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Drug Class Update: Benzodiazepines for Catatonia

Date of Review: June 2026

Date of Last Review: March 2019
Dates of Literature Search: 1/1/2019 - 4/1/2026

Current Status of PDL Class:
See **Appendix 1**.

Purpose for Class Update:
Evaluate new comparative evidence of benzodiazepines used in the treatment of catatonia.

Plain Language Summary:
- Catatonia is a condition that involves a lack of ability to control emotions, speech, and movement.
- Symptoms of catatonia may include reduced or absent speech, extreme lack of movement, refusal to move or respond to requests, unusual body positions held for long periods, repetitive movements or sounds, restlessness, and strange facial behaviors.
- Catatonia may be linked to brain chemical issues, genetics, abnormal immunity, and environmental factors.
- Periods of long immobility can lead to dehydration, malnutrition, muscle weakness, blood clots, and mood disorders.
- A class of medicines called benzodiazepines (especially lorazepam) are often used for short periods to treat catatonia.
- Rapid recognition and treatment are important to prevent complications and reduce risk of hospitalizations and death.
- The Drug Use Research and Management (DURM) group recommends that evidence-based and compendia-supported medicines for catatonia be available at higher doses if necessary for short term treatment (< 1 month) when prior authorization criteria is met.

Research Questions:
1. What is the comparative efficacy and effectiveness of benzodiazepines in the treatment of patients with catatonia?
2. What are the comparative harms of benzodiazepines in the treatment of patients with catatonia?
3. Are there subgroups of patients based on demographic characteristics (e.g., age, race, ethnicity, socioeconomic status), concurrent medications, comorbidities, or pregnancy for which there are differences in the benefits and harms of benzodiazepines used for the treatment of catatonia?

Conclusions:
- There were no clinically important differences between lorazepam and oxazepam for symptomatic improvement of catatonia in people with comorbid schizophrenia or other serious mental illnesses (1 study, N= 17; very low-quality evidence).[1]

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- There were no high-quality guidelines identified to provide recommendations for the treatment of people with catatonia. Guidelines based on lower quality evidence have recommended prompt, short-term (<1 month) treatment with lorazepam (occasionally necessary at higher than FDA-approved doses) and/or electroconvulsive therapy (ECT) as first-line therapy options.[2]

Recommendations:

- No changes to the preferred drug list (PDL) are recommended based on clinical evidence. Evaluate costs in executive session.
- Update benzodiazepine prior authorization (PA) criteria to 1) align with current evidence for the treatment of catatonia and 2) minimize therapy interruptions for treatment of patients with conditions previously approved for long-term use. (**Appendix 1**).

Summary of Current Policy:

- Prior authorization is not required for short-term use (≤ 4 weeks) of benzodiazepines but is required for treatment durations exceeding 30 days use over the previous 120 days to help prevent inappropriate long-term benzodiazepine utilization. Authorization for long-term benzodiazepine use beyond 4 weeks depends upon indication, funding, and whether specific clinical requirements are met. Unfunded diagnoses are denied unless patient is eligible for EPSDT review. Long-term approvals of 6 months may be granted when all PA requirements are met. Longer approval periods of up to 12 months may be authorized for indications such as end-of-life/palliative care and seizure disorders. Shorter approval periods of up to 1 month are reserved for short-term, outpatient treatment of alcohol withdrawal.

Background:

