2025 Antidepressants Reference Sheet

Medication	Geriatric Dosing, Initial (range)	Important Highlights
Selective Serotonin Reuptake Inhibitors (SSRIs): for dosing for GAD and anxiety: used lower initial dose than for depression		
Citalopram	10 mg daily (10-20 mg daily)	Max dose is 20 mg in older adults due to dose-dependent ↑QTc risk Watch for hypokalemia and hypomagnesemia as well as combination with drugs ↑QTc interval
Escitalopram	5 mg daily (5-10 mg daily)	Potential for ↑QTc interval Watch for hypokalemia and hypomagnesemia as well as combination with drugs ↑QTc interval
Fluoxetine	10 mg daily (10-40 daily)	Long $T_{1/2}$, accumulation may occur in older adults More drug interactions due to CYP2D6, CYP3A4 and CYP2C19 inhibition It is also more activating SSRI.
Fluvoxamine	IR 25 mg daily (25 mg BID – 100 mg BID) XR:	More drug interactions ↑ nausea/vomiting and sedation Short $T_{1/2}$ Many drug interactions due to CYP1A2, CYP2D6, CYP3A4 and CYP2C19 inhibition Only FDA-approved for OCD not commonly used for management of depression or anxiety disorders
Paroxetine	IR: 10 mg daily (10-60 mg daily) If CrCl 30-60 mL/min – concentrations are doubled If CrCL < 30mL/min – concentrations are ~ 4x that of normal renal function Max dose is 40 mg/day in renal impairment	Listed on AGS Beers Criteria Most anticholinergic SSRI Short half-life and increased risk for withdrawal symptoms More drug interactions due to CYP2D6 inhibitory properties
Sertraline	25 mg daily (25-200 mg daily)	Highest diarrhea AEs (14% vs ~7%)
Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)		
Desvenlafaxine	50 mg daily (50-100 mg daily) Renal dosage If CrCl 30-50 mL/min max dose 50 mg/day If < 30 mL/min dose either 50 mg every other day	Active metabolite of venlafaxine; renally dosed Higher cost = coverage issues
Duloxetine	20 mg daily or BID; FDA max dose for depression 60 mg/day (in some cases up to 120 mg/day have been used) Avoid use if < 30mL/min	Caution in hepatic impairment Also approved for pain syndromes, useful in chronic neuropathic pain, indicated for DM neuropathy. Less effect on BP increase than venlafaxine doses ≥150 mg/day Renal adjustment necessary Off label stress incontinence use (caution w BPH) CYP2D6 inhibitor
Levomilnacipran	20 mg daily (40-120 mg/day) If CrCL 30-59 mL/min max dose 80 mg, If 15-29 mL/min max dose 40 mg No recommended in ESRD	Renally dosed Higher cost

Venlafaxine	IR: 25 mg BID XR: 37.5 mg daily Range 75-225 mg per day Reduce dose by 25-50% in renal impairment and dialysis	Dose-dependent increased BP; Impact on NE is at doses ≥ 150 mg/day IR formulation has higher risk for withdrawal symptoms due to short $T_{1/2}$
Norepinephrine Dopamine Reuptake Inhibitors (NDRIs)		
Bupropion	SR: 100 mg daily (100 mg BID – 200 mg BID) XL: 150 mg daily (150-450 mg daily)	IR dosed TID, SR dosed BID, XL dosed daily BID dosing should be AM and mid-afternoon to reduce risk of insomnia More activating than other antidepressants – take in the morning; potential loss of appetite, minimal/no sexual dysfunction. Contraindicated in epilepsy and seizure disorders and anorexia/bulimia Potent CYP2D6 inhibitor
Tricyclic Antidepressants (TCAs): On AGS Beers Criteria		
Nortriptyline	10-25 mg qhs (25-100; up to 150 mg qhs)	If a TCA is indicated, best tolerated TCA in older adults Therapeutic monitoring of levels is recommended if dose > 100 mg/day Used off-label for neuropathic pain, sleep disturbances Active metabolite of amitriptyline (secondary amine: less AEs than parental drug)
Desipramine	10-25 mg qhs (25-150 mg qhs)	Metabolite of imipramine (secondary amine: less AEs than parental drug)
Amitriptyline	10-25 mg qhs	Very anticholinergic
Doxepin	Sleep: 3-6 mg qhs Depression: not recommended in older adults	FDA approved at low doses (≤6 mg) for insomnia, less anticholinergic at low doses. AGS Beers Criteria suggests avoiding doses > 6 mg Administer on empty stomach
Dextromethorphan/ bupropion	Dextromethorphan 45 mg/bupropion 105 mg once daily in the morning; after 3 days increase to 45 mg/105 mg twice daily (maximum dose 90 mg/210 mg) In CYP2D6 poor metabolizers: dextromethorphan 45 mg/bupropion 105 mg once daily in the morning	Available as newly approved antidepressant for major depressive disorders as Auvelity™ contraindications in epilepsy and seizure disorders, anorexia and bulimia (high risk for seizures) faster onset of action (1 week) High cost
Miscellaneous		
Buspirone	7.5 mg BID (7.5-30 mg BID)	Delayed onset of action Anxiety treatment with no risk of dependence 5HT1A receptor agonist, at high dose has some antidopaminergic effect. But, antianxiety mechanism unclear.
Hydroxyzine	50 mg daily	On AGS Beers Criteria: anticholinergic Not recommended in older adults Fast sedative and calming onset of action Risk for abuse
Mirtazapine	7.5-15 mg qhs (7.5-45 mg per day)	Useful in depression with target symptoms of weight loss and insomnia Doses > 30 mg switch to morning dosing Clearance is reduced in renal impairment

