Renal dosing quick reference

Psychiatric meds by eGFR band. Lithium first, then the short list that changes clinical decisions. Reviewed against current guidelines as of June 8, 2026.

Kidneys change psychiatric prescribing more than most clinicians realize. Lithium first. Then gabapentin and pregabalin, paliperidone (which behaves differently from risperidone once you're below eGFR 60), duloxetine, and venlafaxine. Atomoxetine is the odd one out because its adjustment is hepatic, not renal. Most SSRIs need little adjustment.

eGFR bands

eGFR (mL/min/1.73 m2)	CKD stage	What changes for psychiatry
Above 90	Normal or CKD 1	Usually nothing. Watch for proteinuria if lithium is on board.
60 to 89	CKD 2 (mild)	Lithium starts to need closer monitoring. Most other meds unchanged.
30 to 59	CKD 3 (moderate)	Lithium often needs dose reduction. Gabapentin, pregabalin, paliperidone, duloxetine all shift.
15 to 29	CKD 4 (severe)	Lithium usually stopped or co-managed by nephrology. Duloxetine off the table. Big cuts to gabapentin and pregabalin.
Below 15 or dialysis	ESRD	Renal handling drops out. Dialyzable drugs (lithium, gabapentin, pregabalin) become dose-after-dialysis conversations.

Main renal-adjusted psychiatric drugs

Drug	eGFR 30 to 59	eGFR 15 to 29	ESRD or dialysis	Notes
Lithium	Reduce, target 0.4 to 0.6 mEq/L	Avoid if possible; co-manage with nephrology	Dialyzable; some dosed only after HD	NSAIDs, ACEi, ARBs, thiazides matter more than baseline eGFR
Gabapentin	400 to 1400 mg a day divided	200 to 700 mg a day	100 to 300 mg after each HD session	Sedation, myoclonus, encephalopathy climb fast when this gets missed
Pregabalin	75 to 300 mg a day	25 to 150 mg a day	25 to 75 mg once daily plus supplement after HD	Same failure mode as gabapentin
Paliperidone (oral)	Max 6 mg if CrCl 50 to 80; max 3 mg if 10 to 49	Max 3 mg a day	Not recommended	LAI (Sustenna, Trinza, Hafyera) not recommended below CrCl 50
Duloxetine	Use caution, no fixed adjustment	Avoid	Avoid	Label says don't use if CrCl below 30
Venlafaxine	Reduce 25 to 50 percent	Reduce 50 percent	Reduce 50 percent, dose after HD	BP creeps up regardless of renal function
Desvenlafaxine	50 mg daily (skip alt day if CrCl 30 to 50)	50 mg every other day	50 mg every other day, after HD	Cleaner PK than venlafaxine but still adjusted
Memantine	Standard dose fine	5 mg BID (max)	Not well studied; use lowest dose	Watch for confusion in moderate CKD too
Amantadine	Reduce (100 mg daily typical)	100 mg every 2 to 3 days	200 mg every 7 days	Underappreciated cause of delirium in older CKD patients
Topiramate	Reduce 50 percent	Reduce 50 percent	Dose after HD; supplement often needed	Metabolic acidosis and stones more likely in CKD

Lamotrigine	Reduce maintenance dose	Reduce further	Titrate slowly, monitor	Package insert is vague; go slow
Atomoxetine	No renal adjustment	No renal adjustment	No renal adjustment	Reduce for hepatic impairment, not renal

SSRIs and other antidepressants that need little adjustment

Drug	Adjustment	Notes
Sertraline	None	Workhorse choice in CKD and dialysis.
Escitalopram, citalopram	Consider lower dose in severe CKD	QT risk climbs with electrolyte shifts in ESRD.
Fluoxetine	None	Long half-life is actually helpful in dialysis where levels swing.
Mirtazapine	Modest reduction if CrCl below 40	Clearance drops about 30 percent.
Bupropion	Reduce dose or frequency if eGFR below 50	Hydroxybupropion accumulates; seizure threshold matters.
Vortioxetine, vilazodone	No adjustment	Limited data in severe CKD.
Trazodone	No formal adjustment	Watch orthostasis, worse in dialysis patients.

Five renal traps to remember

- Paliperidone's renal ceiling. Do not assume it behaves like risperidone. Below CrCl 50, LAIs are off the table.
- Duloxetine below CrCl 30. Label is clear. When eGFR drifts under 30 on chronic duloxetine, taper and switch. Sertraline or mirtazapine are cleaner picks.
- Gabapentin encephalopathy in dialysis. Someone on 900 mg TID before HD who is not dose-adjusted will look demented within days. Post-dialysis dosing fixes it.
- Amantadine in older adults. Prescribed for parkinsonism or dyskinesia. Quiet CKD plus accumulation equals delirium. On the Beers list for a reason.
- Lithium during acute illness. A viral GI bug or a UTI treated at urgent care is the most common way stable patients end up on the tox service. Teach patients to hold for 24 to 48 hours during significant vomiting or diarrhea.

Not medical advice.