The Royal Australian & New Zealand College of Psychiatrists
Tū Te Akaaka Roa
New Zealand National Office
Your Health in Mind
Hauora hinengaro Manatuhia

25 November 2026

PHARMAC | Te Pātaka Whaioranga
PO Box 10254
The Terrace
Wellington 6143
Submitted via PHARMAC's online consultation form

Tēnā koe

Re: Proposal to change lithium carbonate 250 mg brand

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback on PHARMAC's proposal to replace lithium carbonate 250 mg capsules (Douglas) with lithium carbonate 250 mg tablets (Lithium Carbonate Essential Pharma) from 1 February 2027.

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Aotearoa New Zealand and Australia and is responsible for training, educating, and representing psychiatrists. The RANZCP is guided on policy matters by a range of expert committees, including Tū Te Akaaka Roa, the New Zealand National Committee. Tū Te Akaaka Roa is committed to Te Tiriti o Waitangi and to placing tāngata whai ora and whānau at the centre of our advocacy, with a focus on reducing inequities for Māori, Pacific peoples and other communities with high needs.

Key Messages

Tū Te Akaaka Roa acknowledges the supply circumstances behind this proposal and supports PHARMAC's action to ensure continued access to a 250 mg strength of lithium. However, we recommend a longer transition period and careful coordination, clear and timely communication with whānau whai ora, pharmacists, and treatment providers and adequate resource allocation to support monitoring of the proposed changes. Specifically, we recommend:

- **Ensuring clinical supervision**. Tāngata whai ora should change brands only with prescriber awareness, with a serum lithium level checked after the switch (approximately 5–7 days later, as a 12-hour post-dose trough) and further monitoring as clinically indicated. Automatic substitution at the pharmacy without prescriber involvement should be avoided without limiting access to lithium prescription. PHARMAC is recommended to delay discontinuation of Douglas (as supply allows) and fund both brands during the transition period to enable the brand switch to occur as part of routine monitoring appointments.
- **Removing cost barriers to ensure safe monitoring.** PHARMAC should work with Health New Zealand | Te Whatu Ora (Health NZ) and Manatū Hauora to ensure that monitoring appointments and blood tests are free for tāngata whai ora.
- **Communicating early, clearly and through multiple channels.** PHARMAC is recommended to draw on its learnings from the 2020 brand change and work with Medsafe and Health NZ to share relevant information with prescribers and pharmacists,

PO Box 10669 Wellington 6143 New Zealand
T +64 (0)4 472 7247 F +64 (0)4 472 7246
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

including bioequivalence data**,** potential impacts of the brand change, monitoring expectations and responsibilities. PHARMAC should also provide clear resources regarding the change for tāngata whai ora and whānau, distributed through relevant organisations and platforms.

- **Providing targeted, proactive support for priority groups**, including Māori, Pacific peoples, older adults, people with complex health needs or intellectual disability/cognitive impairment, as well as those living in rural communities or from ethnically or linguistically diverse backgrounds.

- **Monitoring and evaluating the transition**. PHARMAC is recommended to evaluate changes and ensure effective monitoring of adverse events.

Recommendations

Ensuring clinical supervision

Lithium remains one of the most effective and well-established treatments for bipolar disorder and Tū Te Akaaka Roa supports PHARMAC's proposal to change brands to ensure continued access to a 250 mg strength of lithium. However, brand changes have been shown to affect plasma lithium levels which may have serious consequences due to lithium's narrow therapeutic range and susceptibility to pharmacokinetic interactions. If lithium plasma levels drop below the therapeutic range, it can trigger a relapse with serious consequences, including hospital admission, disruption to employment and relationships, and an increased risk of suicide. Conversely, lithium plasma levels above the recommended range can cause lithium toxicity which carries serious health risks and lead to kidney failure, impaired thyroid function, as well as cardiac and neurological problems if left untreated.

Recommendation

We therefore recommend tāngata whai ora should change brands only with prescriber awareness, with a serum lithium level checked after the switch (approximately 5–7 days later, as a 12-hour post-dose trough) and further monitoring as clinically indicated. Automatic substitution at the pharmacy without prescriber involvement should be avoided. However, to reduce the risk of non-adherence and unnecessary barriers to accessing lithium prescription, the brand switch should be aligned with routine monitoring where possible. Current bpac NZ guidelines recommend routine testing of lithium serum levels to be conducted every six months. Therefore, PHARMAC is recommended to delay discontinuation of Douglas (as supply allows) and fund both brands during the transition period.