Catatonia is a severe, debilitating neuropsychiatric syndrome that affects emotion, communication, and movement that exists across a wide range of psychiatric and medical conditions.[3] Patients with catatonia may present with a spectrum of clinical features such as stupor, catalepsy, waxy flexibility, and mutism.[4] Other symptoms such as repetitive behavioral symptoms (e.g. echolalia, echopraxia, etc.) may also be present in people with catatonia.[4] With more than 50 observable or elicited signs, the clinical features of catatonia have varying degrees of diagnostic utility.[5] The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision **(**DSM-5-TR) lists 12 common catatonia features with descriptors (see **Table 1**) where 3 or more symptoms are considered indicative of catatonia**.**[6] Akinetic catatonia is the most common form of catatonia where the patient may be physically still and verbally non-responsive but is mentally aware of their surroundings.[5] In contrast, patients with excited catatonia display impulsive, agitated behaviors that can result in self-harm or harm to others.[4] A third type of catatonia known as malignant catatonia has been described as a hazardous, rapid onset catatonic state that creates autonomic instability, severe agitation, and delirium.[7] Often times various forms of malignant catatonia may be considered a medical emergency.[7] Catatonia symptoms may occur rapidly and last anywhere from a few hours to several weeks.[4] Although most cases are acute, some individuals may experience recurring episodes of catatonia.[4] Due to prolonged immobility, there is the potential for secondary complications such as dehydration, malnutrition, muscle wasting, and thrombosis/pulmonary embolism.[8] Therefore, prompt recognition and management of patients with catatonia is crucial to reduce risk of hospitalizations and mortality.[4,8]

Table 1. Diagnostic criteria for catatonia in DSM-5-TR (modified)[6]

Feature	Description
Stupor	No psychomotor activity; not actively relating to environment
Catalepsy	Passive induction of a posture held against gravity
Waxy flexibility	Slight, even resistance to positioning by examiner
Mutism	No, or very little, verbal response (excluded if known aphasia)

Negativism	Opposition or no response to instructions or external stimuli
Posturing	Spontaneous and active maintenance of a posture against gravity
Mannerism	Odd, circumstantial caricature of normal actions
Stereotypy	Repetitive, abnormally frequent, non-goal-directed movements
Agitation	Irritability not influenced by external stimuli
Grimacing	Involuntary facial muscle movements
Echolalia	Mimicking another's speech
Echopraxia	Mimicking another's movements

There are no known age or gender-related differences in the development of catatonia although prevalence may be higher in people with schizophrenia.[9] Catatonia may be associated with other underlying psychiatric or medical conditions as well.[9] It is estimated that up to 20% of acute psychiatric patients experience catatonia.[10-12] Catatonia secondary to mood disorders (e.g. depression, bipolar disorder), neurodevelopmental disorders (e.g. autism), infectious disease (e.g. viral or bacterial meningitis/encephalitis, HIV), environmental toxicities, or traumatic brain injury are commonly observed in neurology and intensive care unit settings.[13-15] Use of antipsychotics (typically first-generation) and rapid discontinuation of psychotropics such as benzodiazepines, gabapentin, and zolpidem have also been implicated in catatonia development.[14] When malignant catatonia arises from exposure to dopamine antagonists or abrupt discontinuation of dopamine agonists, notably with extreme hyperthermia (>100.4°F or >38.0°C) and diaphoresis, it is often referred to as neuroleptic malignant syndrome (NMS).[11]

There are numerous neurological, biological, and environmental factors that contribute to the development of catatonia.[16] Dysregulation of the glutamatergic and Gamma-aminobutyric acid (GABA)-related systems are linked to catatonia pathogenesis.[16] Both N-methyl-D-aspartate (NMDA) receptor antagonism and excitation-inhibition imbalance of GABA-related neurons are believed to cause abnormal neurotransmission resulting in abnormal motor function.[16] Genetic factors may also predispose an individual to catatonia development as observed in 22q11.2 deletion syndrome or in WKL1 gene mutations.[17] Recent findings of anti-NMDA receptor encephalitis have suggested that neuroinflammation from autoimmune involvement may play a significant role in catatonia symptom development.[17,18] Environmental stressors or trauma may also precipitate episodes of catatonia.[19]

Catatonia is associated with a wide range of serious health-related complications that arise from prolonged immobilization and autonomic dysfunction.[20] Besides physiological complications, there are potential psychological issues such as delirium that can worsen patient prognosis and necessitate careful management to reduce mortality risk.[21] Proper treatment of catatonia involves addressing the syndrome, any contributing conditions, and preventing complications.[20] Since catatonia is not a single, uniform illness with a fixed course, clinicians must plan for the potential of reoccurrence.[20] The standard of care for the management of catatonia is benzodiazepines with or without electroconvulsive therapy (ECT).[2] Benzodiazepines, notably lorazepam, are highly effective and produce rapid improvement of symptoms.[22] Acute catatonia may be treated with lorazepam given orally, sublingually, via intramuscular (IM) injection, or intravenously (IV).[2] Benzodiazepines are typically titrated over several days and given in divided daily doses.[2] Patients with catatonia may require doses higher than the suggested FDA labeling and titration should escalate until symptoms resolve or the lorazepam daily dose reaches 16 mg.[2] Generally, patients should experience positive effects within hours following treatment with lorazepam with complete resolution observed in 3-7 days.[2,14] ECT is also highly effective and can be especially useful as an add-on treatment or if benzodiazepines fail.[2] ECT should be used during the early signs of catatonia if the symptoms are severe or life-threatening or if there is malignancy noted.[2]

