Obsessive Compulsive Disorder: ***Usual Initial Dosage:*** PAXIL should be administered as a single daily dose with or without food, usually in the morning. The recommended dose of PAXIL in the treatment of OCD is 40 mg daily. Patients should be started on 20 mg/day and the dose can be increased in 10-mg/day increments. Dose changes should occur at intervals of at least 1 week. Patients were dosed in a range of 20 to 60 mg/day in the clinical trials demonstrating the effectiveness of PAXIL in the treatment of OCD. The maximum dosage should not exceed 60 mg/day.

Maintenance Therapy: Long-term maintenance of efficacy was demonstrated in a 6-month relapse prevention trial. In this trial, patients with OCD assigned to paroxetine demonstrated a lower relapse rate compared to patients on placebo (see CLINICAL PHARMACOLOGY—Clinical Trials). OCD is a chronic condition, and it is reasonable to consider continuation for a responding patient. 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 continued treatment.

Panic Disorder: ***Usual Initial Dosage:*** PAXIL should be administered as a single daily dose with or without food, usually in the morning. The target dose of PAXIL in the treatment of panic disorder is 40 mg/day. Patients should be started on 10 mg/day. Dose changes should occur in 10-mg/day increments and at intervals of at least 1 week. Patients were dosed in a range of 10 to 60 mg/day in the clinical trials demonstrating the effectiveness of PAXIL. The maximum dosage should not exceed 60 mg/day.

Maintenance Therapy: Long-term maintenance of efficacy was demonstrated in a 3-month relapse prevention trial. In this trial, patients with panic disorder assigned to paroxetine demonstrated a lower relapse rate compared to patients on placebo (see CLINICAL PHARMACOLOGY—Clinical Trials). Panic disorder is a chronic condition, and it is reasonable to consider continuation for a responding patient. 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 continued treatment.

Social Anxiety Disorder: ***Usual Initial Dosage:*** PAXIL should be administered as a single daily dose with or without food, usually in the morning. The recommended and initial dosage is 20 mg/day. In clinical trials the effectiveness of PAXIL was demonstrated in patients dosed in a range of 20 to 60 mg/day. While the safety of PAXIL has been evaluated in patients with social anxiety disorder at doses up to 60 mg/day, available information does not suggest any additional benefit for doses above 20 mg/day (see CLINICAL PHARMACOLOGY—Clinical Trials).

Maintenance Therapy: There is no body of evidence available to answer the question of how long the patient treated with PAXIL should remain on it. Although the efficacy of PAXIL beyond 12 weeks of dosing has not been demonstrated in controlled clinical trials, social anxiety disorder is recognized as a chronic condition, and it is reasonable to consider continuation of treatment for a responding patient. 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 continued treatment.

Generalized Anxiety Disorder: ***Usual Initial Dosage:*** PAXIL should be administered as a single daily dose with or without food, usually in the morning. In clinical trials the effectiveness of PAXIL was demonstrated in patients dosed in a range of 20 to 50 mg/day. The recommended starting dosage and the established effective dosage is 20 mg/day. There is not sufficient evidence to suggest a greater benefit to doses higher than 20 mg/day. Dose changes should occur in 10 mg/day increments and at intervals of at least 1 week.

Maintenance Therapy: Systematic evaluation of continuing PAXIL for periods of up to 24 weeks in patients with Generalized Anxiety Disorder who had responded while taking PAXIL during an 8-week acute treatment phase has demonstrated a benefit of such maintenance (see CLINICAL PHARMACOLOGY—Clinical Trials). Nevertheless, patients should be periodically reassessed to determine the need for maintenance treatment.

Posttraumatic Stress Disorder: ***Usual Initial Dosage:*** PAXIL should be administered as a single daily dose with or without food, usually in the morning. The recommended starting dosage and the established effective dosage is 20 mg/day. In 1 clinical trial, the effectiveness of PAXIL was demonstrated in patients dosed in a range of 20 to 50 mg/day. However, in a fixed dose study, there was not sufficient evidence to suggest a greater benefit for a dose of 40 mg/day compared to 20 mg/day. Dose changes, if indicated, should occur in 10 mg/day increments and at intervals of at least 1 week.

