

Prescribing Information

PEXEVA[®]

Brand of

(paroxetine mesylate) tablets

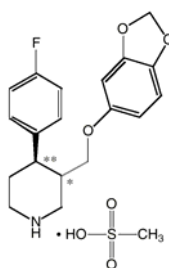
Suicidality in Children and Adolescents

Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of paroxetine mesylate or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. PEXEVA[®] (paroxetine mesylate) is not approved for use in pediatric patients. (See WARNINGS and PRECAUTIONS---Pediatric Use).

Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

DESCRIPTION

PEXEVA[®] (paroxetine mesylate) is an orally administered psychotropic drug with a chemical structure related to paroxetine hydrochloride (Paxil[®]). It is the mesylate salt of a phenylpiperidine compound identified chemically as (-)-*trans*-4R-(4'-fluorophenyl)-3S-[(3',4'-methylenedioxyphenoxy)methyl]piperidine mesylate and has the empirical formula of C₁₉H₂₀FNO₃·CH₃SO₃H. The molecular weight is 425.5 (329.4 as free base). The structural formula is:



paroxetine mesylate

Paroxetine mesylate is an odorless, off-white powder, having a melting point range of 147° to 150°C and a solubility of more than 1 g/ml in water.

Tablets

Each oval, film coated tablet contains paroxetine mesylate equivalent to paroxetine as follows: 10mg (white); 20mg (scored, dark orange); 30mg (yellow); 40mg (rose). Inactive ingredients consist of dibasic calcium phosphate, hydroxypropyl methylcellulose, hydroxypropylcellulose, magnesium stearate, sodium starch glycolate, titanium dioxide, ferric oxide red (C.I. 77491) (20mg, and 40mg only) and ferric oxide yellow (C.I. 77492) (20mg, 30mg and 40mg only).

CLINICAL PHARMACOLOGY

Pharmacodynamics

The efficacy of paroxetine in the treatment of MDD, OCD, panic disorder (PD), and generalized anxiety disorder (GAD) is presumed to be linked to potentiation of serotonergic activity in the central nervous system resulting from inhibition of neuronal reuptake of serotonin (5-hydroxy-tryptamine, 5-HT). Studies at clinically relevant doses in humans have demonstrated that paroxetine blocks the uptake of serotonin into human platelets. *In vitro* studies in animals also suggest that paroxetine is a potent and highly selective inhibitor of neuronal serotonin reuptake and has only very weak effects on norepinephrine and dopamine neuronal reuptake. *In vitro* radioligand binding studies indicate that paroxetine has little affinity for muscarinic α_1 -, α_2 -, beta-adrenergic-, dopamine (D_2)-, 5-HT $_1$ -, 5-HT $_2$ - and histamine (H_1)-receptors; antagonism of muscarinic, histaminergic and α_1 -adrenergic receptors has been associated with various anticholinergic, sedative and cardiovascular effects for other psychotropic drugs.

Because the relative potencies of paroxetine's major metabolites are at most 1/50 of the parent compound, they are essentially inactive.

Pharmacokinetics

Paroxetine mesylate is completely absorbed after oral dosing of the mesylate salt. In a study in which normal male subjects (n = 25) received paroxetine 30 mg tablets daily for 24 days, steady-state paroxetine concentrations were achieved by approximately 13 days for most subjects, although it may take substantially longer in an occasional patient. At steady state, mean values of C_{max} , T_{max} , C_{min} and $T_{1/2}$ were 81.3 ng/ml (CV 41%), 8.1 hr. (CV 56%), 43.2 ng/ml (CV 52%) and 33.2 hr. (CV 52%), respectively. The steady-state C_{max} and C_{min} values were about 7 and 10 times what would be predicted from single dose studies. Steady-state drug exposure based on AUC_{0-24} was about 10 times greater than would have been predicted from single-dose data in these subjects. The excess accumulation is a consequence of the fact that one of the enzymes that metabolizes paroxetine is readily saturable.

In steady-state dose proportionality studies involving elderly and nonelderly patients, at doses of 20 to 40 mg daily for the elderly and 20 to 50 mg daily for the nonelderly, some nonlinearity was observed in both populations, again reflecting a saturable metabolic pathway. In comparison to C_{min} values after 20 mg daily, values after 40 mg were only about 2 to 3 times greater than doubled.

The effects of food on the bioavailability of paroxetine were studied in subjects administered a single dose with and without food. AUC was only slightly increased (6%) when drug was administered with food but the C_{max} was 29% greater, while the time to reach peak plasma concentration decreased from 6.4 hours post-dosing to 4.9 hours.

Paroxetine is extensively metabolized after oral administration. The principal metabolites are polar and conjugated products of oxidation and methylation, which are readily cleared. Conjugates with glucuronic acid and sulfate predominate, and major metabolites have been isolated and identified. Data indicate that the metabolites have no more than 1/50 the potency of the parent compound at inhibiting serotonin uptake. The metabolism of paroxetine is accomplished in part by cytochrome CYP2D6. Saturation of this enzyme at clinical doses appears to account for the nonlinearity of paroxetine kinetics with increasing dose and increasing duration of treatment. The role of this enzyme in paroxetine metabolism also suggests potential drug-drug interactions (see PRECAUTIONS).

Approximately 64% of a 30 mg oral solution dose of paroxetine was excreted in the urine with 2% as the parent compound and 62% as metabolites over a 10-day post-dosing period. About 36% was excreted in the feces (probably via the bile), mostly as metabolites and less than 1% as the parent compound over the 10-day post-dosing period.

Distribution: Paroxetine distributes throughout the body, including the CNS, with only 1% remaining in the plasma.

Protein Binding: Approximately 95% and 93% of paroxetine is bound to plasma protein at 100 ng/ml and 400 ng/ml, respectively. Under clinical conditions, paroxetine concentrations would normally be less than 400 ng/ml. Paroxetine does not alter the *in vitro* protein binding of phenytoin or warfarin.

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Renal and Liver Disease: Increased plasma concentrations of paroxetine occur in subjects with renal and hepatic impairment. The mean plasma concentrations in patients with creatinine clearance below 30 ml/min was approximately 4 times greater than seen in normal volunteers. Patients with creatinine clearance of 30 to 60 ml/min and patients with hepatic functional impairment had about a 2-fold increase in plasma concentrations (AUC, C_{max}).

The initial dosage should therefore be reduced in patients with severe renal or hepatic impairment, and upward titration, if necessary, should be at increased intervals (see DOSAGE AND ADMINISTRATION).

Elderly Patients: In a multiple-dose study in the elderly at daily paroxetine doses of 20, 30 and 40 mg, C_{min} concentrations were about 70% to 80% greater than the respective C_{min} concentrations in nonelderly subjects. Therefore the initial dosage in the elderly should be reduced. (See DOSAGE AND ADMINISTRATION).

Drug-Drug Interactions: In vitro drug interaction studies reveal that paroxetine inhibits CYP2D6. Clinical drug interaction studies have been performed with substrates of CYP2D6 and show that paroxetine can inhibit the metabolism of drugs metabolized by CYP2D6 including desipramine, risperidone, and atomoxetine (see PRECAUTIONS—Drug Interactions).

Clinical Trials

Major Depressive Disorder

The efficacy of paroxetine as a treatment for MDD has been established in 6 placebo-controlled studies of patients with MDD (ages 18 to 73). In these studies paroxetine was shown to be significantly more effective than placebo in treating MDD by at least 2 of the following measures: Hamilton Depression Rating Scale (HDRS), the Hamilton depressed mood item, and the Clinical Global Impression (CGI)-Severity of Illness. Paroxetine was significantly better than placebo in improvement of the HDRS sub-factor scores, including the depressed mood item, sleep disturbance factor and anxiety factor.

A study of outpatients with MDD who had responded to paroxetine (HDRS total score <8) during an initial 8-week open treatment phase and were then randomized to continuation on paroxetine or placebo for 1 year demonstrated a significantly lower relapse rate for patients taking paroxetine (15%) compared to those on placebo (39%). Effectiveness was similar for male and female patients.