The assessment of catatonia in adults is generally performed through use of the Bush Francis Catatonia Rating Scale (BFCRS).[23] A modified form of the BFCRS called the Pediatric Catatonia Rating Scale (PCRS) has been used to assess catatonia in children and adolescents.[24] The BFCRS contains 23 items (e.g. excitement, immobility/stupor, mutism, etc.) and each section is rated on a 3-point symptom scale (0 = Absent; 1 = Occasional; 2 = Frequent; 3 = Constant) with 69 points possible.[23] All items are scored in order and if a symptom is not clearly observed then a score of 0 is given for the section.[23] It has been suggested that a clinically meaningful change for the BFCRS is between 4 and 6 points based on observational clinical studies but the minimal clinically important difference (MCID) has not been validated.[25,26] The PCRS is similar to the BFCRS in the 3-point rating scale, however, it contains 6 additional symptom screening questions (20 total) with a maximum possible score of 60.[24] The MCID for the PCRS is unclear. The Kanner Catatonia Rating Scale (KCRS) is another catatonia assessment tool used in clinical practice and is often used in conjunction with the BFCRS.[27] The emphasis of the KCRS is on patients with intellectual or developmental disabilities or who may be nonverbal.[27,28] It is a 2-part assessment that both identifies and quantifies catatonic signs.[27,28] Part 1 of the KCRS functions as a screening tool and Part 2 establishes symptom severity.[27,28] The KCRS tool has 18 questions with 144 points possible (higher scores = greater severity of symptoms) but no MCID threshold has been reported. [27,28] Catatonia may also be assessed with the Northoff Catatonia Rating Scale (NCRS).[28] The NCRS contains a 3-part scoring system that includes 40 individual descriptions of catatonia in terms of behavior (15 items), motor (13 items), and affective (12 items) categories with each item rated 0 to 2 (80 points possible; higher scores = greater impairment).[28] There has been no MCID proposed for the NCRS tool.[28]

Methods:

A Medline literature search for new systematic reviews and randomized controlled trials (RCTs) assessing clinically relevant outcomes to active controls, or placebo if needed, was conducted. The Medline search strategy used for this review is available in **Appendix 3**, which includes dates, search terms and limits used. The OHSU Drug Effectiveness Review Project, Agency for Healthcare Research and Quality (AHRQ), National Institute for Health and Clinical Excellence (NICE), Department of Veterans Affairs, the Oregon Mental Health Clinical Advisory Group (MHCAG), the Scottish Intercollegiate Guidelines Network (SIGN), and Canada's Drug Agency (CDA-AMA) resources were manually searched for high quality and relevant systematic reviews. When necessary, systematic reviews are critically appraised for quality using the AMSTAR tool and clinical practice guidelines using the AGREE tool. The FDA website was searched for new drug approvals, indications, and pertinent safety alerts.

The primary focus of the evidence is on high quality systematic reviews and evidence-based guidelines. Randomized controlled trials will be emphasized if evidence is lacking or insufficient from those preferred sources.

