

PRODUCT INFORMATION

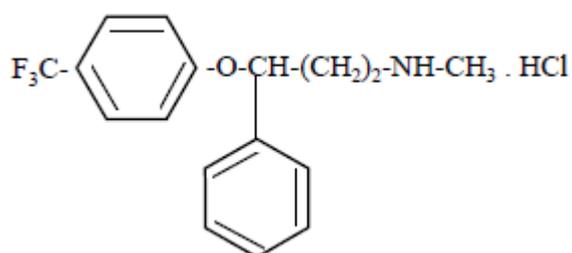
Fluotex 20mg capsules

NAME OF THE MEDICINE

Fluoxetine Hydrochloride

Fluoxetine hydrochloride is an antidepressant for oral administration. It is designated (±)-N-methyl-3-phenyl-3-[(α,α,α-trifluoro-p-tolyl)-oxy]-propylamine hydrochloride, and has the empirical formula of C₁₇H₁₈F₃NO HCl. Its molecular weight is 345.79. The CAS number for fluoxetine hydrochloride is 56296-78-7.

The structural formula is as follows:



DESCRIPTION

Fluoxetine hydrochloride is a white to off-white crystalline solid. Sparingly soluble in water and in methylene chloride, freely soluble in methanol.

Each Fluotex 20mg capsule contains fluoxetine hydrochloride equivalent to 20 mg of fluoxetine. It also contains pregelatinised maize starch, gelatin, brilliant blue FCF, iron oxide yellow, titanium dioxide, sodium lauryl sulfate & black edible ink.

The black printing ink contains the following ingredients: shellac, ethanol absolute, isopropyl alcohol, butan-1-ol, propylene glycol, iron oxide black and purified water

PHARMACOLOGY

Pharmacodynamics

The antidepressant and antiobsessional action of fluoxetine is presumed to be linked to its inhibition of CNS neuronal uptake of serotonin. Studies at clinically relevant doses in man have demonstrated that fluoxetine blocks the uptake of serotonin, but not of noradrenaline, into human platelets. Studies in animals also suggest that fluoxetine is a much more potent uptake inhibitor of serotonin than of noradrenaline.

Antagonism of muscarinic, histaminergic, and α₁-adrenergic receptors has been hypothesised to be associated with various anticholinergic, sedative, and cardiovascular effects of classical tricyclic antidepressant drugs. Fluoxetine binds to these and other membrane receptors from brain tissue much less potently in vitro than do the tricyclic drugs.

Pharmacokinetics:

Absorption - In man, following a single oral 40 mg dose, peak plasma concentrations of fluoxetine from 15 to 55 ng/mL are observed after 6 to 8 hours. Fluoxetine is 80 to 95% absorbed following oral administration. There is linear dose proportionality for the absorption of fluoxetine over the therapeutic dose range.

Food does not appear to affect the systemic bioavailability of fluoxetine, although it may delay its absorption inconsequentially. Thus, fluoxetine may be administered with or without food.

Distribution - The volume of distribution for fluoxetine is estimated at 30-40 L/kg.

Protein Binding - Over the concentration range from 200 to 1,000 ng/mL, approximately 94.5% of fluoxetine is bound in vitro to human serum proteins, including albumin and α -1-glycoprotein. The interaction between fluoxetine and other highly protein-bound drugs has not been fully evaluated, but may be important (see **PRECAUTIONS**).

Metabolism - Fluoxetine is extensively metabolised in the liver to norfluoxetine and a number of other, unidentified metabolites. The only identified active metabolite, norfluoxetine, is formed by demethylation of fluoxetine. In animal models, norfluoxetine's potency and selectivity as a serotonin uptake blocker are essentially equivalent to fluoxetine's.

Multiple cytochrome P450 isoenzymes, including CYP2D6, are responsible for the conversion of fluoxetine to norfluoxetine; thus other nonsaturable oxidative pathways (i.e. non-2D6 pathways) contribute considerably to norfluoxetine formation (see **Interactions with Other Medicines**).

Excretion - The primary route of elimination appears to be hepatic metabolism to inactive metabolites excreted by the kidney.

Clinical Issues Related to Metabolism/Elimination - The complexity of the metabolism of fluoxetine has several consequences which may potentially affect fluoxetine's clinical use.

Accumulation and Slow Elimination - The relatively slow elimination of fluoxetine (elimination half-life of 1 to 3 days after acute administration and 4 to 6 days after chronic administration) and its active metabolite, norfluoxetine (elimination half-life of 4 to 16 days after acute and chronic administration), leads to significant accumulation of these active species in chronic use. After 30 days of dosing at 40 mg/day, plasma concentrations of fluoxetine in the range of 91 to 302 ng/mL and norfluoxetine in the range of 72 to 258 ng/mL have been observed. Plasma concentrations of fluoxetine were higher than those predicted by single dose studies, presumably because fluoxetine's metabolism is not proportional to dose. Norfluoxetine, however, appears to have linear pharmacokinetics. Its mean terminal half-life after a single dose was 8.6 days and after multiple dosing was 9.3 days.

Thus, even if patients are given a fixed dose, steady state plasma concentrations are only achieved after continuous dosing for weeks. Nevertheless, plasma concentrations do not appear to increase without limit. Specifically, patients receiving fluoxetine at doses of 40 to 80 mg/day over periods as long as 3 years exhibited, on average, plasma concentrations similar to those seen among patients treated for 4 or 5 weeks.

Clinical Issues Related to Accumulation and Slow Elimination:

1. The long elimination half-lives of fluoxetine and norfluoxetine assure that, even when dosing is stopped, active drug substance will persist in the body for weeks (primarily depending on individual patient characteristics, previous dosing regimen and length of previous therapy at discontinuation). This is of potential consequence when drug withdrawal is required or when drugs are prescribed that might interact with fluoxetine and norfluoxetine following the discontinuation of fluoxetine hydrochloride.
2. See **PRECAUTIONS - The Long Elimination Half-Lives of Fluoxetine and its Metabolites.**

CLINICAL TRIALS

1. Anxiety Associated with Major Depression –

A meta-analysis of randomised clinical trials provided acceptable evidence that

- (i) fluoxetine shows an efficacy at least equal to that of tricyclic antidepressants and statistically significantly superior to placebo in the treatment of patients who have anxiety symptoms associated with a depressive illness, and
- (ii) the effect of fluoxetine is similar in depressed patients regardless of the presence or absence of associated anxiety.