Obsessive Compulsive Disorder

The effectiveness of paroxetine in the treatment OCD was demonstrated in two 12-week multicenter placebo-controlled studies of adult outpatients (Studies 1 and 2). Patients in all studies had moderate to severe OCD (DSM-IIIIR) with mean baseline ratings on the Yale Brown Obsessive Compulsive Scale (YBOCS) total score ranging from 23 to 26. Study 1, a dose-range finding study where patients were treated with fixed doses of 20, 40 or 60 mg of paroxetine/day demonstrated that daily doses of paroxetine 40 and 60 mg are effective in the treatment of OCD. Patients receiving doses of 40 and 60 mg paroxetine experienced a mean reduction of approximately 6 and 7 points, respectively, on the YBOCS total score which was significantly greater than the approximate 4 point reduction at 20 mg and a 3 point reduction in the placebo-treated patients. Study 2 was a flexible dose study comparing paroxetine (20 to 60 mg daily) with clomipramine (25 to 250 mg daily). In this study, patients receiving paroxetine experienced a mean reduction of approximately 7 points on the YBOCS total score, which was significantly greater than the mean reduction of approximately 4 points in the placebo-treated patients.

The following table provides the outcome classification by treatment group on Global Improvement items of the Clinical Global Impressions (CGI) scale for Study 1.

Outcome Classification (%) on CGI-Global Improvement Item for Completers in Study 1				
Outcome Classification	Placebo (N = 74)	Paroxetine 20 mg (N = 75)	Paroxetine 40 mg (N = 66)	Paroxetine 60 mg (N = 66)
Worse	14%	7%	7%	3%
No Change	44%	35%	22%	19%
Minimally Improved	24%	33%	29%	34%
Much Improved	11%	18%	22%	24%

Very Much Improved	7%	7%	20%	20%
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Subgroup analyses did not indicate that there were any differences in treatment outcomes as a function of age or gender.

The long-term maintenance effects of paroxetine in OCD were demonstrated in a long-term extension to Study 1. Patients who were responders on paroxetine during the 3 month double-blind phase and a 6 month extension on open-label paroxetine (20 to 60 mg/day) were randomized to either paroxetine or placebo in a 6 month double-blind relapse prevention phase. Patients randomized to paroxetine were significantly less likely to relapse than comparably treated patients who were randomized to placebo.

Panic Disorder

The effectiveness of paroxetine in the treatment of PD was demonstrated in three 10- to 12-week multicenter, placebo-controlled studies of adult outpatients (Studies 1-3). Patients in all studies had PD (DSM-III-R), with or without agoraphobia. In these studies, paroxetine was shown to be significantly more effective than placebo in treating PD by at least 2 out of 3 measures of panic attack frequency and on the Clinical Global Impression Severity of Illness score.

Study 1 was a 10-week dose-range finding study: patients were treated with fixed paroxetine doses of 10, 20, or 40 mg/day or placebo. A significant difference from placebo was observed only for the 40 mg/day group. At endpoint, 76% of patients receiving paroxetine 40 mg/day were free of panic attacks, compared to 44% of placebo-treated patients.

Study 2 was a 12-week flexible-dose study comparing paroxetine (10 to 60 mg daily) and placebo. At endpoint, 51% of paroxetine patients were free of panic attacks compared to 32% of placebo-treated patients.

Study 3 was a 12-week flexible-dose study comparing paroxetine (10 to 60 mg daily) to placebo in patients concurrently receiving standardized cognitive behavioral therapy. At endpoint, 33% of the paroxetine-treated patients showed a reduction to 0 or 1 panic attacks compared to 14% of placebo patients.

In both Studies 2 and 3, the mean paroxetine dose for completers at endpoint was approximately 40 mg/day of paroxetine.

Long-term maintenance effects of paroxetine in PD were demonstrated in an extension to Study 1. Patients who were responders during the 10-week double-blind phase and during a 3-month double-blind extension phase were randomized to either paroxetine (10, 20, or 40 mg/day) or placebo in a 3-month double-blind relapse prevention phase. Patients randomized to paroxetine were significantly less likely to relapse than comparably treated patients who were randomized to placebo.

Subgroup analyses did not indicate that there were any differences in treatment outcomes as a function of age or gender.

Generalized Anxiety Disorder

The effectiveness of paroxetine in the treatment of Generalized Anxiety Disorder (GAD) was demonstrated in two 8-week, multicenter, placebo-controlled studies (Studies 1 and 2) of adult outpatients with GAD (DSM-IV).

Study 1 was an 8-week study comparing fixed paroxetine doses of 20mg or 40mg/day with placebo. Doses of 20 mg or 40 mg of paroxetine were both demonstrated to be significantly superior to placebo on the Hamilton Rating Scale for Anxiety (HAM-A) total score. There was not sufficient evidence in this study to suggest a greater benefit for the 40 mg/day dose compared to the 20 mg/day dose.

Study 2 was a flexible-dose study comparing paroxetine (20mg to 50mg daily) and placebo. Paroxetine demonstrated statistically significant superiority over placebo on the Hamilton Rating Scale for Anxiety (HAM-A) total score. A third study, also flexible-dose comparing paroxetine (20 mg to 50 mg daily), did not demonstrate statistically significant superiority of paroxetine over placebo on the Hamilton Rating Scale for Anxiety (HAM-A) total score, the primary outcome.

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Subgroup analyses did not indicate differences in treatment outcomes as a function of race or gender. There were insufficient elderly patients to conduct subgroup analyses on the basis of age.

In a longer-term trial, 566 patients meeting DSM-IV criteria for GAD, who had responded during a single-blind, 8-week acute treatment phase with 20 to 50 mg/day of paroxetine, were randomized to continuation of paroxetine at their same dose, or to placebo, for up to 24 weeks of observation for relapse. Response during the single-blind phase was defined by having a decrease of ≥ 2 points compared to baseline on the CGI-Severity of Illness scale, to a score of ≤ 3 . Relapse during the double-blind phase was defined as an increase of ≥ 2 points compared to baseline on the CGI-Severity of Illness scale to a score of ≥ 4 , or withdrawal due to lack of efficacy. Patients receiving continued paroxetine experienced a significantly lower relapse rate over the subsequent 24 weeks compared to those receiving placebo.

INDICATIONS AND USAGE

Major Depressive Disorder

PEXEVA® (paroxetine mesylate) is indicated for the treatment of MDD.

The efficacy of paroxetine in the treatment of a major depressive episode was established in 6-week controlled trials of outpatients whose diagnoses corresponded most closely to the DSM-III category of MDD (see CLINICAL PHARMACOLOGY). A major depressive episode implies a prominent and relatively persistent depressed or dysphoric mood that usually interferes with daily functioning (nearly every day for at least 2 weeks); it should include at least 4 of the following 8 symptoms: change in appetite, change in sleep, psychomotor agitation or retardation, loss of interest in usual activities or decrease in sexual drive, increased fatigue, feelings of guilt or worthlessness, slowed thinking or impaired concentration, and a suicide attempt or suicidal ideation.

The effects of paroxetine in hospitalized depressed patients have not been adequately studied.

The efficacy of paroxetine in maintaining a response in MDD for up to 1 year was demonstrated in a placebo-controlled trial (see CLINICAL PHARMACOLOGY). Nevertheless, the physician who elects to use PEXEVA® (paroxetine mesylate) for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

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Obsessive Compulsive Disorder

PEXEVA® (paroxetine mesylate) is indicated for the treatment of obsessions and compulsions in patients with OCD as defined in the DSM-IV. The obsessions or compulsions cause marked distress, are time-consuming, or significantly interfere with social or occupational functioning.

The efficacy of paroxetine was established in two 12-week trials with obsessive compulsive outpatients whose diagnoses corresponded most closely to the DSM-III-R category of OCD (see CLINICAL PHARMACOLOGY-Clinical Trials).

OCD is characterized by recurrent and persistent ideas, thoughts, impulses or images (obsessions) that are ego-dystonic and/or repetitive, purposeful and intentional behaviors (compulsions) that are recognized by the person as excessive or unreasonable.

Long-term maintenance of efficacy was demonstrated in a 6-month relapse prevention trial. In this trial, patients assigned to paroxetine showed a lower relapse rate compared to patients on placebo (see CLINICAL PHARMACOLOGY-Clinical Trials). Nevertheless, the physician who elects to use PEXEVA® (paroxetine mesylate) for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see DOSAGE AND ADMINISTRATION).

Panic Disorder

PEXEVA® (paroxetine mesylate) is indicated for the treatment of PD, with or without agoraphobia, as defined in DSM-IV. PD is characterized by the occurrence of unexpected panic attacks and associated concern about having additional attacks, worry about the implications or consequences of the attacks, and/or a significant change in behavior related to the attacks.