		Low dose histamine 1 receptor blockade predominant (more sedating are lower doses 7.5-15 mg) Less sexual dysfunction than SSRI or SNRIs
Vilazodone	10 mg daily (10-40 mg daily)	Higher cost Similar AEs as SSRIs
Vortioxetine	5 mg daily (10-20 mg daily)	Higher cost; "studied" in older adults (age range 55-88; average 62 years)
Trazodone	Not routinely used for depression but if used then 200-400 mg is usual range Sleep: 50-100 mg qhs	Primarily used off-label for insomnia and not anymore much commonly used for management of depression. Most trazodone evidence is in comorbid depression (25-100 mg/day) Higher doses can cause orthostasis Risk of priapism At lower doses alpha-1, histamine -1 and 5HT2A receptor antagonism

2025 Sleep Disturbances Reference Sheet

Medication	Geriatric Dosing	Clinical Pearls
Benzodiazepines (BZDs) : On AGS Beers Criteria		
Estazolam	Avoid	Abuse potential; Very long $T_{1/2}$ for flurazepam and avoid in older adults. Benzodiazepine listed on 2023 AGS Beers Criteria Avoid benzodizepines (BZDs) in obstructive sleep apnea and PTSD
Flurazepam	Avoid	
Quazepam	Avoid	
Temazepam	7.5-30 mg qhs	Abuse potential If a benzodiazepine is indicated in older adults, preferred benzodiazepine; However, it is still on AGS Beers Criteria. LOT (lorazepam, oxazepam and temazepam) BZDs are preferred because only phase II metabolism with no active metabolite. Lorazepam has longer T1/2, oxazepam slightly shorter T1/2 than temazepam.
Triazolam	0.125-0.25 mg qhs	Short $T_{1/2}$; rebound insomnia Abuse potential Shorter acting substances of abuse are more likely to cause addition (more frequent risk of withdrawal and thus drug seeking)
Non-benzodiazepine receptor agonists (NBRAs) or "Z" hypnotics : On AGS Beers Criteria		
Eszopiclone	1-2 mg qhs	AEs: metallic taste Longest $T_{1/2}$ of Z-hypnotics Included on AGS Beers Criteria
Zaleplon	5 mg qhs	Shortest $T_{1/2}$ of Z-hypnotics, can be re-dosed during night if 4 or more hours remain for sleep Included on AGS Beers Criteria
Zolpidem	5 mg qhs	Available in multiple dosage forms (Tab, Tab-CR, SL, oral spray) Warning for increased risk of falls and injury Included on AGS Beers Criteria
Antidepressants		
Doxepin	3-6 mg at bedtime	For sleep only, recommended doses ≤ 6 mg/ night (antihistaminergic effect only) FDA-approved for insomnia No abuse potential
Trazodone	25-100 mg at bedtime up to 150 mg	Off-label use for insomnia. Most evidence is in depression or antidepressant-induced insomnia Monitor for orthostasis and priapism
Melatonin Agonists		
Ramelteon	8 mg 30 mins before bedtime	Less CNS depression CYP1A2 substrate No abuse potential
Tasimelteon	20 mg the same time each night	NOT FDA-approved for insomnia FDA-approved for non-24-hour sleep wake disorder Very expensive
Orexin Antagonists		
Suvorexant	10-20 mg at bedtime	Abuse potential (C-IV) Studied in older adults at higher than FDA approved doses Contraindicated in narcolepsy Very expensive
Lemborexant	5-10 mg at bedtime	Abuse potential (C-IV); Approved in 2019 for management of sleep onset and maintenance in adults (not many data in older adults) Dual orexin receptor (OXR) antagonist that exhibits reversible