New Systematic Reviews:

Cochrane: Benzodiazepines for Catatonia in People with Schizophrenia or other Serious Mental Illnesses[1]

A 2019 Cochrane review assessed the efficacy and safety of benzodiazepines over 3 days for the treatment of catatonia in adults 18 years or older with schizophrenia or other serious mental illnesses. Literature was searched through February 2019.[1] Of 22 relevant studies, only one (N=21) met inclusion criteria.[1] The study was a double blind, randomized, cross-over design.[1] Participants had a mean age of 50.8 years (range 21-77 years) with a history of mutism and psychomotor retardation (diagnosis of schizoaffective disorder, schizophrenia, or schizophreniform disorder, major depressive disorder with or without psychotic features, bipolar disorder (all DSM-III-R)).[1] The study intervention compared lorazepam versus oxazepam to assess a clinically important change in symptoms of catatonia measured as 50% improvement on the Visual Analogue Scale (VAS).[1] There was no placebo control.[1] Lorazepam was most commonly administered as a 2 mg single dose.[1] The review found no difference between groups in the numbers of participants showing a clinically important change in their catatonic symptoms (Relative risk [RR] 0.95, 95% confidence interval [CI] 0.42 to 2.16).[1] The quality of evidence was rated as very low due to small sample size and high risks of bias in the methods such as excluded data from 4 participants.[1] No data were reported for other clinically important outcomes such as

hospital stay, satisfaction with care, adverse effects, or general functioning.[1] More high-quality research is needed to consider whether benzodiazepines are safe or efficacious for the treatment of catatonia in people with schizophrenia or other serious mental illnesses.[1]

After review, 3 systematic reviews were excluded due to poor quality (e.g., indirect network-meta-analyses or failure to meet AMSTAR criteria), wrong study design of included trials (e.g., observational), comparator (e.g., no control or placebo-controlled), or outcome studied (e.g., non-clinical).

New Guidelines:
No high-quality guidelines identified.

Additional Guidelines for Clinical Context:
Evidence-based consensus guidelines for the management of catatonia: Recommendations from the British Association for Psychopharmacology [2]
The British Association for Psychopharmacology released guidance for the management of catatonia.[2] Available evidence was categorized and graded for quality (see **Table 2**).[2] There were no recommendations based solely on evidence derived from meta-analysis or high quality RCTs.[2] The guideline is included for clinical context only because many of the recommendations were largely based on expert opinion.

Strength of Recommendations:

A: Based on evidence from meta-analysis of RCTs or at least one RCT.
B: Based on evidence from non-randomized, controlled studies, quasi-experimental studies, or extrapolated from higher quality studies.
C: Based on evidence from non-experimental descriptive studies (e.g., case-control studies) or extrapolated from higher quality studies.
D: Based on evidence from expert opinions or clinical experience or extrapolated from higher quality studies.
S: Consensus-based in absence of systematic evidence.

Key Points with Strength of Evidence

- No recommendations are supported solely by RCT evidence (no Strength A recommendations).
- Most recommendations rely on lower-quality evidence (Strength B–D) or expert consensus (Strength S).

Table 2. Catatonia Treatment Recommendations- British Association for Psychopharmacology (modified)[2]

Treatment	Recommendation	Strength
Assessment & Diagnosis	Use a validated instrument such as BFCRS or NCRS.	C
	When diagnosis is uncertain, consider a lorazepam diagnostic challenge.	B
	Use a lorazepam challenge to help predict benzodiazepine treatment response.	B
	Titrate benzodiazepines and clozapine slowly and monitor vital signs closely.	S
	Consider a zolpidem diagnostic challenge when lorazepam is unclear or unavailable.	C
Treatment Initiation	Start treatment promptly—do not delay while awaiting diagnostic results.	D
	Consider underlying disorders, side-effect profiles, and availability of ECT when selecting treatment.	S
First-Line Treatment	Use benzodiazepines and/or ECT as first-line therapy.	C
Lorazepam	Lorazepam is the preferred benzodiazepine for catatonia.	S

	High doses beyond labeled maximum may be required; a trial is considered “adequate” when symptoms resolve, side effects limit dosing, or at least 16 mg/day has been reached.	C
Clozapine	Consider clozapine for mild, chronic catatonia associated with schizophrenia.	C
	Restart clozapine in cases of withdrawal-related catatonia; use ECT if needed.	D
	When used with benzodiazepines, titrate slowly with close monitoring.	S
Drug Discontinuation	Do not abruptly discontinue benzodiazepines; taper based on benefit, withdrawal risk, and dependence risk.	S
	In benzodiazepine withdrawal, restart benzodiazepine therapy.	D
Electroconvulsive Therapy (ECT)	Ensure ECT is available and accessible in treatment settings.	S
	Use ECT when benzodiazepines fail.	B
Lack of Response	Reassess diagnosis if no response to first-line therapy.	D

Abbreviations: BFCRS = Bush Francis Catatonia Rating Scale; ECT = electroconvulsive therapy; NCRS = Northoff Catatonia Rating Scale

After review, all other guidelines were excluded due to poor quality.