The efficacy of paroxetine was established in three 10- to 12-week trials in PD patients whose diagnoses corresponded to the DSM-III-R category of PD (see CLINICAL PHARMACOLOGY-Clinical Trials).

PD (DSM-IV) is characterized by recurrent unexpected panic attacks, i.e., a discrete period of intense fear or discomfort in which 4 (or more) of the following symptoms develop abruptly and reach a peak within 10 minutes: (1) palpitations, pounding heart, or accelerated heart rate; (2) sweating; (3) trembling or shaking; (4) sensations of shortness of breath or smothering; (5) feeling of choking; (6) chest pain or discomfort; (7) nausea or abdominal distress; (8) feeling dizzy, unsteady, lightheaded, or faint; (9) derealization (feelings of unreality) or depersonalization (being detached from oneself); (10) fear of losing control; (11) fear of dying; (12) paresthesias (numbness or tingling sensations); (13) chills or hot flushes.

Long-term maintenance of efficacy was demonstrated in a 3-month relapse prevention trial. In this trial, patients with PD assigned to paroxetine demonstrated a lower relapse rate compared to patients on placebo (see CLINICAL PHARMACOLOGY-Clinical Trials). Nevertheless, the physician who prescribes PEXEVA® (paroxetine mesylate) for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

Generalized Anxiety Disorder

Paroxetine is indicated for the treatment of Generalized Anxiety Disorder (GAD), as defined in DSM-IV. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic.

The efficacy of paroxetine in the treatment of GAD was established in two 8-week placebo-controlled trials in adults with GAD. Paroxetine has not been studied in children or adolescents with Generalized Anxiety Disorder (see CLINICAL PHARMACOLOGY-Clinical Trials).

Generalized Anxiety Disorder (DSM-IV) is characterized by excessive anxiety and worry (apprehensive expectation) that is persistent for at least 6 months and which the person finds difficult to control. It must be associated with at least 3 of the following 6 symptoms: Restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, sleep disturbance.

The efficacy of paroxetine in maintaining a response in patients with Generalized Anxiety Disorder, who responded during an 8-week acute treatment phase while taking paroxetine and were then observed for relapse during a period of up to 24 weeks, was demonstrated in a placebo-controlled trial (see CLINICAL

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PHARMACOLOGY-Clinical Trials). Nevertheless, the physician who elects to use paroxetine for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see DOSAGE AND ADMINISTRATION).

CONTRAINDICATIONS

Concomitant use in patients taking either monoamine oxidase inhibitors (MAOIs) or thioridazine is contraindicated (see WARNINGS and PRECAUTIONS).

Concomitant use in patients taking pimozone is contraindicated (see PRECAUTIONS).

PEXEVA® (paroxetine mesylate) tablets are contraindicated in patients with a hypersensitivity to paroxetine or any of the inactive ingredients in PEXEVA® (paroxetine mesylate) tablets.

WARNINGS

Clinical Worsening and Suicide Risk

Patients with MDD, both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. There has been a long-standing concern that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients. Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with MDD and other psychiatric disorders.

Pooled analyses of short-term placebo-controlled trials of 9 antidepressant drugs (selective serotonin reuptake inhibitors) (SSRIs) and others) in children and adolescents with MDD, OCD, or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal behavior or thinking (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. There was considerable variation in risk among drugs, but a tendency toward an increase for almost all drugs studied. The risk of suicidality was most consistently observed in the MDD trials, but there were signals of risk arising from some trials in other psychiatric indications (OCD and social anxiety disorder) as well. **No suicides occurred in any of these trials.** It is unknown whether the suicidality risk in pediatric patients extends to longer-term use, i.e., beyond several months. It is also unknown whether the suicidality risk extends to adults.

All pediatric patients being treated with antidepressants for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. Such observation would generally include at least weekly face-to-face contact with patients or their family members or caregivers during the first 4 weeks of treatment, then every other week visits for the next 4 weeks, then at 12 weeks, and as clinically indicated beyond 12 weeks. Additional contact by telephone may be appropriate between face-to-face visits.

Adults with MDD or comorbid depression in the setting of other psychiatric illness being treated with antidepressants should be observed similarly for clinical worsening and suicidality, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

In addition, patients with a history of suicidal behaviour or thoughts, those patients exhibiting a significant degree of suicidal ideation prior to commencement of treatment, and young adults, are at an increased risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for MDD as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality.

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Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see PRECAUTIONS and DOSAGE AND ADMINISTRATION - Discontinuation of Treatment with Paroxetine, for a description of the risks of discontinuation of paroxetine).

Families and caregivers of pediatric patients being treated with antidepressants for MDD or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers. Prescriptions for PEXEVA® (paroxetine mesylate) should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. Families and caregivers of adults being treated for depression should be similarly advised.

Screening Patients for Bipolar Disorder: A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms 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. It should be noted that PEXEVA® (paroxetine mesylate) is not approved for use in treating bipolar depression.

Potential for Interaction with Monoamine Oxidase Inhibitors

In patients receiving another serotonin reuptake inhibitor drug in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued that drug and have been started on a MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. While there are no human data showing such an interaction with paroxetine, limited animal data on the effects of combined use of paroxetine and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that paroxetine not be used in combination with a MAOI, or within 14 days of discontinuing treatment with a MAOI. At least 2 weeks should be allowed after stopping PEXEVA® (paroxetine mesylate) before starting a MAOI.

Serotonin Syndrome: The development of a potentially life-threatening serotonin syndrome may occur in association with treatment with paroxetine, particularly with concomitant use of serotonergic drugs (including triptans) and with drugs which may have impaired metabolism of serotonin (including MAOIs). Serotonin syndrome symptoms may include mental status changes (e.g. agitation, hallucinations, coma), autonomic instability (e.g. tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g. hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g. nausea, vomiting, diarrhea). The concomitant use of paroxetine with MAOIs intended to treat depression is contraindicated (see CONTRAINDICATIONS and WARNINGS – Potential for Interaction With Monoamine Oxidase Inhibitors). If concomitant use of paroxetine with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see PRECAUTIONS – Drug Interactions). The concomitant use of paroxetine with serotonin precursors (such as tryptophan) is not recommended (see PRECAUTIONS – Drug Interactions).

Potential Interaction with Thioridazine

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Thioridazine administration alone produces prolongation of the QTc interval, which is associated with serious ventricular arrhythmias, such as torsade de pointes-type arrhythmias, and sudden death. This effect appears to be dose-related.

An *in vivo* study suggests that drugs which inhibit CYP2D6, such as paroxetine, will elevate plasma levels of thioridazine. Therefore, it is recommended that paroxetine not be used in combination with thioridazine (see CONTRAINDICATIONS and PRECAUTIONS).

Usage in Pregnancy: Teratogenic Effects: Epidemiological studies have shown that infants born to women who had first trimester paroxetine exposure had an increased risk of cardiovascular malformations, primarily ventricular and atrial septal defects (VSDs and ASDs). In general, septal defects range from those that are symptomatic and may require surgery to those that are asymptomatic and may resolve spontaneously. If a patient becomes pregnant while taking paroxetine, she should be advised of the potential harm to the fetus. Unless the benefits of paroxetine to the mother justify continuing treatment, consideration should be given to either discontinuing paroxetine therapy or switching to another antidepressant (see PRECAUTIONS—Discontinuation of Treatment with PEEXVA® (paroxetine mesylate)). For women who intend to become pregnant or are in their first trimester of pregnancy, paroxetine should only be initiated after consideration of the other available treatment options.

A study based on Swedish national registry data evaluated infants of 6896 women exposed to antidepressants in early pregnancy (5123 women exposed to SSRIs; including 815 for paroxetine). Infants exposed to paroxetine in early pregnancy had an increased risk of cardiovascular malformations (primarily VSDs and ASDs) compared to the entire registry population (OR 1.8; 95% confidence interval 1.1-2.8). The rate of cardiovascular malformations following early pregnancy paroxetine exposure was 2% vs. 1% in the entire registry population. Among the same paroxetine exposed infants, an examination of the data showed no increase in the overall risk for congenital malformations.