2. **Elderly** - Fluoxetine has been studied in four clinical trials in elderly depressed patients (> 60 years of age). The efficacy shown by fluoxetine in these elderly patients was similar to its effects in younger adults. Fluoxetine was well tolerated by elderly depressed patients.

3. Maintenance of Remission of Depression-

In a multicentre randomised double-blind continuation of those who were in remission after 12 weeks of open-label fluoxetine 20 mg/day, after 50 weeks (total duration) of fluoxetine 20mg/day, the fluoxetine-treated patients had a statistically significantly lower rate of re-emergence of depressive symptoms than those on placebo. Although the numbers treated for 62 weeks were too few for efficacy evaluation, treatment with fluoxetine was safe and well-tolerated for this time.

4. Premenstrual Dysphoric Disorder (PMDD)-

The effectiveness of fluoxetine for the treatment of PMDD has been studied in four placebo-controlled trials (one intermittent and three continuous) in a total of 628 patients (415 exposed to fluoxetine).

In an intermittent dosing double-blind, parallel group study of 3 months duration, patients (N=260 randomised) were treated with fluoxetine 10mg/day, fluoxetine 20 mg/day, or placebo. Fluoxetine or placebo was started 14 days prior to the anticipated onset of menstruation and was continued through the first full day of menses. Fluoxetine 20 mg/day was shown to be significantly more effective than placebo as measured by the Daily Record of Severity of Problem (DRSP) total score (including mood and physical symptoms) and the DRSP social and functional impairment symptom cluster score. The DRSP is a patient-rated instrument that mirrors the diagnostic criteria for PMDD as identified in the DSM-IV. Fluoxetine 10 mg/day was shown to be significantly more effective than placebo as measured by the DRSP social and functional impairment symptom cluster score, but did not show a significant difference to placebo for DRSP total score. The average DRSP total score decreased 38% on fluoxetine 20 mg/day, 35% on fluoxetine 10 mg/day and 30% on placebo. The average DRSP social and functional impairment symptom cluster score decreased 42% on fluoxetine 20 mg/day, 40% on

fluoxetine 10 mg/day and 33% on placebo. Both fluoxetine 20 mg/day and 10 mg/day were well-tolerated in this study.

In the first continuous dosing double-blind, parallel study of 6 months duration, fixed doses of fluoxetine 20 mg (n=95) and 60 mg (n=85) per day were shown to be significantly more effective than placebo (n=94) in improving the cyclical mood disturbance characteristic of PMDD as measured by Visual Analogue Scales (VAS) evaluating dysphoria, irritability and tension. The average score calculated from these three VAS items decreased 6% on placebo treatment compared to 37% on 20 mg ($p < .001$ vs placebo) and 42% on 60 mg fluoxetine ($p < .001$ vs placebo). Fluoxetine was also shown to be significantly more effective than placebo in improving physical symptoms of PMDD as measured by the VAS evaluating bloating, breast tenderness and headache. The average score calculated from these 3 VAS items decreased 8% on placebo, 33% on 20 mg ($p = .005$ vs placebo) and 31% on 60 mg fluoxetine ($p = .012$ vs. placebo). Fluoxetine 20 mg and 60 mg per day were also significantly more effective than placebo on a number of secondary measures of mood, physical symptoms and social impairment. The other two continuous dosing clinical studies were supportive of the differences seen between fluoxetine and placebo.

INDICATIONS

Treatment of Major depression.

Treatment of Obsessive Compulsive Disorder.

Treatment of Premenstrual Dysphoric Disorder (PMDD) as defined by DSM-IV criteria.

The essential features of PMDD, according to the Diagnostic and Statistical Manual-4th edition (DSM-IV) include markedly depressed mood, anxiety or tension, affective lability and persistent anger or irritability. Other features include decreased interest in usual activities, difficulty concentrating, lack of energy, change in appetite or sleep and feeling out of control. Physical symptoms associated with PMDD include breast tenderness, headache, joint and muscle pain, bloating and weight gain. These symptoms occur regularly during the luteal phase and remit within a few days following onset of menses; the disturbance markedly interferes with work or school or with usual social activities and relationships with others.

CONTRAINDICATIONS

Fluoxetine is contraindicated in patients known to be hypersensitive to fluoxetine hydrochloride or any of the other ingredients in the formulation.

Monoamine Oxidase Inhibitors - The combined administration of fluoxetine and a monoamine oxidase inhibitor (MAOI) has been associated with the development of serotonin syndrome, a serious, sometimes fatal, reaction in patients receiving an SSRI in combination with a MAOI and in patients treated with fluoxetine and a MAOI in close temporal proximity. Some cases presented with features resembling neuroleptic malignant syndrome. Symptoms and signs of serotonin syndrome include: clonus, myoclonus, tremor, shivering, hyperreflexia, hyperthermia, rigidity, autonomic instability with possible rapid fluctuations of vital signs and mental status changes that include extreme agitation progressing to delirium and coma.

Therefore, fluoxetine hydrochloride should not be used in combination with a MAOI (selective, reversible or irreversible), or within a minimum of 14 days of discontinuing therapy with a MAOI. Since fluoxetine and its major metabolite have very long elimination half-lives, at least 5 weeks (perhaps longer, especially if fluoxetine has been prescribed

chronically and/or at higher doses – see **PHARMACOLOGY - Accumulation and Slow Elimination**) should be allowed after stopping fluoxetine hydrochloride before starting a MAOI. Limited reports suggest that orally administered cyproheptadine (Periactin®) or intravenously administered dantrolene (Dantrium®) may benefit patients experiencing such reactions. Animal studies also suggest that cyproheptadine may be beneficial.

Pimozide - Concomitant use in patients taking pimozide is contraindicated (see PRECAUTIONS).

PRECAUTIONS

Clinical Worsening and Suicide Risk – The risk of suicide attempt is inherent in depression and other psychiatric disorders and may persist until significant remission occurs. As with other drugs with similar pharmacological action (antidepressants), isolated cases of suicidal ideation and suicidal behaviours have been reported during fluoxetine therapy or early after treatment discontinuation. This risk must be considered in all depressed patients.

