PCPs - APS 0-1

Key Observations

- PCPs do treat dementia but do not treat bipolar disorder
- Often they refer dementia patients to neurologists or psychiatrists (scared of psychosis)
- Most bipolar patients get referred to a psychiatrist (very seldom they are treated at PCP office - can't refer)
- PCP mainly refill medication started by specialist, do not start, switch or change dose
- Little knowledge of available agents and the differences among them (most familiar with Haldol
- Very uncomfortable with APS and scared to prescribed (naive - may know Haldol; scared of SEs)
- Afraid of legal ramifications, will no prescribe outside indication
- Side effects are very important (falls, TD, EPS, ortho. Hypertension, drug interactions, anticholinergic)
- Dissatisfied with current agents for dementia (i.e. Aricept, efficacy of other APS)
- Cost is an issue - naïve but concerned, believe that there are HMO restrictions

Implications

- Dementia should be first message
- Compare to Haldol, educate on other agents
- Samples large enough to show efficacy
- Robust peer to peer programs (role of neurologist? NH MD?)
- Message should communicate that Zyprexa is #1 among psychiatrists, proven drug, etc.
- Have a patient profile easily identifiable by PCPs
- Ensure formularies coverage and educate on cost advantages/coverage
- **No label change - no go**

- Raise med legal ?

PCPs - APS 2-3

Key Observations

- PCPs do treat dementia but do not treat bipolar
- Schizophrenia is handled by psychiatrists
- Most bipolar patients get referred to a psychiatrist (very seldom they are treated at PCP office - can't refer), few initiate treatment
- Initiate dementia treatment, might seek diagnosis validation from neurologist
- Treat *behaviors* that are the results of the disorder, not necessarily psychosis
- Goals include relief for families and caregivers
- Barriers to treatment include side effects, knowledge on specific agents, documentation required to prescribe APS, past experience
- When choosing an agent side effects, cost and comfort level play the biggest role
- Aware of main differences between older and newer APS (some have heard of Zyprexa and prescribe it)
- Younger physicians are more likely to prescribe newer APS
- Do not believe APS to work as a mood stabilizer, no effect on depression
- Use Aricept in early dementia, APS in later stages with behavior problems (dissatisfied with Aricept)
- Quick onset of action, QD, drug interaction, low risk of TD and EPS highlights of message

Implications

- Dementia should be first message
- Stress effectiveness and low potential of side effects
- Concentrate message on behavior treatment, advantages to both patient and families/ caregivers
- Might prescribe outside of label
- Ensure formularies coverage and educate on cost advantages/coverage

Pt profile → add age + diagnosis
other description of behaviors w/ goals?

MMD testing?

→ program for families

Bipolar indication psychotic + non psychotic

PCPs - Differences
APS 0-1 vs. APS 2-3

APS 0-1

- Very uncomfortable, scared to prescribe APS
- Limited past experience
- Haldol main choice
- Refer dementia, bipolar and schizophrenia patients to specialists
- Mainly do refills, no change in agent or dosing
- Little knowledge about different agents
- Afraid of legal ramifications

APS 2-3

- More comfortable with APS
- Do not see that many patients with behavioral problems in office (perhaps in nursing homes)
- More experience in treatment of dementia and prescribing APS
- Will initiate treatment for dementia
- Refer bipolar and schizophrenia patients, validate dementia diagnosis with neuros
- More knowledgeable about different agents
- Not afraid of legal ramifications