A separate retrospective cohort study using US United Healthcare data evaluated 5956 infants of mothers dispensed paroxetine or other antidepressants during the first trimester (n = 815 for paroxetine). This study showed a trend towards an increased risk for cardiovascular malformations for paroxetine compared to other antidepressants (OR 1.5; 95% confidence interval 0.8-2.9). The prevalence of cardiovascular malformations following first trimester dispensing was 1.5% for paroxetine vs. 1% for other antidepressants. Nine out of 12 infants with cardiovascular malformations whose mothers were dispensed paroxetine in the first trimester had VSDs. This study also suggested an increased risk of overall major congenital malformations (inclusive of the cardiovascular defects) for paroxetine compared to other antidepressants (OR 1.8; 95% confidence interval 1.2-2.8). The prevalence of all congenital malformations following first trimester exposure was 4% for paroxetine vs. 2% for other antidepressants.

Animal Findings: Reproduction studies were performed at doses up to 50 mg/kg/day in rats and 6 mg/kg/day in rabbits administered during organogenesis. These doses are approximately 8 (rat) and 2 (rabbit) times the MRHD on an mg/m² basis. These studies have revealed no evidence of teratogenic effects. However, in rats, there was an increase in pup deaths during the first 4 days of lactation when dosing occurred during the last trimester of gestation and continued throughout lactation. This effect occurred at a dose of 1 mg/kg/day or approximately one-sixth of the MRHD on an mg/m² basis. The no-effect dose for rat pup mortality was not determined. The cause of these deaths is not known.

Nonteratogenic Effects: Neonates exposed to PEEXVA® (paroxetine mesylate) and other SSRIs or selective serotonin and norepinephrine reuptake inhibitors (SNRIs) late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and

constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (see WARNINGS—Potential for Interaction With Monoamine Oxidase Inhibitors).

Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1 – 2 per 1,000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective case-control study of 377 women whose infants were born with PPHN and 836 women whose infants were born health, the risk for developing PPHN was approximately six-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. There is currently no corroborative evidence regarding the risk for PPHN following exposure to SSRIs in pregnancy; this is the first study that has investigated the potential risk. The study did not include enough cases with exposure to individual SSRIs to determine if all SSRIs posed similar levels of PPHN risk.

There have also been postmarketing reports of premature births in pregnant women exposed to paroxetine or other SSRIs.

When treating a pregnant woman with paroxetine during the third trimester, the physician should carefully consider both the potential risks and benefits of treatment (see DOSAGE AND ADMINISTRATION). Physicians should note that in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication.

PRECAUTIONS

General

Activation of Mania/Hypomania: During premarketing testing, hypomania or mania occurred in approximately 1.0% of paroxetine-treated unipolar patients compared to 1.1% of active-control and 0.3% of placebo-treated unipolar patients. In a subset of patients classified as bipolar, the rate of manic episodes was 2.2% for paroxetine and 11.6% for the combined active-control groups. As with all drugs effective in the treatment of MDD, paroxetine should be used cautiously in patients with a history of mania.

Seizures: During premarketing testing, seizures occurred in 0.1% of paroxetine-treated patients, a rate similar to that associated with other drugs effective in the treatment of MDD. Paroxetine should be used cautiously in patients with a history of seizures. It should be discontinued in any patient who develops seizures.

Discontinuation of Treatment with Paroxetine: Recent clinical trials supporting the various approved indications for paroxetine employed a taper-phase regimen, rather than an abrupt discontinuation of treatment. The taper-phase regimen used in GAD and PTSD clinical trials involved an incremental decrease in the daily dose by 10 mg/day at weekly intervals. When a daily dose of 20 mg/day was reached, patients were continued on this dose for 1 week before treatment was stopped.

With this regimen in those studies, the following adverse events were reported for paroxetine at an incidence at least twice that reported for placebo: abnormal dreams, paresthesia, and dizziness. In the majority of patients, these events were mild to moderate and were self-limiting and did not require medical intervention.

During marketing of paroxetine and other SSRIs and SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors), there have been spontaneous reports of adverse events occurring upon the discontinuation of these drugs (particularly when abrupt), including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g. paresthesias such as electric shock sensations and tinnitus), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms.

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Patients should be monitored for these symptoms when discontinuing treatment with paroxetine. 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 (see DOSAGE and ADMINISTRATION).

See also PRECAUTIONS---Pediatric Use, for adverse events reported upon discontinuation of treatment with **paroxetine** in pediatric patients.

Akathisia: The use of paroxetine or other SSRIs 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.

Hyponatremia: Several cases of hyponatremia have been reported. The hyponatremia appeared to be reversible when paroxetine was discontinued. The majority of these occurrences have been in elderly individuals, some in patients taking diuretics or who were otherwise volume depleted.

Abnormal Bleeding: Published case reports have documented the occurrence of bleeding episodes in patients treated with psychotropic drugs that interfere with serotonin reuptake. Subsequent epidemiological studies, both of the case-control and cohort design, have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding. In two studies, concurrent use of a nonsteroidal anti-inflammatory drug (NSAID) or aspirin potentiated the risk of bleeding (see DRUG INTERACTIONS). Although these studies focused on upper gastrointestinal bleeding, there is reason to believe that bleeding at other sites may be similarly potentiated. Patients should be cautioned regarding the risk of bleeding associated with the concomitant use of paroxetine with NSAIDs, aspirin, or other drugs that affect coagulation.

Use in Patients with Concomitant Illness: Clinical experience with paroxetine in patients with certain concomitant systemic illness is limited. Caution is advisable in using paroxetine in patients with diseases or conditions that could affect metabolism or hemodynamic responses.

As with other SSRIs, mydriasis has been infrequently reported in the premarketing studies with paroxetine. A few cases of acute angle closure glaucoma associated with paroxetine therapy have been reported in the literature. As mydriasis can cause acute angle closure in patients with narrow angle glaucoma, caution should be used when paroxetine is prescribed for patients with narrow angle glaucoma.

Paroxetine 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 excluded from clinical studies during the product's premarket testing. Evaluation of electrocardiograms of 682 patients who received paroxetine in double-blind, placebo-controlled trials, however, did not indicate that paroxetine is associated with the development of significant ECG abnormalities. Similarly, paroxetine does not cause any clinically important changes in heart rate or blood pressure.

Increased plasma concentrations of paroxetine occur in patients with severe renal impairment (creatinine clearance <30 ml/min) or severe hepatic impairment. A lower starting dose should be used in such patients (see DOSAGE AND ADMINISTRATION).

Information for Patients

Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with paroxetine mesylate and should counsel them in its appropriate use. A patient Medication Guide About Using Antidepressants in Children and Teenagers is available for paroxetine mesylate. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. The complete text of the Medication Guide is reprinted at the end of this document.

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Patients should be advised of the following issues and asked to alert their prescriber if these occur while taking paroxetine mesylate.

Pexeva® should not be chewed or crushed, and should be swallowed whole. Patients should be cautioned about the risk of serotonin syndrome with the concomitant use of paroxetine and triptans, tramadol, or other serotonergic agents.

Clinical Worsening and Suicide Risk: Patients, their families, and their caregivers should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during antidepressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to observe for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication.

Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.): Patients should be cautioned about concomitant use of paroxetine with NSAIDs, aspirin, or other drugs that affect coagulation since the combined use of psychotropic drugs that interfere with serotonin reuptake and these agents has been associated with an increased risk of bleeding.

Interference with Cognitive and Motor Performance: Any psychoactive drug may impair judgment, thinking or motor skills. Although in controlled studies paroxetine has not been shown to impair psychomotor performance, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that paroxetine therapy does not affect their ability to engage in such activities.

Completing Course of Therapy: While patients may notice improvement with paroxetine therapy in 1 to 4 weeks, they should be advised to continue therapy as directed.

Concomitant Medication: Patients should be advised to inform their physician if they are taking, or plan to take, any prescription or over-the-counter drugs, since there is a potential for interactions. Patients should be made aware that paroxetine, the active ingredient in PEXEVA® (paroxetine mesylate), is also the active ingredient of Paxil® and that these two medications should not be taken concomitantly.

Alcohol: Although paroxetine has not been shown to increase the impairment of mental and motor skills caused by alcohol, patients should be advised to avoid alcohol while taking PEXEVA® (paroxetine mesylate).

Pregnancy: Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. (See WARNINGS—Usage in Pregnancy: Teratogenic and Nonteratogenic Effects).

Nursing: Patients should be advised to notify their physician if they are breast-feeding an infant (see PRECAUTIONS-Nursing Mothers).

Laboratory Tests

There are no specific laboratory tests recommended.

Paxil (paroxetine hydrochloride)

Paroxetine, the active ingredient in PEXEVA® (paroxetine mesylate), is also the active ingredient of Paxil. Thus, these two agents should not be coadministered.