Although a causal role for fluoxetine in inducing such events has not been established, some analyses from pooled studies of antidepressants in psychiatric disorders found an increased risk for suicidal ideation and/or suicidal behaviours in paediatric and young adult (<25 years of age) patients compared to placebo. Patients with depression may experience worsening of their depressive symptoms and/or the emergence of suicidal ideation and behaviours (suicidality) whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored for clinical worsening and suicidality, especially at the beginning of a course of treatment, or at the time of dose changes, either increases or decreases. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse or whose emergent suicidality is severe, abrupt in onset, or was not part of the patient's presenting symptoms. Patients (and caregivers of patients) should be alerted about the need to closely monitor for any worsening of their condition and/or the emergence of suicidal ideation/behaviour or thoughts of harming themselves and to seek medical advice immediately if these symptoms present. Physicians should encourage patients of all ages to report any distressing thoughts or feelings at any time. Patients with comorbid depression associated with other psychiatric disorders being treated with antidepressants should be similarly observed for clinical worsening and suicidality.

Pooled analyses of 24 short-term (4 to 16 weeks), placebo-controlled trials of nine antidepressant medicines [selective serotonin reuptake inhibitors (SSRIs) and others] in 4400 children and adolescents with major depressive disorder (16 trials), obsessive compulsive disorder (4 trials), or other psychiatric disorders (4 trials) have revealed a greater risk of adverse events representing suicidal behaviour or thinking (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients treated with an antidepressant was 4%, compared with 2% of patients given placebo. There was considerable variation in risk among the antidepressants, but there was a tendency towards an increase for almost all antidepressants studied. The risk of suicidality was most consistently observed in the major depressive disorder trials, but there were signals of risk arising from trials in other psychiatric indications (obsessive compulsive disorder and social anxiety disorder) as well. No suicides occurred in these trials. It is unknown whether the suicidality risk in children and adolescent patients extends to use beyond several months. The nine antidepressant medicines in the pooled analyses included five SSRIs (citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline) and four non-SSRIs (bupropion, mirtazapine, nefazodone, venlafaxine).

Symptoms of anxiety, agitation, panic attacks, insomnia, irritability, hostility (aggressiveness), impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adults, adolescents and children being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either worsening of depression and/or emergence of suicidal impulses has not been established, there is concern that such symptoms may be precursors of emerging suicidality.

Families and caregivers of children and adolescents being treated with antidepressants for major depressive disorder or for any other condition (psychiatric or nonpsychiatric) should be informed about the need to monitor these patients for the emergence of agitation, irritability, unusual changes in behaviour, and other symptoms described above, as well as the emergence of suicidality, and to report such symptoms to health care providers immediately. It is particularly important that monitoring be undertaken during the initial few months of antidepressant treatment or at times of dose increase or decrease.

Prescriptions for fluoxetine should be written for the smallest quantity of medicine consistent with good patient management, in order to reduce the risk of overdose.

Serotonin syndrome - Development of serotonin syndrome may occur in association with treatment with SSRIs and SNRIs, particularly when given in combination with MAOIs or other serotonergic agents. Symptoms and signs of serotonin syndrome include rapid onset of neuromuscular excitation (hyperreflexia, incoordination, myoclonus, tremor), altered mental status (confusion, agitation, hypomania) and autonomic dysfunction (diaphoresis, diarrhoea, fever, shivering and rapidly fluctuating vital signs). Treatment with fluoxetine should be discontinued if such events occur and supportive symptomatic treatment initiated.

Cardiovascular Effects - QT prolongation can occur with fluoxetine treatment. Fluoxetine should be used with caution in patients with conditions such as congenital long QT syndrome; acquired long QT syndrome (e.g., due to concomitant use of a drug that prolongs the QT); a family history of QT prolongation; or other clinical conditions that predispose to arrhythmias (e.g., hypokalemia or hypomagnesemia) or increased exposure to fluoxetine (e.g., hepatic impairment).

Rash and Possibly Allergic Events - During premarketing testing of more than 5,600 U.S. patients given fluoxetine, approximately 4% developed a rash and/or urticaria. Among these cases, almost a third were withdrawn from treatment because of the rash and/or systemic signs or symptoms associated with the rash. Clinical findings reported in association with rash include fever, leucocytosis, arthralgias, oedema, carpal tunnel syndrome, respiratory distress, lymphadenopathy, proteinuria, and mild transaminase elevation. Most patients improved promptly with discontinuation of fluoxetine and/or adjunctive treatment with antihistamines or steroids, and all patients experiencing these events were reported to recover completely.

Two patients are known to have developed a serious cutaneous systemic illness. In neither patient was there an unequivocal diagnosis, but one was considered to have a leucocytoclastic vasculitis and the other a severe desquamating syndrome that was considered variously to be a vasculitis or erythema multiforme. Several other patients have had systemic syndromes suggestive of serum sickness.

Since the introduction of fluoxetine hydrochloride, systemic events possibly related to vasculitis, have developed in patients with rash. Although these events are rare, they may be

serious, involving the lung, kidney, or liver. Death has been reported to occur in association with these systemic events.

Anaphylactoid events, including bronchospasm, angioedema and urticaria, alone and in combination, have been reported.

Pulmonary events, including inflammatory processes of varying histopathology and/or fibrosis, have been reported rarely. These events have occurred with dyspnoea as the only preceding symptom.

Whether these systemic events and rash have a common underlying cause or are due to different aetiologies or pathogenic processes is not known. Upon the appearance of rash or of other possibly allergic phenomena for which an alternative aetiology cannot be identified, fluoxetine hydrochloride should be discontinued.

Anxiety and Insomnia - Anxiety, nervousness and insomnia were reported by 10% to 15% of patients treated with fluoxetine hydrochloride. These symptoms led to drug discontinuation in 5% of patients treated with fluoxetine hydrochloride.

Altered Appetite and Weight - Significant weight loss, especially in underweight depressed patients, may be an undesirable result of treatment with fluoxetine hydrochloride. In controlled clinical trials, approximately 9% of patients treated with fluoxetine hydrochloride experienced anorexia. This incidence is approximately sixfold that seen in placebo controls. A weight loss of greater than 5% of body weight occurred in 13% of fluoxetine hydrochloride treated patients compared to 4% of placebo and 3% of tricyclic antidepressant treated patients. However, only rarely have fluoxetine hydrochloride patients been discontinued for weight loss.

