobenzamide *(Tebamide, Tigan)*
- Thiethylperazine *(Torecan)*
- Metoclopramide *(Reglan)*

Older patients treated with antipsychotics have a greater risk for TD, even when treated with lower doses for a shorter duration[5-10]

Contact your Neurocrine representative for additional information about TD

Recognize and report symptoms of TD

Each resident's medication regimen must be managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.[2]

SELECT CMS REGULATIONS & GUIDANCE

F757 – §483.45(D) UNNECESSARY DRUGS AND F758 – §483.45(C)(3) AND (E) PSYCHOTROPIC DRUGS[2]	• The use of a medication without adequate monitoring may increase the risk of adverse consequences
MEDICATION MANAGEMENT MONITORING FOR EFFICACY AND ADVERSE CONSEQUENCES[2]	• Monitoring and accurate documentation of the resident's response to any medication(s) is essential to evaluate the ongoing benefits as well as risks of various medications
PSYCHOTROPIC MEDICATIONS AND ANTIPSYCHOTIC MEDICATIONS (F758 ONLY GUIDANCE)[2]	• Residents who take these medications must be monitored for any adverse consequences. TD is considered a potential adverse consequence
MONITORING OF PSYCHOTROPIC MEDICATIONS[2]	• If psychotropic medication is identified as possibly causing or contributing to an adverse consequence, the facility and prescriber must document it in the medical record. TD is considered a potential adverse consequence

Select guidance is provided for education and information purposes. See full *CMS State Operations Manual* for long-term facilities for complete information.

CLINICAL GUIDANCE & RECOMMENDATIONS

AMERICAN PSYCHIATRIC ASSOCIATION, DSM-5-TR[1]	• Abnormal, involuntary movements that may be choreiform (rapid, jerky, nonrepetitive), athetoid (slow, sinuous, continual), or semirhythmic (eg, stereotypies) in nature • Orofacial movements are the most obvious presentation, but involuntary movements may also impact upper and lower limbs, the neck, and trunk • Generally, emerges 3 months to years after initiating antipsychotics but **may emerge as early as 1 month in individuals ≥60 years**
2020 AMERICAN PSYCHIATRIC ASSOCIATION GUIDELINES[11]	• Screen for TD before starting or changing DRBA treatment • Monitor for signs of TD at every clinical encounter • Conduct a structured TD assessment every 6 to 12 months, depending on patient's risk, and if new or worsening movements are detected at any clinical encounter
STRUCTURED TD ASSESSMENTS INCLUDE:	• The Abnormal Involuntary Movement Scale (AIMS)[12] • The Dyskinesia Identification System Condensed User Scale (DISCUS)[13]
KEY TOUCHPOINTS FOR TD MONITORING MAY INCLUDE[2]:	• Initial assessment and care plan development • Observation of the resident during normal activities of daily living • Monthly drug regimen review by the consultant pharmacist • During regularly scheduled physician visits, MDS reviews, or care plan updates

Consider VMAT2 inhibitors first line for TD

ICD-10 code for tardive dyskinesia: G24.01 Drug-induced subacute dyskinesia

This coding information is intended solely for educational purposes regarding possible codes applicable to tardive dyskinesia. Coding information is subject to change. Neurocrine disclaims any responsibility for claims submitted by providers or physicians. It is the provider's responsibility to determine appropriate codes, charges, and modifiers, and to submit bills for services and products consistent with what was rendered as well as the patient's insurer requirements. Third-party payers may have different coding requirements. Such policies can change over time. Providers are encouraged to contact third-party payers for each patient to verify specific information on their coding policies.

