Updated September 2026

Fluoxetine

Brand name - Prozac *Oral adult dosing for MDD, OCD, Panic Disorder*

Fluoxetine is a selective serotonin reuptake inhibitor (SSRI). Its therapeutic mechanism may be related to increasing serotonergic activity in the central nervous system via inhibiting serotonin reuptake. It is FDA approved for major depressive disorder (MDD), obsessive compulsive disorder (OCD), and panic disorder, and is often used off-label for other anxiety disorders.

	MDD or OCD	Panic Disorder
Initial Dose	20 mg/day	10 mg/day
Titration Timeline	Consider titrating by 10-20 mg/day depending on clinical need and tolerability. Wait at least a few weeks before increasing dose.	
Usual Range	20-60 mg/day	20-60mg/day
Max Dose	80 mg/day	Dosages higher than 60 mg/day not systematically evaluated but maximum of 80mg could be considered based on tolerability

Prescribing Pearls

- Administer once daily. May cause insomnia; morning dosing generally preferred.
- Consider starting dose of 10 mg/day in patients with increased medication sensitivity, hepatic impairment, older age, or tolerability concerns.
- Fluoxetine and its metabolite have long half-lives. Dose changes, adverse effects, and drug interactions may persist for several weeks after a dose change or discontinuation.
- Assess for a history of mania/hypomania and other bipolar-spectrum risk factors. Antidepressants may precipitate a manic, mixed, or hypomanic episode.
- Common side effects include nausea, diarrhea, anxiety, insomnia, headache, increased sweating, decreased appetite, and sexual dysfunction.
- Transient activation/anxiety may occur early in treatment in some patients; distinguish this from worsening of the underlying anxiety disorder or emerging mania.

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Prescribing Pearls Cont'd

- Wait ≤14 days after stopping an MAOI before starting fluoxetine. Wait ≤5 weeks after stopping fluoxetine before starting an MAOI. Review other serotonergic rx; monitor for serotonin syndrome.
- Avoid abrupt discontinuation when possible. Gradually taper and monitor for symptoms of discontinuation: dizziness, irritability, anxiety, sensory/sleep disturbances, headache, or mood change.

Safety

- **Pregnancy.** Use an individualized risk-benefit assessment. Several decades of data has **not** established increased risk of major birth defects or miscarriage with fluoxetine. Some studies – which do **not** establish a causal relationship – reported associations with cardiovascular malformations. **Untreated MDD and anxiety carry maternal and perinatal risks.**
  - Late-pregnancy SSRI exposure may be associated with poor neonatal adaptation, e.g. respiratory distress, feeding difficulty, temperature instability, abnormal muscle tone, tremor, jitteriness, irritability, and other symptoms. Some infants may require respiratory support, tube feeding, or prolonged hospitalization. SSRI exposure later in pregnancy has been associated with persistent pulmonary hypertension of the newborn.
  - SSRI exposure, particularly near delivery, has also been associated with a modest increase in postpartum hemorrhage risk.
- **Lactation.** Fluoxetine and its metabolite are present in human milk. Infant exposure is generally higher than other SSRIs. Fluoxetine treatment is **not** automatically a reason to stop breastfeeding when clinically indicated, particularly if it was effective during pregnancy or other treatments have failed. As with any infant, monitor weight, irritability, and sedation.
- Monitor for worsening symptoms, unusual behavioral changes, and suicidal thoughts, particularly in young adults and around treatment changes.
- May increase **bleeding risk,** esp. w/ NSAIDs, aspirin, antiplatelet therapy, or anticoagulants.
- May cause hyponatremia, esp. in patients who are older, taking diuretics, or volume-depleted.
- **QT risk.** Use additional caution in patients with clinically important QT-prolongation risk, electrolyte abnormalities, significant cardiac disease, or other QT-prolonging medications.
- Drug interactions: Fluoxetine inhibits CYP2D6 and may substantially increase exposure to CYP2D6 substrates, including some TCAs, antipsychotics, beta-blockers, and antiarrhythmics. Interaction effects can persist after discontinuation due to its long half-life.

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