Drug interactions

Tryptophan: As with other serotonin reuptake inhibitors, an interaction between paroxetine and tryptophan may occur when they are coadministered. Adverse experiences, consisting primarily of headache, nausea, sweating and dizziness, have been reported when tryptophan was administered to patients taking paroxetine. Consequently, concomitant use of paroxetine with tryptophan is not recommended.

Monoamine Oxidase Inhibitors: See CONTRAINDICATIONS and WARNINGS.

Pimozide: In a controlled study of healthy volunteers, after paroxetine was titrated to 60 mg daily, co-administration of a single dose of 2 mg pimozide was associated with mean increases in pimozide AUC of 151% and C_{max} of 62%, compared to pimozide administered alone. Due to the narrow therapeutic index of pimozide and its known ability to prolong the QT interval, concomitant use of pimozide and paroxetine is contraindicated (see CONTRAINDICATIONS).

Serotonergic Drugs: Based on the mechanism of action of paroxetine and the potential for serotonin syndrome, caution is advised when paroxetine is coadministered with other drugs or agents that may affect the serotonergic neurotransmitter systems, such as triptans, linezolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, or St. John's Wort (see WARNINGS – Serotonin Syndrome). The concomitant use of paroxetine with other SSRIs, SNRIs or tryptophan is not recommended (see PRECAUTIONS – Drug Interactions, *Tryptophan*)

Thioridazine: See CONTRAINDICATIONS and WARNINGS.

Warfarin: Preliminary data suggest that there may be a pharmacodynamic interaction (that causes an increased bleeding diathesis in the face of unaltered prothrombin time) between paroxetine and warfarin. Since there is little clinical experience, the concomitant administration of paroxetine and warfarin should be undertaken with caution.

Triptans: There have been rare postmarketing reports of serotonin syndrome with the use of an SSRI and a triptan. If concomitant use of paroxetine with a triptan is warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see WARNINGS – Serotonin Syndrome).

Drugs Affecting Hepatic Metabolism: The metabolism and pharmacokinetics of paroxetine may be affected by the induction or inhibition of drug-metabolizing enzymes.

Cimetidine -Cimetidine inhibits many cytochrome P450 (oxidative) enzymes. In a study where paroxetine (30 mg q.d.) was dosed orally for 4 weeks, steady-state plasma concentrations of paroxetine were increased by approximately 50% during coadministration with oral cimetidine (300 mg t.i.d.) for the final week. Therefore, when these drugs are administered concurrently, dosage adjustment of paroxetine after the 20 mg starting dose should be guided by clinical effect. The effect of paroxetine on cimetidine's pharmacokinetics was not studied.

Phenobarbital-Phenobarbital induces many cytochrome P450 (oxidative) enzymes. When a single oral 30 mg dose of paroxetine was administered at phenobarbital steady state (100 mg q.d. for 14 days), paroxetine AUC and T_{1/2} were reduced (by an average of 25% and 38%, respectively) compared to paroxetine administered alone. The effect of paroxetine on phenobarbital pharmacokinetics was not studied. Since paroxetine exhibits nonlinear pharmacokinetics, the results of this study may not address the case where the 2 drugs are both being chronically dosed. No initial paroxetine dosage adjustment is considered necessary when co-administered with phenobarbital; any subsequent adjustment should be guided by clinical effect.

Phenytoin-When a single oral 30 mg dose of paroxetine was administered at phenytoin steady state (300 mg q.d. for 14 days), paroxetine AUC and T_{1/2} were reduced (by an average of 50% and 35%, respectively) compared to paroxetine administered alone. In a separate study, when a single oral 300 mg dose of phenytoin was administered at paroxetine steady state (30 mg q.d. for 14 days), phenytoin AUC was slightly reduced (12% on average) compared to phenytoin administered alone. Since both drugs exhibit nonlinear pharmacokinetics, the above studies may not address the case where the two drugs are both being chronically dosed. No initial dosage adjustments are considered necessary when these drugs are co-administered; any subsequent adjustments should be guided by clinical effect (see ADVERSE REACTIONS-Postmarketing Reports).

Drugs Metabolized by Cytochrome CYP2D6: Many drugs, including most drugs effective in the treatment of MDD (paroxetine, other SSRIs and many tricyclics), are metabolized by the cytochrome P450 isozyme CYP2D6. Like other agents that are metabolized by CYP2D6, paroxetine may significantly inhibit the activity

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of this isozyme. In most patients (>90%), this CYP2D6 isozyme is saturated early during paroxetine dosing. In one study, daily dosing of paroxetine (20 mg q.d.) under steady-state conditions increased single dose desipramine (100 mg) C_{max} , AUC and $T_{1/2}$ by an average of approximately two-, five-, and three-fold, respectively. Concomitant use of paroxetine with risperidone, a CYP2D6 substrate has also been evaluated. In 1 study, daily dosing of paroxetine 20 mg in patients stabilized on risperidone (4 to 8 mg/day) increased mean plasma concentrations of risperidone approximately 4-fold, decreased 9-hydroxyrisperidone concentrations approximately 10%, and increased concentrations of the active moiety (the sum of risperidone plus 9-hydroxyrisperidone) approximately 1.4-fold. The effect of paroxetine on the pharmacokinetics of atomoxetine has been evaluated when both drugs were at steady state. In healthy volunteers who were extensive metabolizers of CYP2D6, paroxetine 20 mg daily was given in combination with 20 mg atomoxetine every 12 hours. This resulted in increases in steady state atomoxetine AUC values that were 6- to 8-fold greater and in atomoxetine C_{max} values that were 3- to 4-fold greater than when atomoxetine was given alone. Dosage adjustment of atomoxetine may be necessary and it is recommended that atomoxetine be initiated at a reduced dose when it is given with paroxetine.

Concomitant use of paroxetine with other drugs metabolized by cytochrome CYP2D6 has not been formally studied but may require lower doses than usually prescribed for either paroxetine or the other drug.

Therefore, coadministration of PEEXVA® (paroxetine mesylate) with other drugs that are metabolized by this isozyme, including certain drugs effective in the treatment of MDD (e.g., nortriptyline, amitriptyline, imipramine, desipramine and fluoxetine), phenothiazines, risperidone, and Type 1C antiarrhythmics (e.g., propafenone, flecainide and encainide), or that inhibit this enzyme (e.g., quinidine), should be approached with caution.

However, due to the risk of serious ventricular arrhythmias and sudden death potentially associated with elevated plasma levels of thioridazine, paroxetine and thioridazine should not be co-administered (see CONTRAINDICATIONS and WARNINGS).

At steady state, when the CYP2D6 pathway is essentially saturated, paroxetine clearance is governed by alternative P450 isozymes, which, unlike CYP2D6, show no evidence of saturation. (See PRECAUTIONS-Tricyclic Antidepressants).

Drugs Metabolized by Cytochrome CYP3A4: An *in vivo* interaction study involving the co-administration under steady-state conditions of paroxetine and terfenadine, a substrate for cytochrome CYP3A4 revealed no effect of paroxetine on terfenadine pharmacokinetics. In addition, *in vitro* studies have shown ketoconazole, a potent inhibitor of CYP3A4 activity, to be at least 100 times more potent than paroxetine as an inhibitor of the metabolism of several substrates for this enzyme, including terfenadine, astemizole, cisapride, triazolam, and cyclosporine. Based on the assumption that the relationship between paroxetine's *in vitro* K_i and its lack of effect on terfenadine's *in vivo* clearance predicts its effect on other 3A4 substrates, paroxetine's extent of inhibition of CYP3A4 activity is not likely to be of clinical significance.

Tricyclic Antidepressants (TCA): Caution is indicated in the co-administration of tricyclic antidepressants (TCAs) with PEEXVA® (paroxetine mesylate), because paroxetine may inhibit TCA metabolism. Plasma TCA concentrations may need to be monitored and the dose of TCA may need to be reduced, if a TCA is co-administered with PEEXVA® (paroxetine mesylate) (see PRECAUTIONS-Drugs Metabolized by Cytochrome CYP2D6).

Drugs Highly Bound to Plasma Protein: Because paroxetine is highly bound to plasma protein, administration of PEEXVA® (paroxetine mesylate) to a patient taking another drug that is highly protein bound may cause increased free concentrations of the other drug, potentially resulting in adverse events. Conversely, adverse effects could result from displacement of paroxetine by other highly bound drugs.

Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.): Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the

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occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin potentiated the risk of bleeding. Thus, patients should be cautioned about the use of such drugs concurrently with paroxetine.

Alcohol: Although paroxetine does not increase the impairment of mental and motor skills caused by alcohol, patients should be advised to avoid alcohol while taking PEXEVA® (paroxetine mesylate).

Lithium: A multiple-dose study has shown that there is no pharmacokinetic interaction between paroxetine and lithium carbonate. However, since there is little clinical experience, the concurrent administration of paroxetine and lithium should be undertaken with caution.

Digoxin: The steady-state pharmacokinetics of paroxetine was not altered when administered with digoxin at steady state. Mean digoxin AUC at steady state decreased by 15% in the presence of paroxetine. Since there is little clinical experience, the concurrent administration of paroxetine and digoxin should be undertaken with caution.

Diazepam: Under steady-state conditions, diazepam does not appear to affect paroxetine kinetics. The effects of paroxetine on diazepam were not evaluated.

Procyclidine: Daily oral dosing of paroxetine (30 mg q.d.) increased steady-state AUC₀₋₂₄, C_{max} and C_{min} values of procyclidine (5 mg oral q.d.) by 35%, 37%, and 67%, respectively, compared to procyclidine alone at steady state. If anticholinergic effects are seen, the dose of procyclidine should be reduced.

Beta-Blockers: In a study where propranolol (80 mg b.i.d.) was dosed orally for 18 days, the established steady-state plasma concentrations of propranolol were unaltered during co-administration with paroxetine (30 mg q.d.) for the final 10 days. The effects of propranolol on paroxetine have not been evaluated. See ADVERSE REACTIONS-Postmarketing Reports.

Theophylline: Reports of elevated theophylline levels associated with paroxetine treatment have been reported. While this interaction has not been formally studied, it is recommended that theophylline levels be monitored when these drugs are concurrently administered.

Fosamprenavir/Ritonavir: Coadministration of fosamprenavir/ritonavir with paroxetine significantly decreased plasma levels of paroxetine. Any dose adjustment should be guided by clinical effect (tolerability and efficacy).

Electroconvulsive Therapy (ECT): There are no clinical studies of the combined use of ECT and paroxetine.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis: Two-year carcinogenicity studies were conducted in rodents given paroxetine in the diet at 1, 5, and 25 mg/kg/day (mice) and 1, 5, and 20 mg/kg/day (rats). These doses are up to 2.4 (mouse) and 3.9 (rat) times the maximum recommended human dose (MRHD) for MDD and GAD on a mg/m² basis. Because the MRHD for MDD is slightly less than that for OCD (50 mg vs. 60 mg), the doses used in these carcinogenicity studies were only 2.0 (mouse) and 3.2 (rat) times the MRHD for OCD. There was a significantly greater number of male rats in the high-dose group with reticulum cell sarcomas (1/100, 0/50, 0/50 and 4/50 for control, low-, middle- and high-dose groups, respectively) and a significantly increased linear trend across groups for the occurrence of lymphoreticular tumors in male rats. Female rats were not affected. Although there was a dose-related increase in the number of tumors in mice, there was no drug-related increase in the number of mice with tumors. The relevance of these findings to humans is unknown.

Mutagenesis: Paroxetine produced no genotoxic effects in a battery of 5 *in vitro* and 2 *in vivo* assays that included the following: bacterial mutation assay, mouse lymphoma mutation assay, unscheduled DNA synthesis assay, and tests for cytogenetic aberrations *in vivo* in mouse bone marrow and *in vitro* in human lymphocytes and in a dominant lethal test in rats.

Impairment of Fertility: A reduced pregnancy rate was found in reproduction studies in rats at a dose of paroxetine of 15 mg/kg/day, which is 2.9 times the MRHD for MDD and GAD or 2.4 times the MRHD for

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OCD on a mg/m² basis. Irreversible lesions occurred in the reproductive tract of male rats after dosing in toxicity studies for 2 to 52 weeks. These lesions consisted of vacuolation of epididymal tubular epithelium at 50 mg/kg/day and atrophic changes in the seminiferous tubules of the testes with arrested spermatogenesis at 25 mg/kg/day (9.8 and 4.9 times the MRHD for MDD and GAD; 8.2 and 4.1 times the MRHD for OCD and PD on a mg/m² basis).

Pregnancy

Pregnancy Category D. See WARNINGS—Usage in Pregnancy: Teratogenic and Nonteratogenic Effects.

Labor and Delivery

The effect of paroxetine on labor and delivery in humans is unknown.

Nursing Mothers

Like many other drugs, paroxetine is secreted in human milk, and caution should be exercised when PEXEVA® (paroxetine mesylate) is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in the pediatric population have not been established (see BOX WARNING and WARNINGS – Clinical Worsening and Suicide Risk). Three placebo-controlled trials in 752 pediatric patients with MDD have been conducted with paroxetine, and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of paroxetine mesylate in a child or adolescent must balance the potential risks with the clinical need.

In placebo-controlled clinical trials conducted with pediatric patients, the following adverse events were reported in at least 2% of pediatric patients treated with paroxetine and occurred at a rate at least twice that for pediatric patients receiving placebo: emotional lability (including self-harm, suicidal thoughts, attempted suicide, crying, and mood fluctuations), hostility, decreased appetite, tremor, sweating, hyperkinesia, and agitation.

Events reported upon discontinuation of treatment with paroxetine in the pediatric clinical trials that included a taper phase regimen, which occurred in at least 2% of patients who received paroxetine and which occurred at a rate at least twice that of placebo, were: emotional lability (including suicidal ideation, suicide attempt, mood changes, and tearfulness), nervousness, dizziness, nausea, and abdominal pain (see Discontinuation of Treatment With paroxetine).

Geriatric Use

In worldwide pre-marketing paroxetine clinical trials, 17% of paroxetine-treated patients (approximately 700) were 65 years of age or older. Pharmacokinetic studies revealed a decreased clearance in the elderly, and a lower starting dose is recommended; there were, however, no overall differences in the adverse event profile between elderly and younger patients, and effectiveness was similar in younger and older patients. (See CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS**Associated with Discontinuation of Treatment**

Twenty percent (1,199/6,145) of patients treated with paroxetine in worldwide clinical trials in MDD and 11.8% (64/542), 9.4% (44/469), and 10.7% (79/735) of patients treated with paroxetine in worldwide trials in OCD, PD, and GAD, respectively, discontinued treatment due to an adverse event. The most common events ($\geq 1\%$) associated with discontinuation and considered to be drug related (i.e., those events associated with dropout at a rate approximately twice or greater for paroxetine compared to placebo) included the following:

	MDD		OCD		PD		GAD	
	Paroxetine	Placebo	Paroxetine	Placebo	Paroxetine	Placebo	Paroxetine	Placebo
CNS								
Somnolence	2.3%	0.7%	-	-	1.9%	0.3%	2.0%	0.2%
Insomnia	-	-	1.7%	0%	1.3%	0.3%	-	-
Agitation	1.1%	0.5%	-	--	-	-	-	-
Tremor	1.1%	0.3%	-	-	-	-	-	-
Dizziness	-	-	1.5%	0%	-	-	1.0%	0.2%
Gastrointestinal								
Constipation	-	-	1.1%	0%	-	-	-	-
Nausea	3.2%	1.1%	1.9%	0%	3.2%	1.2%	2.0%	0.2%
Diarrhea	1.0%	0.3%	-	-	-	-	-	-
Dry mouth	1.0%	0.3%	-	-	-	-	-	-
Vomiting	1.0%	0.3%	-	-	-	-	-	-
Other								
Asthenia	1.6%	0.4%	1.9%	0.4%	-	-	1.8%	0.2%
Abnormal Ejaculation ¹	1.6%	0%	2.1%	0%	-	-	2.5%	0.5%
Sweating	1.0%	0.3%	-	-	-	-	1.1%	0.2%
Impotence ¹	-	-	1.5%	0%	-	-	-	-

Where numbers are not provided the incidence of the adverse events in patients treated with paroxetine was not $>1\%$ or was not greater than or equal to two times the incidence of placebo.

¹. Incidence corrected for gender.

Commonly Observed Adverse Events**Major Depressive Disorder**

The most commonly observed adverse events associated with the use of paroxetine (incidence of 5% or greater and incidence for paroxetine at least twice that for placebo, derived from Table 1 below) were: asthenia, sweating, nausea, decreased appetite, somnolence, dizziness, insomnia, tremor, nervousness, ejaculatory disturbance and other male genital disorders.