Screening for Bipolar Disorder - A major depressive episode may be the initial presentation of Bipolar Disorder. It is generally believed that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk of Bipolar Disorder. Prior to initiating treatment with an antidepressant, patients should be adequately screened to determine if they are at risk for Bipolar Disorder; such screening should include a detailed psychiatric history, including a family history of suicide, Bipolar Disorder, and depression.

Activation of Mania/Hypomania - During premarketing testing, hypomania or mania occurred in approximately 1% of fluoxetine treated patients. Activation of mania/hypomania has also been reported in a small proportion of patients with Major Affective Disorder treated with other marketed antidepressants.

Seizures - Twelve patients among more than 6,000 evaluated worldwide in the course of premarketing development of fluoxetine experienced convulsions (or events described as possibly having been seizures), a rate of 0.2% that appears to be similar to that associated with other marketed antidepressants. Fluoxetine hydrochloride should be introduced with care in patients with a history of seizures.

The Long Elimination Half-Lives of Fluoxetine and Its Metabolites - Because of the long elimination half-lives of the parent drug (1 to 3 days) and its major active metabolite (4 to 16 days), changes in dose will not be fully reflected in plasma for several weeks, affecting both strategies for titration to final dose and withdrawal from treatment. (See **PHARMACOLOGY** and **DOSAGE AND ADMINISTRATION** sections.)

Withdrawal Reactions - Discontinuation symptoms have been reported in association with SSRIs. Because of the long elimination half-life of fluoxetine, and its active metabolite norfluoxetine, plasma fluoxetine and norfluoxetine concentrations decrease gradually at the conclusion of therapy, which reduces greatly the likelihood of developing discontinuation symptoms and makes dosage tapering unnecessary in most patients. Common symptoms associated with withdrawal of SSRIs include dizziness, paraesthesia, headache, anxiety and nausea. Onset of symptoms can occur within a day of discontinuation but may be delayed, particularly in the case of fluoxetine, due to its long half-life. The majority of symptoms experienced on withdrawal of SSRIs are non serious, self-limiting and have varying durations. Fluoxetine has been only rarely associated with such symptoms.

Tamoxifen – Some studies have shown that the efficacy of tamoxifen, as measured by the risk of breast cancer relapse, may be reduced when co-prescribed with fluoxetine as a result of inhibition of CYP2D6 (see **INTERACTIONS**). This risk may increase with longer duration of co-administration. When tamoxifen is used for the treatment or prevention of breast cancer, prescribers should consider using an alternative anti-depressant with little or no CYP2D6 inhibition.

Hepatic Impairment – see **DOSAGE AND ADMINISTRATION**.

Renal Impairment – see **DOSAGE AND ADMINISTRATION**.

Use in Patients with Concomitant Illness - Clinical trial experience with fluoxetine hydrochloride in patients with concomitant systemic illness is limited. Caution is advisable in using fluoxetine hydrochloride in patients with diseases or conditions that could affect metabolism or haemodynamic responses.

Fluoxetine has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were systematically excluded from clinical studies during the product's premarket testing. However, the electrocardiograms of 312 patients who received fluoxetine hydrochloride in double-blind trials were retrospectively evaluated; no conduction abnormalities that resulted in heart block were observed. The mean heart rate was reduced by approximately 3 beats/min.

In subjects with cirrhosis of the liver, the clearances of fluoxetine and its active metabolite, norfluoxetine, were decreased, thus increasing the elimination half-lives of these substances. A lower or less frequent dose should be used in patients with cirrhosis.

Since fluoxetine is extensively metabolised, excretion of unchanged drug in urine is a minor route of elimination. However, until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with fluoxetine, it should be used with caution in such patients.

In patients with diabetes, fluoxetine hydrochloride may alter glycaemic control. Hypoglycaemia has occurred during therapy with fluoxetine hydrochloride and hyperglycaemia has developed following discontinuation of the drug. As is true with many other types of medication when taken concurrently by patients with diabetes, insulin and/or oral hypoglycaemic dosage may need to be adjusted when therapy with fluoxetine hydrochloride is instituted or discontinued.

Mydriasis has been reported in association with fluoxetine; therefore, caution should be used when prescribing fluoxetine in patients with raised intraocular pressure or those at risk of acute narrow-angle glaucoma.

Abnormal Bleeding: SSRIs and SNRIs, including fluoxetine, may increase the risk of bleeding events, including gastrointestinal bleeding (**see ADVERSE EFFECTS**). Therefore, caution is advised in patients taking fluoxetine concomitantly with anticoagulants and/or medicinal products known to affect platelet function (e.g., NSAIDs, aspirin) and in patients with known bleeding tendencies.

Interference with Cognitive and Motor Performance - Patients should be cautioned about operating hazardous machinery, or driving a car, until they are reasonably certain that treatment with fluoxetine does not affect them adversely.

Information for Patients - Physicians are advised to discuss the following issues with patients for whom they prescribe fluoxetine:

Because fluoxetine hydrochloride may impair judgment, thinking or motor skills, patients should be advised to avoid driving a car or operating hazardous machinery until they are reasonably certain that their performance is not affected.

Patients should be advised to inform their physician if they are taking or plan to take any prescription or over-the-counter drugs or alcohol.

Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy.

Patients should be advised to notify their physician if they are breast feeding an infant.

Patients should be advised to notify their physician if they develop a rash or hives.

Hyponatraemia - Several cases of hyponatraemia (some with serum sodium lower than 110 mmol/L) have been reported. The hyponatraemia appeared to be reversible when fluoxetine hydrochloride was discontinued. Although these cases were complex with varying possible aetiologies, some were possibly due to the syndrome of inappropriate antidiuretic hormone secretion (SIADH). The majority of these occurrences have been in older patients and in patients taking diuretics or who were otherwise volumes depleted. In a placebo-controlled, double-blind trial, 10 of 313 fluoxetine patients and 6 of 320 placebo recipients had a lowering of serum sodium below the reference range; this difference was not statistically significant. The lowest observed concentration was 129 mmol/L. The observed decreases were not clinically significant in this trial.

Hyponatraemia in the Elderly - There have been seven reports (total 5628) of hyponatraemia (serum sodium 114-128 mmol/L) in elderly patients taking fluoxetine 20 mg daily. In five, hyponatraemia occurred within 19 days of commencement of fluoxetine, however fluoxetine withdrawal was associated with recovery in all cases. Hence, it may be advisable to monitor electrolytes in geriatric patients during the first weeks of therapy.