New Formulations or Indications:
None identified.

New FDA Safety Alerts:

Table 3. Description of new FDA Safety Alerts[29,30]

Generic Name	**Brand Name**	**Month / Year of Change**	**Location of Change (Boxed Warning, Warnings, CI)**	**Addition or Change and Mitigation Principles (if applicable)**
alprazolam	XANAX	9/2020	Warnings	Newborn risks of: -Neonatal withdrawal syndrome -Sedation / excessive sleepiness -Respiratory depression -Low muscle tone (hypotonia)
chlordiazepoxide	LIBRIUM			
clonazepam	KLONOPIN			
diazepam	VALIUM			
lorazepam	ATIVAN		Boxed Warnings	Strengthened warnings for: -Abuse and misuse -Addiction -Physical dependence -Severe withdrawal reactions -Risks when combined with opioids
oxazepam	(formerly SERAX)			

Randomized Controlled Trials:
A total of 9 citations were manually reviewed from the initial literature search. After further review, all citations were excluded because of wrong study design (e.g., observational), comparator (e.g., no control or placebo-controlled), or outcome studied (e.g., non-clinical).

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Appendix 1: Current Preferred Drug List

Generic	Brand	Form	PDL	Carveout
alprazolam	ALPRAZOLAM INTENSOL	ORAL CONC		Y
alprazolam	ALPRAZOLAM ER	TAB ER 24H		Y
alprazolam	ALPRAZOLAM XR	TAB ER 24H		Y
alprazolam	XANAX XR	TAB ER 24H		Y
alprazolam	ALPRAZOLAM ODT	TAB RAPDIS		Y
alprazolam	ALPRAZOLAM	TABLET		Y
alprazolam	XANAX	TABLET		Y
amitriptyline/chlordiazepoxide	CHLORDIAZEPOXIDE-AMITRIPTYLINE	TABLET		Y
chlordiazepoxide HCl	CHLORDIAZEPOXIDE HCL	CAPSULE		Y
clorazepate dipotassium	CLORAZEPATE DIPOTASSIUM	TABLET		Y
diazepam	DIAZEPAM	ORAL CONC		Y
diazepam	DIAZEPAM	SOLUTION		Y
diazepam	DIAZEPAM	TABLET		Y
lorazepam	LOREEV XR	CAP ER 24H		Y
lorazepam	LORAZEPAM	ORAL CONC		Y
lorazepam	LORAZEPAM INTENSOL	ORAL CONC		Y
lorazepam	LORAZEPAM	TABLET		Y
oxazepam	OXAZEPAM	CAPSULE		Y
chlordiazepoxide/clidinium Br	CHLORDIAZEPOXIDE-CLIDINIUM	CAPSULE		
clonazepam	CLONAZEPAM	TAB RAPDIS	N	
clonazepam	CLONAZEPAM	TABLET	Y	
clonazepam	KLONOPIN	TABLET	Y	

Appendix 2: Medline Search Strategy

Ovid MEDLINE(R) ALL 1946 to January 09, 2026

1	exp Alprazolam/	1926
2	exp Chlordiazepoxide/	3904
3	chlordiazepoxide-amitriptyline.mp.	12
4	exp Clorazepate Dipotassium/	325
5	exp Diazepam/	18429
6	exp Lorazepam/	3137
7	exp Oxazepam/	1315
8	chlordiazepoxide-clidinium.mp.	18
9	exp Clonazepam/	2758
10	exp Benzodiazepines/	72431
11	exp Catatonia/	3084
12	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10	72431
13	11 and 12	489
14	limit 13 to English language and humans and yr="2019 -Current" and (clinical trial, phase iii or guideline or meta analysis or practice guideline or randomized controlled trial or "systematic review")	9