Obsessive Compulsive Disorder

The most commonly observed adverse events associated with the use of paroxetine (incidence of 5% or greater and incidence for paroxetine at least twice that of placebo, derived from Table 2 below) were: nausea, dry mouth, decreased appetite, constipation, dizziness, somnolence, tremor, sweating, impotence and abnormal ejaculation.

Panic Disorder

The most commonly observed adverse events associated with the use of paroxetine (incidence of 5% or greater and incidence for paroxetine at least twice that for placebo, derived from Table 2 below) were: asthenia, sweating, decreased appetite, libido decreased, tremor, abnormal ejaculation, female genital disorders and impotence.

Generalized Anxiety Disorder

The most commonly observed adverse events associated with the use of paroxetine (incidence of 5% or greater and incidence for paroxetine at least twice that for placebo, derived from Table 3) were: Asthenia, infection, constipation, decreased appetite, dry mouth, nausea, libido decreased, somnolence, tremor, sweating, and abnormal ejaculation.

Incidence in Controlled Clinical Trials

The prescriber should be aware that the figures in the tables following cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and nondrug factors to the side effect incidence rate in the populations studied.

Major Depressive Disorder

Table 1 enumerates adverse events that occurred at an incidence of 1% or more among paroxetine-treated patients who participated in short-term (6-week) placebo-controlled trials in which patients were dosed in a range of 20 to 50 mg/day. Reported adverse events were classified using a standard COSTART-based Dictionary terminology.

TABLE 1

Treatment-Emergent Adverse Experience Incidence in Placebo-Controlled Clinical Trials for MDD¹			
Body System	Preferred Term	Paroxetine (n = 421)	Placebo (n = 421)
Body as a Whole	Headache	18%	17%
	Asthenia	15%	6%
Cardiovascular	Palpitation	3%	1%
	Vasodilation	3%	1%
Dermatologic	Sweating	11%	2%
	Rash	2%	1%
Gastrointestinal	Nausea	26%	9%
	Dry Mouth	18%	12%
	Constipation	14%	9%
	Diarrhea	12%	8%
	Decreased Appetite	6%	2%
	Flatulence	4%	2%
	Oropharynx Disorder ²	2%	0%
	Dyspepsia	2%	1%
Musculoskeletal	Myopathy	2%	1%
	Myalgia	2%	1%
	Myasthenia	1%	0%
Nervous System	Somnolence	23%	9%
	Dizziness	13%	6%
	Insomnia	13%	6%
	Tremor	8%	2%
	Nervousness	5%	3%

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	Anxiety	5%	3%
	Paresthesia	4%	2%
	Libido Decreased	3%	0%
	Drugged Feeling	2%	1%
	Confusion	1%	0%
Respiration	Yawn	4%	0%
Special Senses	Blurred Vision	4%	1%
	Taste Perversion	2%	0%
Urogenital System	Ejaculatory Disturbance ^{3,4}	13%	0%
	Other Male Genital Disorders ^{3,5}	10%	0%
	Urinary Frequency	3%	1%
	Urination Disorder ⁶	3%	0%
	Female Genital Disorders ^{3,7}	2%	0%

1. Events reported by at least 1% of patients treated with paroxetine are included, except the following events which had an incidence on placebo \geq paroxetine: abdominal pain, agitation, back pain, chest pain, CNS stimulation, fever, increased appetite, myoclonus, pharyngitis, postural hypotension, respiratory disorder (includes mostly "cold symptoms" or "URI"), trauma and vomiting.
2. Includes mostly "lump in throat" and "tightness in throat."
3. Percentage corrected for gender.
4. Mostly "ejaculatory delay."
5. Includes "anorgasmia", "erectile difficulties", "delayed ejaculation/orgasm" and "sexual dysfunction" and "impotence".
6. Includes mostly "difficulty with micturition" and "urinary hesitancy."
7. Includes mostly "anorgasmia" and "difficulty reaching climax/orgasm."

Obsessive Compulsive Disorder and Panic Disorder

Table 2 enumerates adverse events that occurred at a frequency of 2% or more among OCD patients on paroxetine who participated in placebo-controlled trials of 12-weeks duration in which patients were dosed in a range of 20 to 60 mg/day or among patients with PD on paroxetine who participated in placebo-controlled trials of 10- to 12-weeks duration in which patients were dosed in a range of 10 to 60 mg/day.

TABLE 2
Treatment-Emergent Adverse Experience
Incidence in Placebo-Controlled Clinical Trials
for OCD and PD¹

Body System	Preferred term	Obsessive Compulsive Disorder		Panic Disorder	
		Paroxetine (n = 542)	Placebo (n = 265)	Paroxetine (n = 469)	Placebo (n = 324)
Body as a Whole	Asthenia	22%	14%	14%	5%
	Abdominal Pain	-	-	4%	3%
	Chest Pain	3%	2%	-	-
	Back Pain	-	-	3%	2%
	Chills	2%	1%	2%	1%
Cardiovascular	Vasodilation	4%	1%	-	-
	Palpitation	2%	0%	-	-
Dermatologic	Sweating	9%	3%	14%	6%
	Rash	3%	2%	-	-
Gastrointestinal	Nausea	23%	10%	23%	17%
	Dry Mouth	18%	9%	18%	11%
	Constipation	16%	6%	8%	5%
	Diarrhea	10%	10%	12%	7%
	Decreased Appetite	9%	3%	7%	3%
	Increased Appetite	4%	3%	2%	1%
Nervous System	Insomnia	24%	13%	18%	10%
	Somnolence	24%	7%	19%	11%
	Dizziness	12%	6%	14%	10%
	Tremor	11%	1%	9%	1%
	Nervousness	9%	8%	-	-
	Libido Decreased	7%	4%	9%	1%
	Agitation	-	-	5%	4%
	Anxiety	-	-	5%	4%
	Abnormal Dreams	4%	1%	-	-
	Concentration Impaired	3%	2%	-	-
	Depersonalization	3%	0%	-	-
	Myoclonus	3%	0%	3%	2%
	Amnesia	2%	1%	-	-

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Respiratory System	Rhinitis	-	-	3%	0%
Special Senses	Abnormal Vision	4%	2%	-	-
	Taste Perversion	2%	0%	-	-
Urogenital System	Abnormal Ejaculation ²	23%	1%	21%	1%
	Female Genital Disorder ²	3%	0%	9%	1%
	Impotence ²	8%	1%	5%	0%
	Urinary Frequency	3%	1%	2%	0%
	Urination Impaired	3%	0%	-	-
	Urinary Tract Infection	2%	1%	2%	1%

- Events reported by at least 2% of OCD or PD paroxetine-treated patients are included, except the following events which had an incidence on placebo \geq paroxetine [OCD]: abdominal pain, agitation, anxiety, back pain, cough increased, depression, headache, hyperkinesia, infection, paresthesia, pharyngitis, respiratory disorder, rhinitis and sinusitis. [PD]: abnormal dreams, abnormal vision, chest pain, cough increased, depersonalization, depression, dysmenorrhea, dyspepsia, flu syndrome, headache, infection, myalgia, nervousness, palpitation, paresthesia, pharyngitis, rash, respiratory disorder, sinusitis, taste perversion, trauma, urination impaired and vasodilation.
- Percentage corrected for gender.

Dose Dependency of Adverse Events: A comparison of adverse event rates in a fixed-dose study comparing paroxetine 10, 20, 30 and 40 mg/day with placebo in the treatment of **MDD** revealed a clear dose dependency for some of the more common adverse events associated with paroxetine use, as shown in the following table:

Generalized Anxiety Disorder

Table 3 enumerates adverse events that occurred at a frequency of 2% or more among GAD patients on paroxetine who participated in placebo-controlled trials of 8-weeks duration in which patients were dosed in a range of 10 mg/day to 50 mg/day.