Platelet Function - There have been reports of altered platelet function and/or abnormal results from laboratory studies in patients taking fluoxetine. While there have been reports of abnormal bleeding in several patients taking fluoxetine, it is unclear whether fluoxetine had a causative role.

Electroconvulsive Therapy - There are no clinical studies establishing the benefit of the combined use of ECT and fluoxetine. There have been some reports of prolonged seizures in patients on fluoxetine receiving ECT treatment.

Animal Toxicology - Phospholipids are increased in some tissues of mice, rats, and dogs given fluoxetine chronically. This effect is reversible after cessation of fluoxetine treatment. Phospholipid accumulation in animals has been observed with many cationic amphiphilic drugs, including fenfluramine, imipramine, and ranitidine. The significance of this effect in humans is unknown.

Administration of fluoxetine to juvenile rats from weaning to young adulthood was associated with growth retardation, skeletal muscle degeneration and adverse effects on male and female reproductive systems (See **Effects on Fertility**). Post treatment assessment revealed impaired nervous system function and adverse effects in reproductive parameters (See **Effects on Fertility**). These effects were observed at systemic exposures (plasma AUC) to fluoxetine and norfluoxetine of 5- 20 fold higher than clinical paediatric exposure at a dose of 20 mg/day and a 2-7 fold higher than clinical paediatric exposure of 60 mg/day. At the no effect level for these changes, exposure to fluoxetine and norfluoxetine was less than clinical exposure to 8 fold higher than clinical exposure. The significance of these findings for human risk is unknown.

Drug Abuse and Dependence

Physical and Psychological Dependence - Fluoxetine hydrochloride has not been systematically studied, in animals or humans, for its potential for abuse, tolerance, or physical dependence. While the premarketing clinical experience with fluoxetine hydrochloride did not reveal any tendency for a withdrawal syndrome or any drug seeking behaviour, these observations were not systematic and it is not possible to predict on the basis of this limited experience the extent to which a CNS active drug will be misused, diverted, and/or abused once marketed. Consequently, physicians should carefully evaluate patients for history of drug abuse and follow such patients closely, observing them for signs of fluoxetine hydrochloride misuse or abuse (e.g. development of tolerance, incrementation of dose, drug-seeking behaviour).

Effects on Fertility

Two fertility studies conducted in rats at dose levels of up to 9 - 12.5 mg/kg/day indicated that fluoxetine had no adverse effects on fertility. A slight decrease in neonatal survival was noted but this was probably associated with depressed maternal food consumption and suppressed weight gain.

Administration of fluoxetine to juvenile rats from weaning to young adulthood was associated with delayed sexual maturation, degenerative testicular and epididymal changes, and immaturity and inactivity of the female reproductive tract. Post-treatment assessment revealed reduced sperm concentrations and fertility, prolonged pairing-coitus interval, and histopathological changes indicative of irreversible seminiferous tubular degeneration and reversible epididymal vacuolation. These effects were observed at systemic exposures (plasma AUC) to fluoxetine and norfluoxetine of 5 –20 fold higher than clinical paediatric exposure at a dose of 20 mg/day, and 2-7 fold higher than clinical paediatric exposure at 60 mg/day. At the no-effect level for these changes, exposure to fluoxetine and norfluoxetine was from less than clinical exposure to 8 fold higher than clinical exposure. The significance of these findings for human risk is unknown.

Use in Pregnancy

Pregnancy Category C.

This drug crosses the placenta.

Results of a number of epidemiological studies assessing the risk of fluoxetine exposure in early pregnancy have been inconsistent and have not provided conclusive evidence of an increased risk of congenital malformations. However, one meta-analysis suggests a potential risk of cardiovascular defects in infants of women exposed to fluoxetine during the first trimester of pregnancy compared to infants of women who were not exposed to fluoxetine.

Fluoxetine use should be considered during pregnancy only if the potential benefit justifies the potential risk to the foetus, taking into account the risks of untreated depression.

Transitory withdrawal symptoms have been reported rarely in the neonate after maternal use near term.

Neonates exposed to fluoxetine and other SSRIs or serotonin and noradrenaline reuptake inhibitors (SNRIs), late in the third trimester have been uncommonly reported to have clinical findings of respiratory distress, cyanosis, apnoea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycaemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability and constant crying. Such events can arise immediately upon delivery and are usually transient. These features could be consistent with either a direct effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. When treating a pregnant woman with fluoxetine during the third trimester, the physician should carefully consider the potential risks and benefits of treatment.

Epidemiological data have suggested that the use of SSRIs in pregnancy, particular in late pregnancy, may increase the risk of persistent pulmonary hypertension in the newborn (PPHN). The observed risk was approximately 5 cases per 1000 pregnancies. In the general population 1 to 2 cases of PPHN per 1000 pregnancies occur.

Teratogenic Effects - Reproduction studies have been performed in rats and rabbits at doses of up to 12.5 and 15 mg/kg/day and have revealed no evidence of harm to the foetus due to fluoxetine hydrochloride. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Labour and Delivery - The effect of fluoxetine on labour and delivery in humans is unknown.

Use in Lactation

Because fluoxetine is excreted in human milk, breastfeeding while on fluoxetine is not recommended. In one breast milk sample, the concentration of fluoxetine plus norfluoxetine was 70.4 ng/mL. The concentration in the mother's plasma was 295.0 ng/mL. No adverse effects on the infant were reported. In another case, an infant breastfed by a mother on fluoxetine developed crying, sleep disturbance, vomiting and watery stools. The infant's plasma drug levels were 340 ng/mL of fluoxetine and 208 ng/mL of norfluoxetine on the second day of feeding.

Paediatric Use (<18 years)

While clinical studies have been conducted in children and adolescents, the use of fluoxetine is not recommended in this population. (see **PRECAUTIONS, Clinical Worsening and Suicide Risk, Effects on Fertility, Animal Toxicology, ADVERSE EFFECTS**).

Use in the Elderly

Evaluation of patients over the age of 60 who receive fluoxetine 20 mg daily revealed no unusual pattern of adverse events relative to the clinical experience in younger patients. However, these data are insufficient to rule out possible age-related differences during

chronic use, particularly in elderly patients who have concomitant systemic illnesses or who are receiving concomitant drugs. (See **DOSAGE AND ADMINISTRATION** and **PRECAUTIONS - Hyponatraemia**)

Genotoxicity

Fluoxetine and norfluoxetine have been shown to have no genotoxic effects based on the following assays: bacterial mutation assay, DNA repair assay in cultured rat hepatocytes, and in vivo sister chromatid exchange assay in Chinese hamster bone marrow cells.