Maintenance Therapy: There is no body of evidence available to answer the question of how long the patient treated with PAXIL should remain on it. Although the efficacy of PAXIL beyond 12 weeks of dosing has not been demonstrated in controlled clinical trials, PTSD is recognized as a chronic condition, and it is reasonable to consider continuation of treatment for a responding patient. 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 continued treatment.

Special Populations: ***Treatment of Pregnant Women During the Third Trimester:*** Neonates exposed to PAXIL and other SSRIs or SNRIs, late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding (see WARNINGS). When treating pregnant women with paroxetine during the third trimester, the physician should carefully consider the potential risks and benefits of treatment. The physician may consider tapering paroxetine in the third trimester.

Dosage for Elderly or Debilitated Patients, and Patients With Severe Renal or Hepatic Impairment: The recommended initial dose is 10 mg/day for elderly patients, debilitated patients, and/or patients with severe renal or hepatic impairment. Increases may be made if indicated. Dosage should not exceed 40 mg/day.

Switching Patients to or From a Monoamine Oxidase Inhibitor: At least 14 days should elapse between discontinuation of an MAOI and initiation of therapy with PAXIL. Similarly, at least 14 days should be allowed after stopping PAXIL before starting an MAOI.

Discontinuation of Treatment With PAXIL: Symptoms associated with discontinuation of PAXIL have been reported (see PRECAUTIONS). Patients should be monitored for these

symptoms when discontinuing treatment, regardless of the indication for which PAXIL is being prescribed. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate.

NOTE: SHAKE SUSPENSION WELL BEFORE USING.

HOW SUPPLIED

Tablets: Film-coated, modified-oval as follows:

10-mg yellow, scored tablets engraved on the front with PAXIL and on the back with 10.
NDC 0029-3210-13 Bottles of 30

20-mg pink, scored tablets engraved on the front with PAXIL and on the back with 20.
NDC 0029-3211-13 Bottles of 30
NDC 0029-3211-59 Bottles of 90
NDC 0029-3211-21 SUP 100s (intended for institutional use only)

30-mg blue tablets engraved on the front with PAXIL and on the back with 30.
NDC 0029-3212-13 Bottles of 30

40-mg green tablets engraved on the front with PAXIL and on the back with 40.
NDC 0029-3213-13 Bottles of 30

Store tablets between 15° and 30°C (59° and 86°F).

Oral Suspension: Orange-colored, orange-flavored, 10 mg/5 mL, in 250 mL white bottles.
NDC 0029-3215-48

Store suspension at or below 25°C (77°F).

PAXIL is a registered trademark of GlaxoSmithKline.

Medication Guide
PAXIL® (PAX-il) (paroxetine hydrochloride) Tablets and Oral Suspension
About Using Antidepressants in Children and Teenagers

What is the most important information I should know if my child is being prescribed an antidepressant?

Parents or guardians need to think about 4 important things when their child is prescribed an antidepressant:

1. There is a risk of suicidal thoughts or actions
2. How to try to prevent suicidal thoughts or actions in your child
3. You should watch for certain signs if your child is taking an antidepressant
4. There are benefits and risks when using antidepressants

1. There is a Risk of Suicidal Thoughts or Actions

Children and teenagers sometimes think about suicide, and many report trying to kill themselves.

Antidepressants increase suicidal thoughts and actions in some children and teenagers. But suicidal thoughts and actions can also be caused by depression, a serious medical condition that is commonly treated with antidepressants. Thinking about killing yourself or trying to kill yourself is called *suicidality* or *being suicidal.*

A large study combined the results of 24 different studies of children and teenagers with depression or other illnesses. In these studies, patients took either a placebo (sugar pill) or an antidepressant for 1 to 4 months. ***No one committed suicide in these studies,*** but some patients became suicidal. On sugar pills, 2 out of every 100 became suicidal. On the antidepressants, 4 out of every 100 patients became suicidal.

