Clozapine monitoring worksheet

ANC schedule, myocarditis surveillance, metabolic monitoring, seizure risk. Reviewed against current guidelines as of June 8, 2026.

The FDA eliminated the clozapine REMS program on February 24, 2025. ANC monitoring itself remains standard of care and is what the label describes, but pharmacies and prescribers no longer need to be certified through a central registry and are not required to submit ANC values before dispensing. Monitoring frequency below reflects the historical REMS schedule, which most clinicians continue to follow.

ANC monitoring schedule

Time on clozapine	ANC monitoring frequency	Notes
Baseline (before first dose)	ANC	Must be at least 1500 per microliter (or at least 1000 in benign ethnic neutropenia)
0 to 6 months	Weekly	Six months from first dose
6 to 12 months	Every 2 weeks	
After 12 months	Every 4 weeks	Continue for as long as the patient is on clozapine
After any dose interruption	Restart weekly for a period based on gap length	28 days or more off: restart weekly x 6 months. Under 28 days: resume prior frequency.

Benign ethnic neutropenia (BEN) is common in patients of African, Middle Eastern, and West Indian ancestry. Baseline ANC 1000 to 1499 with normal WBC differential can be BEN. Lower ANC thresholds apply. Hematology consult if unclear.

ANC action thresholds

ANC (per microliter)	General population	BEN patient
1500 or above	Continue treatment	Continue treatment
1000 to 1499	Mild neutropenia; continue with monitoring, recheck 3x weekly until ANC above 1500	Continue treatment (may still be within baseline)
500 to 999	Moderate; interrupt clozapine, hematology consult, daily ANC until above 1000, resume if ANC recovers	Interrupt clozapine, hematology consult
Below 500	Severe; discontinue clozapine, hospitalize if febrile, daily ANC, do not rechallenge without hematology sign-off	Same as general population

Myocarditis surveillance

Highest risk in the first 4 weeks. Baseline and follow-up screening catch most cases.

- [ ] Baseline: troponin, CRP, ECG. Document baseline vitals including HR.
- [ ] Week 4: repeat troponin, CRP, ECG. Some centers repeat weekly for the first month.
- [ ] At any time: unexplained tachycardia, fever, chest pain, dyspnea, palpitations, flu-like symptoms, or new heart failure signs. Check troponin and CRP; hold clozapine and get cardiology.
- [ ] Rising troponin, rising CRP, sinus tachycardia over 100, or eosinophilia in the first 4 weeks: stop clozapine and evaluate.

Metabolic monitoring

Parameter	Baseline	Week 12	Annually or as clinically indicated
Weight and BMI	Yes	Yes	Every visit
Fasting glucose or HbA1c	Yes	Yes	Yes
Fasting lipid panel	Yes	Yes	Yes
Blood pressure	Yes	Yes	Every visit
Waist circumference	Yes	Yes	Yes

Seizure risk

- Seizure risk is dose-related. Below 300 mg a day about 1 percent, 300 to 600 mg about 2 to 3 percent, above 600 mg about 4 to 5 percent.
- Titrate slowly. Split doses. Avoid concurrent seizure-lowering drugs (bupropion, tramadol) when possible.
- If seizure occurs, reduce dose by 50 percent and consider adjunctive anticonvulsant (valproate is common; lamotrigine is an alternative that avoids sedation additivity).
- Do not stop clozapine reflexively after a single seizure at a therapeutic dose; the risk-benefit often favors dose reduction plus anticonvulsant cover.

Other things to track

- Sialorrhea. Very common. Try glycopyrrolate 1 to 2 mg BID or clonidine patch at night before topical anticholinergics.
- Constipation. Clozapine-induced ileus is a preventable cause of death. Screen at every visit. Start a bowel regimen prophylactically.
- Sedation. Titrate slowly. If persistent, dose more at night.
- Orthostasis and tachycardia. Slow titration is the main intervention. Persistent tachycardia over 100 after week 4 deserves a workup.
- Fever in the first 3 weeks. Benign flu-like reaction is common. But check troponin, CRP, ANC, and rule out infection and myocarditis before attributing.

Not medical advice.