Carcinogenicity

There is no evidence of carcinogenicity with fluoxetine hydrochloride from animal studies. The dietary administration of fluoxetine to rats for two years at dose levels of 8-11 mg/kg/day produced no evidence of carcinogenicity.

Effects on Laboratory Tests

No specific drug-laboratory interactions involving cross-reactivity of fluoxetine with assays for other substances (i.e. producing a false-positive or false-negative result) have been identified.

INTERACTIONS WITH OTHER MEDICINES

As with all drugs, the potential for interaction by a variety of mechanisms (i.e. pharmacodynamic, pharmacokinetic drug inhibition or enhancement, etc.) is a possibility (see **PHARMACOLOGY - Accumulation and Slow Elimination**).

Drugs Metabolised by P4502D6 (CYP2D6) - Approximately 3% to 10% of the normal population has a genetic defect that leads to reduced levels of activity of cytochrome P4502D6 (CYP2D6). Such individuals have been referred to as "poor metabolisers" of drugs such as dextromethorphan and tricyclic antidepressants. Many drugs, such as antipsychotics (eg. phenothiazines and some atypical) and most antidepressants including fluoxetine and other selective uptake inhibitors of serotonin, are metabolised by this isoenzyme; thus, both the pharmacokinetic properties and relative proportion of metabolites are altered in poor metabolisers.

Fluoxetine, like other agents that are metabolised by P4502D6 (CYP2D6), inhibits the activity of this isoenzyme and thus may make normal metabolisers resemble poor metabolisers. Therapy with medications that are predominantly metabolised by P4502D6 (CYP2D6) and that have a relatively narrow therapeutic index (eg. flecainide, carbamazepine and tricyclic antidepressants) should be initiated at the low end of the dose range if a patient is taking fluoxetine concurrently or have taken it in the previous 5 weeks.

Tamoxifen has an important active metabolite, endoxifen, which is produced by CYP2D6 and contributes significantly to the efficacy of tamoxifen. Inhibition of CYP2D6 by fluoxetine leads to reduced plasma concentration of endoxifen (see **PRECAUTIONS**).

Drugs Metabolised by P4503A4 - In vitro studies have shown ketoconazole, a potent inhibitor of P4503A4 activity, to be at least 100 times more potent than fluoxetine or norfluoxetine as an inhibitor of the metabolism of several substrates for this enzyme, including astemizole, cisapride and midazolam. In an in vivo interaction study involving co-administration of fluoxetine with single doses of terfenadine (a cytochrome P4503A4 substrate), no increase in plasma terfenadine concentrations occurred with concomitant fluoxetine. No change in the pharmacokinetic profile or cognitive effect of midazolam 10 mg orally was observed, following a course of fluoxetine administration intended to produce

steady state conditions, when compared with baseline determinations. These data indicate that fluoxetine's extent of inhibition of P4503A4 activity is not likely to be of clinical significance.

Potential Effects of Coadministration of Drugs Highly Bound to Plasma Proteins - Because fluoxetine is tightly bound to plasma protein, the administration of fluoxetine to a patient taking another drug which is tightly bound to protein (e.g. warfarin) may cause a shift in plasma concentrations potentially resulting in an adverse effect. Conversely, adverse effects may result from displacement of protein bound fluoxetine by other tightly bound drugs (see **PHARMACOLOGY - Accumulation and Slow Elimination**).

Tryptophan - Five patients receiving fluoxetine hydrochloride in combination with tryptophan experienced adverse effects, including agitation, restlessness and gastrointestinal distress.

Warfarin - Altered anticoagulant effects (laboratory values and/or clinical signs and symptoms), with no consistent pattern, but including increased bleeding, have been reported uncommonly when fluoxetine is co-administered with warfarin. As is prudent in the concomitant use of warfarin with many other drugs, patients receiving warfarin therapy should receive careful coagulation monitoring when fluoxetine is initiated or stopped.

CNS Active Drugs

The risk of using fluoxetine in combination with other CNS active drugs has not been systematically evaluated. Data have been derived from circumstances which do not directly reflect the clinical setting. The clinical significance of *in vitro* and individual case report data is unknown. Nonetheless, caution is advised if the concomitant administration of fluoxetine and such drugs is required. In evaluating individual cases, consideration should be given to using lower initial doses of the concomitantly administered drugs, using conservative titration schedules, and monitoring of clinical status. (See **PHARMACOLOGY -Accumulation and Slow Elimination**).

Anticonvulsants - Patients on stable doses of phenytoin and carbamazepine have developed elevated plasma anticonvulsant concentrations and clinical anticonvulsant toxicity following initiation of concomitant fluoxetine treatment.

Antipsychotics - Some evidence suggests a possible pharmacodynamic and/or pharmacokinetic interaction between some serotonin specific reuptake inhibitors (SSRIs) and some antipsychotics, including possible elevation of blood levels of haloperidol and clozapine. Clinical studies of pimozone with other antidepressants demonstrate an increase in drug interaction or QTc prolongation. While a specific study with pimozone and fluoxetine has not been conducted, the potential for drug interactions or QTc prolongation warrants restricting the concurrent use of pimozone and fluoxetine. Concomitant use of fluoxetine and pimozone is contraindicated (see **CONTRAINDICATIONS**).

Benzodiazepines - The half-life of concurrently administered diazepam may be prolonged in some patients and coadministration of alprazolam may result in increased plasma alprazolam concentrations.

Lithium - There have been reports of both increased and decreased lithium levels when lithium was used concomitantly with fluoxetine. Cases of lithium toxicity and increased serotonergic effects have been reported. Lithium levels should be monitored when these drugs are administered concomitantly.

Serotonergic drugs – Coadministration with serotonergic drugs (e.g. SNRIs, SSRIs, tramadol or triptans such as sumatriptan) may result in serotonin syndrome.

Monoamine Oxidase Inhibitors - See CONTRAINDICATIONS

Other Antidepressants - In two studies, previously stable plasma levels of imipramine and desipramine have increased greater than 2 to 10-fold when fluoxetine has been administered in combination. This influence may persist for three weeks or longer after fluoxetine is discontinued. Thus, the dose of tricyclic antidepressant (TCA) may need to be reduced and plasma TCA concentrations may need to be monitored temporarily when fluoxetine is coadministered or has been recently discontinued. (See **Interactions with Other Medicines - Drugs Metabolised by P4502D6**).

