Medications for Alzheimer's

AChE inhibitors and memantine, where anti-amyloid antibodies fit, and how to handle agitation. Reviewed against current guidelines as of June 8, 2026.

For Alzheimer's, the symptomatic medications are the AChE inhibitors (donepezil, rivastigmine, galantamine) and memantine. Neither class stops progression; both give modest symptomatic benefit. Lecanemab and donanemab target underlying pathology in early disease with strict patient selection and MRI surveillance. Antipsychotics for agitation carry a boxed warning for mortality in dementia. Brexpiprazole is the first FDA-approved antipsychotic for Alzheimer's agitation. Companion to the full guide at psychiatryrx.org/guides/medications-for-alzheimers/.

First-line options

Drug	Class	Notes
Donepezil	AChE inhibitor	5 to 10 mg once daily. 23 mg for moderate to severe (more GI). Simple dosing. Bradycardia, vivid dreams.
Rivastigmine	AChE inhibitor	Oral 1.5 to 6 mg BID or patch (4.6, 9.5, 13.3 mg/24h). Patch has fewer GI side effects. Also for PD dementia.
Galantamine	AChE inhibitor	8 to 24 mg ER daily. Additional nicotinic allosteric effect. Similar profile to donepezil.
Memantine	NMDA antagonist	5 to 20 mg titrated over 4 weeks. Moderate to severe Alzheimer's. Well-tolerated: dizziness, headache, constipation.
Donepezil plus memantine (Namzaric)	Combination	Standard of care in moderate to severe disease.

Second-line: anti-amyloid antibodies and behavioral

Drug	Class	When to consider
Lecanemab (Leqembi)	Anti-amyloid mAb	IV every 2 weeks. Early AD with confirmed amyloid pathology. ~27 percent slowing over 18 months. ARIA risk, MRI surveillance required. Higher risk in ApoE4 homozygotes.
Donanemab (Kisunla)	Anti-amyloid mAb	IV every 4 weeks. Similar efficacy and risks. Can discontinue once amyloid clearance is confirmed.
Brexpiprazole	Atypical antipsychotic	2 to 3 mg. FDA-approved 2023 for Alzheimer's agitation. Boxed warning for mortality in dementia still applies.
Citalopram	SSRI (off-label agitation)	20 to 30 mg. CitAD trial evidence. QT limits ceiling to 20 mg over 60.
Trazodone	Sedating antidepressant	25 to 100 mg. Off-label for mild agitation and sleep. Watch orthostasis.
Sertraline	SSRI	First-line for depression comorbid with dementia. Well-tolerated.
Mirtazapine	Atypical antidepressant	Low doses when depression, poor appetite, and insomnia coexist.
Rivastigmine	AChE inhibitor	Well-supported in dementia with Lewy Bodies and PD dementia.
Pimavanserin, low-dose quetiapine	For DLB	When an antipsychotic is needed in DLB. Avoid typical antipsychotics.

Special considerations

- Anticholinergic burden worsens cognition and can precipitate delirium. Common offenders: diphenhydramine, oxybutynin, TCAs, first-gen antipsychotics, paroxetine. Review the whole list at each visit.
- For overactive bladder, mirabegron is a non-anticholinergic alternative.
- Insomnia in dementia: trazodone low-dose, ramelteon, or melatonin. Avoid z-drugs and benzodiazepines.
- Depression in dementia: sertraline is the standard first-line. Escitalopram is a reasonable alternative with QT dose caps.
- Vitamin E 2000 IU daily has some evidence for slowing functional decline (TEAM-AD). Reasonable in select patients.
- End of life: deprescribe statins, aspirin, bisphosphonates when they no longer serve function. Taper AChE inhibitors and memantine slowly if stopping.
- DLB: severe neuroleptic sensitivity (rigidity, cognitive worsening, autonomic instability). Typical antipsychotics are contraindicated.
- FTD: AChE inhibitors do not help and can worsen behaviors. SSRIs or trazodone for behavioral symptoms.

What tips the choice

Newly diagnosed mild to moderate Alzheimer's: donepezil, rivastigmine, or galantamine. Any is reasonable, and donepezil has the simplest dosing. Can't tolerate oral AChE inhibitor: rivastigmine patch. Moderate to severe: add memantine. Early Alzheimer's (MCI due to AD or mild dementia due to AD) with confirmed amyloid pathology: lecanemab or donanemab if the patient meets selection criteria and can tolerate MRI surveillance and infusion schedule. Agitation with non-pharm failing: brexpiprazole is the FDA-approved option. Citalopram is reasonable. Insomnia: trazodone low-dose, ramelteon, or melatonin. Depression: sertraline first-line. DLB: rivastigmine, and avoid typical antipsychotics. Frontotemporal dementia: SSRIs or trazodone.

Watchouts

- Antipsychotics carry a class boxed warning for increased mortality in dementia. Brexpiprazole is the only FDA-approved antipsychotic for Alzheimer's agitation; others are off-label with the mortality warning.
- ARIA (amyloid-related imaging abnormalities): ARIA-E (edema) and ARIA-H (microhemorrhages) are the main safety concern with anti-amyloid mAbs. Baseline MRI, ApoE4 status, and surveillance MRI matter. ApoE4 homozygotes have ~15 percent symptomatic ARIA on lecanemab.
- AChE inhibitor bradycardia: baseline HR and syncope history matter. Consider stopping if new bradycardia or syncope.
- Anticholinergic burden: the whole list, not just one drug. Review at every visit.
- DLB neuroleptic sensitivity: rigidity, cognitive worsening, autonomic instability. Avoid typicals.
- Abrupt AChE inhibitor or memantine discontinuation can produce clinical worsening. Taper if stopping.

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