Removing cost barriers to safe monitoring

While PHARMAC has rightly recognised the clinical significance of the proposed lithium brand change, we are concerned that no specific funding has been allocated to the safety of tāngata whai ora and their whānau during the transition. While brand switching is recommended to take place as part of routine appointments, current pressures on primary care providers and specialist mental health services may limit access to a timely review and follow-up blood test, and GP consultation fees, prescription fees and travel costs may lead some people to delay or forgo monitoring, increasing the risk of toxicity or relapse going undetected. Tāngata whai ora

living in rural areas may be particularly vulnerable, due to the additional travel costs and limited access to health care services in rural areas.

Recommendation

Tū Te Akaaka Roa recommends that PHARMAC work with Health NZ and Manatū Hauora to provide financial support for monitoring appointments and associated costs, particularly for vulnerable groups (e.g., tāngata whai ora with reduced renal function), and access to telehealth review and point-of-care testing for rural and remote communities.

Communicating early, clearly and through multiple channels

Tū Te Akaaka Roa supports all implementation measures listed in the consultation document. While we acknowledge that prescribers and pharmacists play an important role in communicating and implementing the brand change, PHARMAC must support the transition by providing adequate resources and ensuring frontline staff understand their responsibilities and whānau whai ora have access to all required information.

Recommendations

- We recommend publishing clear and consistent guidance on managing the switch through bpacnz, HealthPathways, the New Zealand Formulary, local services and professional bodies before the start of the transition period. The information should clarify responsibilities and monitoring requirements, including lithium levels, renal and thyroid function, dose adjustment, signs of toxicity and relapse, and drug interactions. Tū Te Akaaka Roa would be pleased to review clinical guidance and consumer resources as required and share information about the change with our members through our newsletter and networks.

- We recommend that plain-language resources for tāngata whai ora and their whānau be available through pharmacies, Healthify, mental health services and kaupapa Māori and Pacific providers. Resources should include information on:
    - why the change is happening, and reassurance that the tablet contains the same medicine at the same strength
    - that they should keep taking their current medicine and not change brands or doses without talking to their prescriber
    - when and how the change will happen, and who to speak to if they are concerned
    - why a blood test is needed after the switch, when to have it taken, and whether there is any cost
    - signs of lithium toxicity that need urgent attention, such as vomiting, diarrhoea, blurred vision, worsening tremor, unsteadiness or confusion and what to do if they these occur
    - early warning signs of relapse and what to do if they occur
    - other factors that can affect lithium levels, such as dehydration, illness, and some common medicines, including anti-inflammatories

- If possible, PHARMAC and Health NZ should use dispensing data to help prescribers and services identify people currently taking Douglas 250 mg capsules and use point-of-

care alerts to identify relevant individuals, prompt prescriber review and lithium level monitoring, and discourage substitution without prescriber awareness.

Providing targeted, proactive support for priority groups

Tū Te Akaaka Roa is committed to Te Tiriti o Waitangi and reducing inequities for Māori, Pacific peoples and other priority populations. Māori experience a higher community prevalence of bipolar disorder, and research with Māori patients, whānau and clinicians has identified persistent inequities in access to timely, consistent, culturally safe care for bipolar disorder in Aotearoa. Medication changes can widen these inequities if they are not planned with equity in mind. Additional consideration must also be given to support provided for tāngata whai ora with complex health needs (particularly impaired renal functioning), intellectual disability/cognitive impairment, older adults, as well as those living in rural communities or from ethnically or linguistically diverse backgrounds.

Recommendation

- Tū Te Akaaka Roa recommends proactive, whānau-inclusive support delivered in partnership with kaupapa Māori and Pacific providers, and the following groups should also be prioritised for additional support. As possible, resources should be provided in te reo Māori, Pacific languages, other commonly spoken languages, and in easy-read and accessible formats and distributed through relevant community organisations.

Publishing clear product information and monitoring and evaluating the transition

Tū Te Akaaka Roa recommends PHARMAC work with Medsafe, Health NZ and the Centre for Adverse Reactions Monitoring to encourage reporting of adverse events, update bioequivalence data and assess the effectiveness of communication strategies. Relevant updates should be provided to prescribers through the transition period, and a final evaluation should be provided to drive system improvement.

Thank you for the opportunity to provide feedback. We look forward to working with PHARMAC to support a safe and equitable transition for tāngata whai ora and their whānau. If you have any questions about this submission, please contact the New Zealand National Office – Tū Te Akaaka Roa via nzoffice@ranzcp.org or on +64 (0)4 472 7247.

Ngā manaakitanga



Dr Hiran Thabrew
National Chair, Tū Te Akaaka Roa