St John's Wort - In common with other SSRIs, pharmacodynamic interactions between fluoxetine and the herbal remedy St John's Wort (*Hypericum perforatum*) may occur, which may result in an increase of undesirable effects.

ADVERSE EFFECTS

Adverse effects are dose-dependent and more common at higher doses than 20 mg per day.

Associated with Discontinuation of Treatment:

Fifteen percent of approximately 4,000 patients who received fluoxetine hydrochloride in U.S. premarketing clinical trials discontinued treatment due to an adverse event. The more common events causing discontinuation included: psychiatric (5.3%), primarily nervousness, anxiety and insomnia; digestive (3.0%), primarily nausea; nervous system (1.6%), primarily dizziness; body as a whole (1.5%), primarily asthenia and headache; and skin (1.4%), primarily rash and pruritus.

In obsessive compulsive disorder studies, 12.1% of fluoxetine treated patients discontinued treatment early because of adverse events. Anxiety and rash at incidences of less than 2% were the most frequently reported events.

Events Observed During Therapy with Fluoxetine - Clinical Trials:

The following events listed by body system have been observed. Very common adverse events are defined as those occurring in 1 or more occasions in at least 1/10 patients; common adverse events are defined as those occurring in 1 or more occasions in at least 1/100 patients; uncommon adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in less than 1/1000 patients; very rare events are those occurring in less than 1/10000 patients. It is important to emphasise that, although the events reported did occur during treatment with fluoxetine, they were not necessarily caused by it.

Body as a Whole - Very Common: fatigue (includes asthenia); Common: allergic reaction, chills; Uncommon: feeling abnormal; Rare: photosensitivity reaction, serum sickness; Very Rare: anaphylactoid reaction, serotonin syndrome (neuroleptic malignant syndrome-like effects), mild intensity headache.

Cardiovascular System - Common: palpitations, vasodilatation; Uncommon: Hypotension; Very Rare: orthostatic hypotension.

Digestive System - Very Common: diarrhoea, nausea; Common: anorexia, dyspepsia, gastrointestinal disorder, mouth dryness, vomiting; Uncommon: dysphagia; Rare: oesophageal pain.

Haemic and Lymphatic Systems - Uncommon: ecchymosis.

Metabolic and Nutritional Disorders - Common: weight loss.

Musculoskeletal System - Common: twitching.

Nervous System - Very Common: anxiety, dizziness, headache, insomnia, nervousness, somnolence, tremor; Common: abnormal dreams, libido decreased, sleep disorder, thinking abnormal; Uncommon: akathisia, ataxia, balance disorder, bruxism, buccoglossal syndrome, depersonalisation, dyskinesia, manic reaction, myoclonus, seizures.

Respiratory System - Common: yawn.

Skin and Appendages - Common: pruritus, rash, sweating, urticaria; Uncommon: alopecia.

Special Senses - Common: abnormal vision, taste perversion; Uncommon: mydriasis.

Urogenital System - Common: abnormal ejaculation, gynaecological bleeding, impotence, urinary frequency; Uncommon: anorgasmia, breast pain, sexual dysfunction (occasionally persisting after treatment discontinuation), urination impaired, Rare: priapism.

Investigations – Common: Electrocardiogram Data: QT interval prolongation (QTcF \geq 450 msec)

Children and Adolescents: Common: epistaxis

Weight loss and decreased height gain: As with other SSRIs, decreased weight gain has been observed in association with the use of fluoxetine in children and adolescent patients. After 19 weeks of treatment in a clinical trial, paediatric subjects treated with fluoxetine gained an average of 1.1 cm less in height ($p=0.004$) and 1.1 kg less in weight ($p=0.008$) than subjects treated with placebo. Fluoxetine treatment was also associated with a decrease in serum alkaline phosphatase levels in this study. In a retrospective matched control observational study with a mean of 1.8 years of exposure to fluoxetine, paediatric subjects treated with fluoxetine had no difference in growth (0.0cm) adjusted for expected growth in height from their matched, untreated controls (95% CI: -0.6 to 0.6, $p=0.9673$). The subjects grew more than their controls in observed-minus-expected BMI by 0.5kg/m^2 (95% CI: 0.0 to 1.0, $p=0.0328$). The mean additional change associated with fluoxetine treatment would amount to an extra 1.2kg in a 152cm tall person weighing 45kg. Limited evidence is available concerning the longer-term effects of fluoxetine on the development and maturation of children and adolescent patients. Height and weight should be monitored periodically in paediatric patients receiving fluoxetine. (See **PRECAUTIONS**).

Spontaneous Events:

The following events have not been reported in clinical trials of fluoxetine, but have been reported in clinical practice and are possibly related to fluoxetine therapy. All these events are classified as very rare (occurring in less than 1/10000 patients).

Body as a Whole - malignant hyperthermia, Stevens-Johnson syndrome, erythema multiforme.

Cardiovascular - angioedema.

Digestive System – abnormal hepatic function, aggravation of hepatic damage, hepatic failure/necrosis, idiosyncratic hepatitis, gastrointestinal bleeding¹.

Endocrine System - inappropriate secretion of antidiuretic hormone.

Haemic and Lymphatic Systems - eosinophilia, thrombocytopenic purpura.

Nervous System - oculogyric crisis, tardive dyskinesia, memory impairment, confusion.

Skin and Appendages - epidermal necrolysis.

Urogenital System - enlarged clitoris.

Reproduction System and Breast Disorders - gynaecomastia, galactorrhea, hyperprolactinemia

Discontinuation Symptoms – Discontinuation symptoms have been reported when fluoxetine treatment is stopped. The most commonly reported symptoms include dizziness, sleep disorders, sensory disturbances/paraesthesia, anxiety, agitation, asthenia, confusion, headache, and irritability.

DOSAGE AND ADMINISTRATION

**Fluotex is only available as a 20 mg capsule and therefore only appropriate for use in patients prescribed ≥ 20 mg of fluoxetine. For patients requiring treatment with lower strengths of fluoxetine, fluoxetine dispersible tablets are available from other brands. Fluotex capsules should be swallowed whole.*

Depression:

A dose of 20 mg/day, administered in the morning, is the usual recommended initial dose.