		competitive antagonism at OXR1 and OXR2 (> affinity at OXR2) 5 mg initial dose in women and 5-10 mg in men Contraindicated in narcolepsy Very expensive
Others (OTC and Nutraceuticals)		
Diphenhydramine	Avoid	Avoid use in older adults, increased confusion and risk for strong anticholinergic effects. Included on 2023 AGS Beers Criteria
Melatonin	Dose not standardized	Conflicting evidence It causes less CNS depression than other Sedative and hypnotics Prolonged-release melatonin improves sleep quality and sleep latency in patients > 55 years (high level evidence)- British Association for Psychopharmacology consensus statement on evidence –based treatment of insomnia, parasomnias and circadian rhythm disorders: an update. *J Psychopharmacol*. 2019; 33(8):923-47. Melatonin has evidence for efficacy in REM sleep behavior disorder seen in Parkinson's disease, dementia with Lewy bodies, multiple system atrophy: Melatonin 3-15 mg one hour before sleep

2025 Substance Use Disorders Reference Sheet

Medication	Geriatric Dosing	Important Highlights
Maintenance of Alcohol Use Disorder		
Acamprosate	333 mg, 2 tabs TID Renal impairment 30-50 mL/min: 333 mg, 1 cap TID Avoid if CrCl <30 mL/min	Helps achieve abstinence; normalization or basal GABA, blocks glutamate increases observed during withdrawal. 1st-line (unless renally impaired) Requires renal dose adjustment, avoid (contraindicated) in severe renal impairment; OK with concurrent opioids
Disulfiram	Initial dose 500 mg daily [can consider lower 250 mg in older adults] Insufficient data in older adults. Maintenance dose 125-500 mg daily	Type of aversive therapy Must be alcohol free for at least 12 hours prior to initiating Monitor LFTs Interactions with alcohol containing products (e.g. cough syrups, elixirs, mouthwash) Not known to be effective
Naltrexone	PO: 50 mg daily IM: 380 mg every 4 weeks	Do not use with opioids or those who are not opioid-naive Monitor LFTs Doses > 50 mg daily can increase risk of hepatic injury Available as PO, depot-IM 1st-line; helps with cravings and achieving abstinence Prevents release of opioid induced DA release which in turn blocks reinforcing effects of EtOH Avoid in hepatitis, hepatic failure, cirrhosis Useful for co-morbid AUD and OUD

Medication	Geriatric Dosing	Important Highlights
Benzodiazepines for Alcohol Withdrawal		
Lorazepam	1-4 mg single dose Dosed per CIWA-Ar score	Preferred in older adults; No active metabolites
Chlordiazepoxide	Not preferred in older adults	Risk of accumulation in older adults Long $T_{1/2}$ with active metabolites Not recommended in older adults
Diazepam	Not preferred in older adults	Risk of accumulation in older adults Long $T_{1/2}$ with active metabolites-not recommended in older adults

Medication	Geriatric Dosing	Important Highlights
Opioid Use Disorder Medication Assisted Treatment		
Buprenorphine	2-4 mg to 16 mg daily	Multiple dosage forms (SL tabs, implants, SQ injection) Partial opioid agonist, ceiling effect Need special training to prescribe (DATA waiver)
Buprenorphine/ Naloxone	4 mg/1mg to 242 mg/6 mg daily	Combo preferred, theoretically less abuse potential. Available SL tabs or films Need to be in moderate withdrawal to initiate DATA waiver required Can receive Rx for multiple days

		No renal adjustment, caution in hepatic impairment
Naltrexone	50 mg daily	Not opioid replacement Must be opioid free for 7-10 days before starting Opioid antagonist Useful for co-existing AUD and OUD Tablets, depot IM Caution in renal and hepatic impairment
Methadone	80-120 mg day divided doses	For OUD Can only be dispensed from a Methadone Maintenance Program; typically given in liquid formulation given once daily; Monitor QTc (ECG) 8-59 hours T ½ (very long acting) More likely to have drug interactions (CYP3A4 and CYP2D6) Many drug interactions Renal adjustment