Appendix 3: Key Inclusion Criteria

Population	Adult and pediatric patients with catatonia disorder
Intervention	Drugs in Appendix 1
Comparator	Drugs in Appendix 1, ECT, or placebo
Outcomes	Efficacy: symptom improvement, function, quality of life, time to onset of effectiveness, duration of effectiveness Safety: withdrawals due to adverse events, serious and long-term (>12 months) adverse events
Setting	Outpatient

Benzodiazepines

Goal(s):

- Approve only for OHP-funded diagnoses.
- Prevent inappropriate long-term benzodiazepine use beyond 4 weeks for new starts (no history within the last 120 days).
- Approve long-term use only for indications supported by the medical literature.

Length of Authorization:

- Initial: 1 month to 12 months (criteria-specific)
- Renewal: 12 months to 2 years (criteria-specific)

Requires PA:

- All benzodiazepines used beyond 4 weeks. Short-term use (≤4 weeks) does not require PA.

Note: Benzodiazepines indicated for seizure rescue (routes: rectal, nasal, buccal) are subject to the Non-preferred Drugs in PDL classes criteria.

Covered Populations: FFS and CCO enrolled patients for drugs in in standard therapeutic classes 7 or 11 (pharmacy claims only).

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code	
2. Does the patient have a malignant neoplasm or other end-of-life diagnosis (ICD10 C00.xx-D49.xx or Z51.5)?	**Yes:** Approve for 12 months	**No:** Go to #3

Approval Criteria		
3. Is the diagnosis an OHP-funded diagnosis?	**Yes:** Go to #4	**No:** If not eligible for EPSDT review: Pass to RPh. Deny; not funded by the OHP If eligible for EPSDT review: Go to #5
4. Is this a request for a patient to be treated for any of the following: • Add-on therapy for ongoing seizure regimen? • Documentation of catatonia diagnosis in the chart notes AND symptom improvement with a benzodiazepine? • Short-term outpatient management of alcohol withdrawal syndrome in a patient enrolled in a program? Note: benzodiazepines are not indicated for alcohol dependence.	**Yes:** Approve for the following: • Adjunct therapy for seizure disorders: up to 12 months • Catatonia: Initially up to 6 months. Subsequent renewal requests up to 1 year. • Alcohol withdrawal: up to 1 month	**No:** Go to #5
5. Is the prescriber enrolled in the Oregon Prescription Drug Monitoring Program (www.orpdmp.com) and has the prescriber evaluated the PDMP at least once in the past 3 months for this patient?	**Yes:** Go to #6	**No:** Pass to RPh. Deny; medical appropriateness.
6. Is the request for a decrease in daily dose OR a change in drug with the intent to taper the dose?	**Yes:** Approve for up to 6 months or length of taper, whichever is less.	**No:** Go to #7
7. Is the request for continuation of therapy previously approved by the FFS program?	**Yes:** Go to **Renewal Criteria**	**No:** Go to #8

Approval Criteria		
8. Is the request for treatment of post-traumatic stress disorder (PTSD)? Note: Risks of benzodiazepine treatment outweigh benefits for patients with PTSD. Treatment with benzodiazepines is not recommended.	**Yes:** Pass to RPh. Deny; medical appropriateness.	**No:** Go to #9
9. Is the request for treatment of anxiety or panic disorder?	**Yes:** Go to #10	**No:** Go to #11
10. Is there documentation of the following: • The medication is prescribed by or in consultation with a prescribing mental health specialist OR • Trial and failure, contraindication, intolerance, or inability to access recommended first-line treatments*? *Note: First-line treatments include **antidepressants PLUS psychotherapy** [e.g. behavioral therapy, relaxation response training, mindfulness meditation training, eye movement desensitization and reprocessing]) →An adequate trial to determine efficacy of an SSRI or SNRI is 4-6 weeks.	**Yes:** Go to #13 Document trial, contraindication, or intolerance to treatment options.	**No:** Pass to RPh; Deny; medical appropriateness. Recommend adequate trial of first-line therapies. If provider requests short-term approval with a plan to start additional therapy, approval may be granted for up to 3 months. Subsequent requests must document experience with first-line treatment options.
11. Is the request for treatment of psychosis, schizophrenia or schizoaffective disorder?	**Yes:** Go to #12	**No:** Go to #13