For some children and teenagers, the risks of suicidal actions may be especially high. These include patients with

- Bipolar illness (sometimes called manic-depressive illness)
- A family history of bipolar illness
- A personal or family history of attempting suicide

If any of these are present, make sure you tell your healthcare provider before your child takes an antidepressant.

2. How to Try to Prevent Suicidal Thoughts and Actions

To try to prevent suicidal thoughts and actions in your child, pay close attention to changes in her or his moods or actions, especially if the changes occur suddenly. Other important people in your child's life can help by paying attention as well (e.g., your child, brothers and sisters, teachers, and other important people). The changes to look out for are listed in Section 3, on what to watch for.

Whenever an antidepressant is started or its dose is changed, pay close attention to your child. After starting an antidepressant, your child should generally see his or her healthcare provider:

- Once a week for the first 4 weeks
- Every 2 weeks for the next 4 weeks
- After taking the antidepressant for 12 weeks
- After 12 weeks, follow your healthcare provider's advice about how often to come back
- More often if problems or questions arise (see Section 3)

You should call your child's healthcare provider between visits if needed.

3. You Should Watch for Certain Signs If Your Child is Taking an Antidepressant

Contact your child's healthcare provider ***right away*** if your child exhibits any of the following signs for the first time, or if they seem worse, or worry you, your child, or your child's teacher:

- Thoughts about suicide or dying
- Attempts to commit suicide
- New or worse depression
- New or worse anxiety
- Feeling very agitated or restless
- Panic attacks
- Difficulty sleeping (insomnia)
- New or worse irritability
- Acting aggressive, being angry, or violent
- Acting on dangerous impulses
- An extreme increase in activity and talking
- Other unusual changes in behavior or mood

Never let your child stop taking an antidepressant without first talking to his or her healthcare provider. Stopping an antidepressant suddenly can cause other symptoms.

4. There are Benefits and Risks When Using Antidepressants

Antidepressants are used to treat depression and other illnesses. Depression and other illnesses can lead to suicide. In some children and teenagers, treatment with an antidepressant increases suicidal thinking or actions. It is important to discuss all the risks of treating depression and also the risks of not treating it. You and your child should discuss all treatment choices with your healthcare provider, not just the use of antidepressants.

Other side effects can occur with antidepressants (see section below).

Of all the antidepressants, only fluoxetine (Prozac®)* has been FDA approved to treat pediatric depression.

For obsessive compulsive disorder in children and teenagers, FDA has approved only fluoxetine (Prozac®)*, sertraline (Zoloft®)*, fluvoxamine, and clomipramine (Anafranil®)*.

Your healthcare provider may suggest other antidepressants based on the past experience of your child or other family members.

Is this all I need to know if my child is being prescribed an antidepressant?

No. This is a warning about the risk for suicidality. Other side effects can occur with antidepressants. Be sure to ask your healthcare provider to explain all the side effects of the particular drug he or she is prescribing. Also ask about drugs to avoid when taking an antidepressant. Ask your healthcare provider or pharmacist where to find more information.

*The following are registered trademarks of their respective manufacturers: Prozac®/Eli Lilly and Company; Zoloft®/Pfizer Pharmaceuticals; Anafranil®/Mallinckrodt Inc.

This Medication Guide has been approved by the U.S. Food and Drug Administration for all antidepressants.

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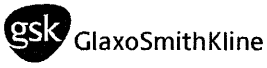

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Seroxat Tablets 20mg, 30mg, Liquid 20mg/10ml

1. NAME OF THE MEDICINAL PRODUCT

Seroxat® 20 mg tablets

Seroxat® 30 mg tablets

Seroxat® 20 mg/10ml liquid

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 20 mg or 30 mg paroxetine.

Each ml of oral suspension contains 2mg of paroxetine.

3. PHARMACEUTICAL FORM

Film-coated tablet

Oral suspension

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Treatment of

- Major Depressive Episode
- Obsessive Compulsive Disorder
- Panic Disorder with and without agoraphobia
- Social Anxiety Disorders/Social phobia
- Generalised Anxiety Disorder
- Post-traumatic Stress Disorder

4.2 Posology and method of administration

It is recommended that paroxetine is administered once daily in the morning with food.