If no clinical improvement is observed, a dose increase may be considered after several weeks. Doses above 20 mg/day should be administered on a b.i.d. schedule (i.e. morning and noon) and should not exceed a maximum dose of 80 mg/day. (See **PHARMACOLOGY - Clinical Issues related to Accumulation and Slow Elimination.**)

As with other antidepressants, the full antidepressant effect may be delayed until 4 weeks of treatment or longer. (See **PHARMACOLOGY - Clinical Issues related to Accumulation and Slow Elimination.**)

As with many other medications, a lower* or less frequent dosage should be used in patients with hepatic impairment. A lower or less frequent dosage should also be considered for patients, such as the elderly, with concurrent disease or on multiple medications.

Obsessive-Compulsive Disorder:

Initial Treatment - A dose of 20 mg/day, administered in the morning, is recommended as the initial dose. If insufficient clinical improvement is observed, a dose increase may be considered after several weeks. The full therapeutic effect may be delayed until 5 weeks of treatment or longer.

¹ Includes: esophageal varices hemorrhage, gingival and mouth bleeding, hematemesis, hematochezia, hematomas [intraabdominal, peritoneal], hemorrhage [anal, esophageal, gastric, gastrointestinal (upper and lower), haemorrhoidal, peritoneal, rectal], hemorrhagic diarrhoea and enterocolitis, hemorrhagic diverticulitis, hemorrhagic gastritis, melaena, and ulcer hemorrhage [esophageal, gastric, duodenal].

Doses above 20 mg/day may be administered on a once a day (i.e. morning) or b.i.d. schedule (i.e. morning and noon). A dose range of 20 to 60 mg/day is recommended, however, doses of up to 80 mg/day have been well tolerated in open studies of OCD. The maximum fluoxetine dose should not exceed 80 mg/day.

A lower* or less frequent dosage should be used in patients with hepatic impairment. A lower or less frequent dosage should also be considered for patients, such as the elderly (see **PRECAUTIONS - Use in the Elderly**), with concurrent disease or on multiple medications.

Maintenance/Continuation Treatment - While there are no systematic studies that answer the question of how long to continue fluoxetine, OCD is a chronic condition and it is reasonable to consider continuation for a responding patient.

However, dosage adjustments should be made to maintain the patient on the lowest effective dosage and patients should be periodically reassessed to determine the need for treatment.

Premenstrual Dysphoric Disorder (PMDD):

The recommended dose of fluoxetine for the treatment of PMDD is 20 mg/day given continuously (every day of the menstrual cycle) or intermittently (defined as starting a daily dose 14 days prior to the anticipated onset of menstruation through the first full day of menses and repeating with each new cycle).

General:

Liver Disease - As might be predicted from its primary site of metabolism, liver impairment can affect the elimination of fluoxetine. The elimination half-life of fluoxetine was prolonged in a study of cirrhotic patients, with a mean of 7.6 days compared to the range of 2 to 3 days seen in subjects without liver disease; norfluoxetine elimination was also delayed, with a mean duration of 12 days for cirrhotic patients compared to the range of 7 to 9 days in normal subjects. This suggests that the use of fluoxetine in patients with liver disease must be approached with caution. If fluoxetine is administered to patients with liver disease, a lower* or less frequent dose should be used (see **PRECAUTIONS**).

Renal Disease - In depressed patients on dialysis (N=12), fluoxetine administered as 20 mg once daily for two months produced steady-state fluoxetine and norfluoxetine plasma concentrations comparable to those seen in patients with normal renal function. While the possibility exists that renally excreted metabolites of fluoxetine may accumulate to higher levels in patients with severe renal dysfunction, use of a lower or less frequent dose is not routinely necessary in renally impaired patients.

Age – Adjustment of dosage should not be required on the basis of age alone (see **PRECAUTIONS** for information on **Hepatic Impairment, Renal Impairment, Use in Patients with Concomitant Illness** and **Interactions with Other Medicines**).

Children and Adolescents (<18 years) – While clinical studies have been conducted in children and adolescents, the use of fluoxetine is not recommended in this population.

OVERDOSAGE

Symptoms - Cases of overdose of fluoxetine alone usually have an uncomplicated course and resolve without residual effects. Symptoms of overdose have included nausea, vomiting, seizures, cardiovascular dysfunction ranging from asymptomatic arrhythmias (including nodal rhythm and ventricular arrhythmias) or ECG changes indicative of QTc prolongation to cardiac arrest (including very rare cases of Torsade de Pointes), pulmonary dysfunction and

signs of altered CNS status ranging from excitation to coma. During a 13-year period, there were 34 fatal reports of overdose where fluoxetine was the only reported ingestant although many of the case reports were incomplete.

Management of Overdose - Establish and maintain an airway; insure adequate oxygenation and ventilation. Activated charcoal, which may be used with sorbitol, should be considered in treating overdose.

Cardiac and vital signs monitoring is recommended, along with general symptomatic and supportive measures. Based on experience in animals, which may not be relevant to humans, fluoxetine-induced seizures which fail to remit spontaneously may respond to diazepam.

There are no specific antidotes for fluoxetine hydrochloride.

Due to the large volume of distribution of fluoxetine hydrochloride, forced diuresis, dialysis, haemoperfusion, and exchange transfusion are unlikely to be of benefit.

In managing overdosage, consider the possibility of multiple drug involvement. The physician should consider contacting the Poisons Information Centre on 13 11 26 for advice on the treatment and management of any overdosage.

PRESENTATION AND STORAGE CONDITIONS

Fluotex 20mg capsules:

20 mg fluoxetine (present as the hydrochloride) green/off-white hard gelatin self locked capsules of size '2' imprinted with 'FLX' and 'MIL' on cap/body in black edible ink containing white powder.

Blister pack (PVC/PVDC/Al) of 28 capsules.

Storage conditions

Store below 30°C. Protect from light.

NAME AND ADDRESS OF THE SPONSOR

Arrow Pharma Pty Ltd
15-17 Chapel Street
Cremorne VIC 3121

POISON SCHEDULE OF THE MEDICINE

S4 - Prescription only medicine

DATE OF FIRST INCLUSION IN THE AUSTRALIAN REGISTER OF THERAPEUTIC GOODS (THE ARTG):

23/02/2017

DATE OF MOFS RECENT AMENDMENT:

29 January 2018