Approval Criteria		
12. Is there documentation of the following: • The medication is prescribed by or in consultation with a prescribing mental health specialist OR • Trial and failure, contraindication, intolerance, or inability to access recommended first-line treatments*? *Note: First-line treatments include **second-generation antipsychotics AND psychotherapy** [e.g. counseling, cognitive behavioral therapy, social skills training, or psychoeducation])? →For continued symptoms, assess adherence and dose optimization. For patients on an adequate dose of antipsychotic, guidelines recommend trial of a second antipsychotic or augmentation with a mood stabilizer.	**Yes:** Go to #13 Document trial, contraindication, or intolerance to treatment options.	**No:** Pass to RPh; Deny; medical appropriateness. Recommend adequate trial of first-line therapies. If provider requests short-term approval with a plan to start additional therapy, approval may be granted for up to 3 months. Subsequent requests must document experience with first-line treatment options.
13. Is the patient on a concurrent sedative, hypnotic, muscle relaxant, or opioid?	**Yes:** Go to #14	**No:** Go to #16

Approval Criteria		
14. Is concurrent sedative therapy part of a plan to switch and taper off a long-acting benzodiazepine (such as diazepam, clonazepam, or chlordiazepoxide) AND has the provider included a detailed strategy to taper? Note: Documented taper strategy should include: • Planned dose reductions. • Length of time between each dose modification. • Documented follow-up plan to monitor progress and manage withdrawal symptoms (regular check-ins are essential for a successful taper). • Triazolam may be discontinued without a taper in most cases (2-hour half-life prevents physical dependence).	**Yes:** Approve duplicate therapy for the duration specified in the taper plan (not to exceed 6 months).	**No:** Go to #15
15. Has the prescriber supplied documentation of the following: • Implementation of a specific risk mitigation plan OR • Clinical justification for concurrent sedative therapy (i.e. evidence that prescriber has evaluated risks associated with combination therapy and determined that benefits outweigh risks)?	**Yes:** Approve concurrent sedative therapy for the duration specified in the plan (not to exceed 6 months).	**No:** Pass to RPh. Deny; medical appropriateness.
16. RPh only: Is there appropriate rationale to support long-term benzodiazepine use for this indication? Note: For anxiety, panic disorder, or schizophrenia, provider rationale should include information from relevant chart notes. For other diagnoses, provider must document supporting medical literature.	**Yes:** Approve for up to 6 months.	**No:** Deny; medical appropriateness.

Renewal Criteria		
1. Is the request for an increase in dose?	**Yes:** Go to #2	**No:** Go to #3
2. Has the patient failed all clinically appropriate first-line adjunct treatment options OR, when applicable, is the patient adherent to recommended first-line treatment options for their condition?	**Yes:** Go to #3	**No:** Pass to RPh; Deny; medical appropriateness. Recommend trial of alternative therapies. If provider requests short-term approval with a plan to start additional therapy, approval may be granted for up to 3 months. Subsequent requests must document experience with first-line treatment options.
3. Is there documentation based on medical records that provider and patient have discussed whether benefits of long-term therapy (e.g. symptom improvement, social function, number of hospitalizations, etc) continue to outweigh risks of therapy (e.g. sedation, dependence, cognitive dysfunction and/or psychiatric instability)?	**Yes:** First-time renewals: Approve for up to 12 months. Second-time renewals: Approve for 2 years	**No:** Pass to RPh; Deny; medical appropriateness. Recommend trial of gradual taper plan. Approval may be granted for up to 3 months to allow time to develop a taper plan. Subsequent requests must document progress toward taper.

P&T Review: *6/26 (DE); 8/22; 3/19 (SS); 9/18, 3/14*
Implementation: *TBD; 10/1/22; 5/1/19; 11/1/2018; 5/1/16*

Clinical Notes:

How to Discontinue Benzodiazepines.