The tablet should be swallowed rather than chewed. For paroxetine liquid, shake the bottle before use.

MAJOR DEPRESSIVE EPISODE

The recommended dose is 20 mg daily. In general, improvement in patients starts after one week but may only become evident from the second week of therapy.

As with all antidepressant medicinal products, dosage should be reviewed and adjusted if necessary within 3 to 4 weeks of initiation of therapy and thereafter as judged clinically appropriate. In some patients, with insufficient response to 20 mg, the dose may be increased gradually up to a maximum of 50 mg a day in 10 mg steps according to the patient's response.

Patients with depression should be treated for a sufficient period of at least 6 months to ensure that they are free from symptoms.

OBSESSIVE COMPULSIVE DISORDER

The recommended dose is 40 mg daily. Patients should start on 20 mg/day and the dose may be increased gradually in 10 mg increments to the recommended dose. If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually up to a maximum of 60 mg/day.

Patients with OCD should be treated for a sufficient period to ensure that they are free from symptoms. This period may be several months or even longer. (see section 5.1 Pharmacodynamic properties)

PANIC DISORDER

The recommended dose is 40 mg daily. Patients should be started on 10 mg/day and the dose gradually increased in 10 mg steps according to the patient's response up to the recommended dose. A low initial starting dose is recommended to minimise the potential worsening of panic symptomatology, which is generally recognised to occur early in the treatment of this disorder. If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually up to a maximum of 60 mg/day.

Patients with panic disorder should be treated for a sufficient period to ensure that they are free from symptoms. This period may be several months or even longer (see section 5.1 Pharmacodynamic properties)

SOCIAL ANXIETY DISORDER/SOCIAL PHOBIA

The recommended dose is 20 mg daily.If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually in 10 mg steps up to a maximum of 50 mg/day.Long-term use should be regularly evaluated (see section 5.1 Pharmacodynamic properties).

GENERALISED ANXIETY DISORDER

The recommended dose is 20 mg daily.If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually in 10 mg steps up to a maximum of 50 mg/day.Long-term use should be regularly evaluated (see section 5.1 Pharmacodynamic properties).

POST-TRAUMATIC STRESS DISORDER

The recommended dose is 20 mg daily.If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually in 10 mg steps up to a maximum of 50 mg/day.Long-term use should be regularly evaluated (see section 5.1 Pharmacodynamic properties).

GENERAL INFORMATION

WITHDRAWAL SYMPTOMS SEEN ON DISCONTINUATION OF PAROXETINE

Abrupt discontinuation should be avoided (see sections 4.4 Special Warnings and Precautions for Use & 4.8 Undesirable Effects). The taper phase regimen used in clinical trials involved decreasing the daily dose by 10 mg at weekly intervals.. If intolerable symptoms occur following a decrease in the

Seroxat Tablets 20mg, 30mg, Liquid 20mg/10ml , SPC from the eMC 2/15 ページ

http://emc.medicines.org.uk/emc/assets/c/html/displayDocPrinterFriendly.asp?d... 2006/01/16

dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose, but at a more gradual rate.

Special populations:

•Elderly

Increased plasma concentrations of paroxetine occur in elderly subjects, but the range of concentrations overlaps with that observed in younger patients. Dosing should commence at the adult starting dose. Increasing the dose might be useful in some patients, but the maximum dose should not exceed 40 mg daily.

•Children and adolescents (7-17 years)

Paroxetine should not be used for the treatment of children and adolescents as controlled clinical trials have found paroxetine to be associated with increased risk for suicidal behaviour and hostility. In addition, in these trials efficacy has not been adequately demonstrated (see section 4.4 Special warnings and special precautions for use and section 4.8 Undesirable effects).

•Children aged below 7 years

The use of paroxetine has not been studied in children less than 7 years. Paroxetine should not be used, as long as safety and efficacy in this age group have not been established.

•Renal/hepatic impairment

Increased plasma concentrations of paroxetine occur in patients with severe renal impairment (creatinine clearance less than 30 ml/min) or in those with hepatic impairment. Therefore, dosage should be restricted to the lower end of the dosage range.