SELECT CMS REGULATIONS & GUIDANCE

F757 – §483.45(D) UNNECESSARY DRUGS AND F758 – §483.45(C)(3) AND (E) PSYCHOTROPIC DRUGS[2]	• Proper medication selection and prescribing (including dose, duration, and type of medication(s)) may help stabilize or improve a resident's outcome, quality of life, and functional capacity • The Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults provides information on safely prescribing medications for older adults
F759 – §483.45(F) MEDICATION ERRORS AND F760 – §483.45(F)(2) SIGNIFICANT MEDICATION ERRORS[2]	• A facility must ensure that its medication error rates are not 5% or greater and that there are no significant medication errors

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CLINICAL GUIDANCE & RECOMMENDATIONS

VMAT2 inhibitors are the only FDA-approved treatment for TD[11,14]

2020 AMERICAN PSYCHIATRIC ASSOCIATION GUIDELINES[11]	• Treatment with a VMAT2 inhibitor is recommended in patients with moderate to severe TD and may also be considered in patients with mild TD

Anticholinergics are not recommended for the treatment of TD[11,15,16]

BENZTROPINE PACKAGE INSERT[16]	• Benztropine is indicated as an adjunct to the treatment of parkinsonism and is useful in the control of extrapyramidal disorders (other than TD) due to neuroleptic drugs • Benztropine is not recommended for use in patients with TD • Antiparkinsonism agents do not alleviate the symptoms of TD, and in some instances may aggravate them
2020 AMERICAN PSYCHIATRIC ASSOCIATION GUIDELINES[11]	• Anticholinergic medications do not improve and may even worsen TD
2013 AMERICAN ACADEMY OF NEUROLOGY GUIDELINES[15]	• There are insufficient data to recommend anticholinergics for the treatment of TD
BEERS CRITERIA[17]	• Benztropine may be associated with delirium, worsened cognitive impairment, worsened cognition, and worsened urinary retention; not recommended to prevent antipsychotic-induced extrapyramidal effects; not very effective for Parkinson's disease

Preserve stable antipsychotic regimens

CMS guidance emphasizes the importance of seeking an appropriate dose and duration for each medication and minimizing the risk of adverse consequences.[2]

SELECT CMS REGULATIONS & GUIDANCE

F758 – §483.45(E)(2) PSYCHOTROPIC DRUGS[2]	• Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs
MEDICATION MANAGEMENT – PSYCHOTROPIC MEDICATIONS AND ANTIPSYCHOTIC MEDICATIONS (F758 ONLY GUIDANCE)[2]	• The medical record must show documentation of the diagnosed condition for which a medication is prescribed
USE OF PSYCHOTROPIC MEDICATIONS IN SPECIFIC CIRCUMSTANCES[2]	• Psychotropic medications may be used to treat an enduring (ie, non-acute; chronic or prolonged) condition • Before initiating or increasing a psychotropic medication for enduring conditions, the resident's symptoms and therapeutic goals must be clearly and specifically identified and documented
ANTIPSYCHOTIC MEDICATIONS[2]	• Documentation must clearly show the indication for the antipsychotic medication, the multiple attempts to implement care-planned, non-pharmacological approaches, and ongoing evaluation of the effectiveness of these interventions
GRADUAL DOSE REDUCTION FOR PSYCHOTROPIC MEDICATIONS[2]	• For any resident who is receiving a psychotropic medication to treat a disorder other than expressions or indications of distress related to dementia (eg, schizophrenia, bipolar mania, depression with psychotic features, or another medical condition, other than dementia, which may cause psychosis), the gradual dose reduction may be considered clinically contraindicated

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CLINICAL GUIDANCE & RECOMMENDATIONS

VMAT2 inhibitors offer the ability to treat TD while preserving stable antipsychotic regimens[14]

2020 AMERICAN PSYCHIATRIC ASSOCIATION GUIDELINES[11]	• TD may persist, and may even worsen, despite reduction in dose or discontinuation of antipsychotics
2013 AMERICAN ACADEMY OF NEUROLOGY GUIDELINES[15]	• There is a lack of clear evidence to support or refute withdrawing or switching antipsychotics to treat TD • Changing a patient's antipsychotic regimen may destabilize the underlying psychiatric condition

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