Adapted from the following guidance on benzodiazepine tapering:

- Tapering Benzodiazepines; The Oregon Health Authority Mental Health Clinical Advisory Group, May 2022. Available at https://www.oregon.gov/oha/HPA/DSI-Pharmacy/MHCAGDocs/Tapering-Benzodiazepines.pdf.

1. Importance of Deprescribing Benzodiazepines

- Long-term use causes tolerance, physical dependence, cognitive impairment, falls, accidents, and overdose risk when combined with opioids.
- Benzodiazepines lose effectiveness for anxiety/insomnia after weeks of continuous use.
- They worsen PTSD outcomes and can increase aggression and depression.

2. Recommended Tapering Schedule of Benzodiazepines

Duration of Use	Taper Recommendation
2–8 weeks	≥2 weeks; slower if high-dose or alprazolam; triazolam may not need taper
8 weeks–6 months	≥4 weeks; go slower in later taper; avoid alcohol/stimulants
6 months–1 year	≥8 weeks
>1 year	6–18 months

Note: Taper duration should be individualized based on patient factors, severity of dependence, and withdrawal response.

3. Best Practices for Safe and Effective Tapering

- Use one prescriber and pharmacy; maintain regular, scheduled follow-ups.
- Avoid alcohol and stimulants during tapering.
- Plan initial taper steps but adjust based on patient response.
- Longer intervals between reductions improve comfort and safety.

4. Diazepam Transition Strategy

- Most patients benefit from transitioning to diazepam due to its long half-life, smoother serum level decline, and availability of small tablet strengths.
- Short-acting benzodiazepines such as alprazolam produce more withdrawal symptoms.
- Diazepam allows twice-daily dosing, reducing focus on medication.
- Avoid diazepam in hepatic impairment; taper the original benzodiazepine instead.

Benzodiazepines Grouped by Duration of Action and Diazepam Dose Equivalence

Duration of Action	Benzodiazepine	Approx. Diazepam Equivalent
Short-acting (half-life of drug and metabolites < 6 hours)	Oxazepam 20 mg	≈10 mg diazepam
	Triazolam 0.5 mg	
Intermediate-acting (half-life of drug and metabolites 6-24 hours)	Alprazolam 0.5 mg	
	Lorazepam 1 mg	
	Temazepam 20 mg	
Long-acting	Clonazepam 0.5 mg	

(half-life of drug and metabolites > 24 hours)	Chlordiazepoxide 25 mg	
	Clorazepate 15 mg	
	Diazepam 10 mg	Reference standard

Note: Equivalencies are approximations; individual response varies and adjustments may be required during taper.

Tapering Approach
- Transition one dose at a time to diazepam, usually starting with the nighttime dose.
- Dose reductions typically ~10% every 1–2 weeks; smaller reductions required at low doses.
- Avoid PRN benzodiazepine doses as they disrupt neuroadaptation.

For specific tapering examples, see https://www.oregon.gov/oha/HPA/DSI-Pharmacy/MHCAGDocs/Tapering-Benzodiazepines.pdf.

4. **Managing Withdrawal Symptoms**
   - Symptoms fluctuate; avoid increasing doses when symptoms worsen.
   - Supportive medications may be used briefly for pain, GI upset, nausea, or muscle spasms.
   - There is no evidence that adding antidepressants, antiepileptics, or melatonin improves taper success.

Possible Treatments for Withdrawal Symptoms

Condition	Recommended Treatment
Headache or pain	Acetaminophen 1000 mg q4–6h; Ibuprofen 400 mg TID
Diarrhea	Loperamide: 4 mg initially, then 2 mg after loose stools
Nausea	Metoclopramide 10 mg q4–6h; Ondansetron 8 mg daily
Muscle Spasms	Methocarbamol 1500 mg TID; Cyclobenzaprine 5–10 mg TID

Note: Symptom management should be short-term only; adding long-term medications does not improve taper success.

7. Counseling and Patient Engagement
- Shared decision-making is essential—patients should understand risks, withdrawal expectations, and the long-term benefits of discontinuation.
- Educate that withdrawal may occur but is manageable with a gradual taper.
- Encourage CBT, mindfulness, relaxation practices, and avoidance of alcohol/cannabis substitution