4.3 Contraindications

Known hypersensitivity to paroxetine or any of the excipients.

Paroxetine is contraindicated in combination with monoamine oxidase inhibitors (MAOIs). Treatment with paroxetine can be initiated:

- two weeks after discontinuation of an irreversible MAOI, or

- at least 24hrs after discontinuation of a reversible MAOI (e.g. moclobemide).

At least one week should elapse between discontinuation of paroxetine and initiation of therapy with any MAOI.

Paroxetine should not be used in combination with thioridazine because, as with other drugs which inhibit the hepatic enzyme CYP450 2D6, paroxetine can elevate plasma levels of thioridazine (see Section 4.5, Interactions with other medicinal products and other forms of interaction). Administration of thioridazine alone can lead to QTc interval prolongation with associated serious ventricular arrhythmia such as torsades de pointes, and sudden death.

4.4 Special warnings and special precautions for use

Treatment with paroxetine should be initiated cautiously two weeks after terminating treatment with an irreversible MAOI or 24 hours after terminating treatment with a reversible MAO inhibitor. Dosage of paroxetine should be increased gradually until an optimal response is reached (see section 4.3 Contraindications and section 4.5 Interactions with other medicinal products and other forms of interaction).

Children and adolescents (7-17 years)

Paroxetine should not be used in the treatment of children and adolescents under the age of 18 years. Suicide related behaviours (suicide attempts and suicidal thoughts) and hostility

(predominantly aggression, oppositional behaviour and anger) were more frequently observed in clinical trials among children and adolescents treated with antidepressants compared to those treated with placebo. If based on clinical needs, a decision to treat is nevertheless taken, the patient should be carefully monitored for the appearance of suicidal symptoms. In addition, in these trials efficacy has not been adequately demonstrated and long-term safety data in children and adolescents concerning growth, maturation and cognitive and behavioural development are lacking (see section 4.8 Undesirable effects).

Suicide/suicidal ideation

Depression is associated with an increased risk of suicidal thoughts, self harm and suicide. This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience with all antidepressant therapies that the risk of suicide may increase in the early stages of recovery.

Other psychiatric conditions for which paroxetine is prescribed can also be associated with an increased risk of suicidal behaviour. In addition, these conditions may be co-morbid with major depressive disorder. The same precautions observed when treating patients with major depressive disorder should therefore be observed when treating patients with other psychiatric disorders.

Patients with a history of suicidal behaviour or thoughts, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment, are at a greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment.

There is a possibility of an increased risk of suicide related behaviour in young adults ages 18-29.

Young adults should therefore be monitored carefully throughout treatment.

There are insufficient data concerning the risk of suicide related behaviour in treatment naïve patients, but careful monitoring might be warranted.

Patients, (and caregivers of patients) should be alerted about the need to monitor for the emergence of suicidal ideation/behaviour or thoughts of harming themselves and to seek medical advice immediately if these symptoms present.

Akathisia

The use of paroxetine has been associated with the development of akathisia, which is characterized by an inner sense of restlessness and psychomotor agitation such as an inability to sit or stand still usually associated with subjective distress. This is most likely to occur within the first few weeks of treatment. In patients who develop these symptoms, increasing the dose may be detrimental.

Serotonin syndrome/neuroleptic malignant syndrome

On rare occasions development of a serotonin syndrome or neuroleptic malignant syndrome-like events may occur in association with treatment of paroxetine, particularly when given in combination with other serotonergic and/or neuroleptic drugs. As these syndromes may result in potentially life-threatening conditions, treatment with paroxetine should be discontinued if such events (characterised by clusters of symptoms such as hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, mental status changes including confusion, irritability, extreme agitation progressing to delirium and coma) occur and supportive symptomatic treatment should be initiated. Paroxetine should not be used in combination with serotonin-precursors (such as L-tryptophan, oxitriptan) due to the risk of serotonergic syndrome.

(See Sections 4.3 Contraindications and 4.5 Interactions with other medicinal products and other forms of interaction).

Mania

As with all antidepressants, paroxetine should be used with caution in patients with a history of mania. Paroxetine should be discontinued in any patient entering a manic phase.