TABLE 3

Treatment-Emergent Adverse Experience Incidence in Placebo-Controlled Clinical Trials for Generalized Anxiety Disorder¹			
Body System	Preferred Term	Paroxetine (n=735)	Placebo (n=529)
Body as a Whole	Asthenia	14%	6%
	Headache	17%	14%
	Infection	6%	3%
Cardiovascular	Vasodilation	3%	1%
Dermatologic	Sweating	6%	2%
Gastrointestinal	Nausea	20%	5%
	Dry Mouth	11%	5%
	Constipation	10%	2%
	Diarrhea	9%	7%
	Decreased Appetite	5%	1%
Nervous System	Vomiting	3%	2%
	Insomnia	11%	8%
	Somnolence	15%	5%
	Dizziness	6%	5%

Respiratory System	Tremor	5%	1%
	Nervousness	4%	3%
	Libido Decreased	9%	2%
	Respiratory Disorder	7%	5%
	Sinusitis	4%	3%
Special Senses Urogenital System	Yawn	4%	-
	Abnormal Vision	2%	1%
	Abnormal Ejaculation ²	25%	2%
	Female Genital Disorder ²	4%	1%
	Impotence ²	4%	3%

1. Events reported by at least 2% of GAD patients treated with paroxetine are included, except the following events which had an incidence on placebo \geq paroxetine: Abdominal pain, back pain, trauma, dyspepsia, myalgia, and pharyngitis.
2. Percentage corrected for gender.

TABLE 4

Treatment-Emergent Adverse Experience Incidence in a Dose-Comparison Trial in the Treatment of MDD*

Body System/ Preferred Term	Placebo	Paroxetine			
	n=51	10 mg n=102	20 mg n=104	30 mg n=101	40 mg n=102
Body as a Whole					
Asthenia	0.0%	2.9%	10.6%	13.9%	12.7%
Dermatology					
Sweating	2.0%	1.0%	6.7%	8.9%	11.8%
Gastrointestinal					
Constipation	5.9%	4.9%	7.7%	9.9%	12.7%
Decreased Appetite	2.0%	2.0%	5.8%	4.0%	4.9%
Diarrhea	7.8%	9.8%	19.2%	7.9%	14.7%
Dry Mouth	2.0%	10.8%	18.3%	15.8%	20.6%
Nausea	13.7%	14.7%	26.9%	34.7%	36.3%
Nervous System					
Anxiety	0.0%	2.0%	5.8%	5.9%	5.9%
Dizziness	3.9%	6.9%	6.7%	8.9%	12.7%
Nervousness	0.0%	5.9%	5.8%	4.0%	2.9%
Paresthesia	0.0%	2.9%	1.0%	5.0%	5.9%
Somnolence	7.8%	12.7%	18.3%	20.8%	21.6%
Tremor	0.0%	0.0%	7.7%	7.9%	14.7%

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Special Senses					
Blurred Vision	2.0%	2.9%	2.9%	2.0%	7.8%
Urogenital System					
Abnormal Ejaculation	0.0%	5.8%	6.5%	10.6%	13.0%
Impotence	0.0%	1.9%	4.3%	6.4%	1.9%
Male Genital Disorders	0.0%	3.8%	8.7%	6.4%	3.7%

*Rule for including adverse events in table: incidence at least 5% for one of paroxetine groups and \geq twice the placebo incidence for at least one paroxetine group.

In a fixed-dose study comparing placebo and paroxetine 20, 40 and 60 mg in the treatment of OCD, there was no clear relationship between adverse events and the dose of paroxetine to which patients were assigned. No new adverse events were observed in the paroxetine 60 mg dose group compared to any of the other treatment groups.

In a fixed-dose study comparing placebo and paroxetine 10, 20 and 40 mg in the treatment of PD, there was no clear relationship between adverse events and the dose of paroxetine to which patients were assigned, except for asthenia, dry mouth, anxiety, libido decreased, tremor and abnormal ejaculation.

In a fixed-dose study comparing placebo and 20 and 40 mg of paroxetine in the treatment of GAD, for most of the adverse events, there was no clear relationship between adverse events and the dose of paroxetine to which patients were assigned, except for the following adverse events: Asthenia, constipation, and abnormal ejaculation.

In flexible dose studies, no new adverse events were observed in patients receiving paroxetine 60 mg compared to any of the other treatment groups.

Adaptation to Certain Adverse Events: Over a 4- to 6-week period, there was evidence of adaptation to some adverse events with continued therapy (e.g., nausea and dizziness), but less to other effects (e.g., dry mouth, somnolence and asthenia).

Male and Female Sexual Dysfunction with SSRIs: Although changes in sexual desire, sexual performance and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences.

Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labelling are likely to underestimate their actual incidence.

In placebo-controlled clinical trials involving more than 3,200 patients the ranges for the reported incidence of sexual side effects in males and female with MDD, OCD, PD, social anxiety disorder, GAD, and post traumatic stress disorder (PTSD)are displayed in Table 5

Table 5: Incidence of Sexual Adverse Events in Controlled Clinical Trials

	Paroxetine	Placebo
n (males)	1446	1042
Decreased Libido	6% - 15%	0% - 5%
Ejaculatory Disturbance	13% - 28%	0% - 2%
Impotence	2% - 9%	0% - 3%
n (females)	1822	1340
Decreased Libido	0% - 9%	0% - 2%
Orgasmic Disturbance	2% - 9%	0% - 1%

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There are no adequate and well-controlled studies examining sexual dysfunction with paroxetine treatment.

Paroxetine treatment has been associated with several cases of priapism. In those cases with a known outcome, patients recovered without sequelae.

While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects.

Weight and Vital Sign Changes: Significant weight loss may be an undesirable result of treatment with paroxetine for some patients but, on average, patients in controlled trials had minimal (about 1 pound) weight loss vs. smaller changes on placebo and active control. No significant changes in vital signs (systolic and diastolic blood pressure, pulse and temperature) were observed in patients treated with paroxetine in controlled clinical trials.

ECG Changes: In an analysis of ECGs obtained in 682 patients treated with paroxetine and 415 patients treated with placebo in controlled clinical trials, no clinically significant changes were seen in the ECGs of either group.

Liver Function Tests: In placebo-controlled clinical trials, patients treated with paroxetine exhibited abnormal values on liver function tests at no greater rate than that seen in placebo-treated patients. In particular, the paroxetine vs. placebo comparisons for alkaline phosphatase, SGOT, SGPT and bilirubin revealed no differences in the percentage of patients with marked abnormalities.

Hallucinations: In pooled clinical trials of immediate-release paroxetine hydrochloride, hallucinations were observed in 22 of 9089 patients receiving drug and 4 of 3187 patients receiving placebo.

Other Events Observed During the Premarketing Evaluation of Paroxetine

During its premarketing assessment in MDD, multiple doses of paroxetine were administered to 6,145 patients in phase 2 and 3 studies. The conditions and duration of exposure to paroxetine varied greatly and included (in overlapping categories) open and double-blind studies, uncontrolled and controlled studies, inpatient and outpatient studies, and fixed-dose and titration studies. During premarketing clinical trials in OCD, PD, and GAD, 542, 469, and 735 patients, respectively, received multiple doses of paroxetine. Untoward events associated with this exposure were recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of untoward events into a smaller number of standardized event categories.

In the tabulations that follow, reported adverse events were classified using a standard COSTART-based Dictionary terminology. The frequencies presented, therefore, represent the proportion of the 9089 patients exposed to multiple doses of paroxetine who experienced an event of the type cited on at least one occasion while receiving paroxetine. All reported events are included except those already listed in Tables 1 to 3, those reported in terms so general as to be uninformative and those events where a drug cause was remote.

It is important to emphasize that although the events reported occurred during treatment with paroxetine, they were not necessarily caused by it.

Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients (only those not already listed in the tabulated results from placebo-controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. Events of major clinical importance are also described in the PRECAUTIONS section.

Body as a Whole: *infrequent:* allergic reaction, chills, face edema, malaise, neck pain; *rare:* adrenergic syndrome, cellulitis, moniliasis, neck rigidity, pelvic pain, peritonitis, sepsis, ulcer.

Cardiovascular System: *frequent:* hypertension, tachycardia; *infrequent:* bradycardia, hematoma, hypotension, migraine, syncope; *rare:* angina pectoris, arrhythmia nodal, atrial fibrillation, bundle branch block, cerebral ischemia, cerebrovascular accident, congestive heart failure, heart block, low cardiac output, myocardial infarct,

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myocardial ischemia, pallor, phlebitis, pulmonary embolus, supraventricular extrasystoles, thrombophlebitis, thrombosis, varicose vein, vascular headache, ventricular extrasystoles.

Digestive System: *infrequent:* bruxism, colitis, dysphagia, eructation, gastritis, gastroenteritis, gingivitis, glossitis, increased salivation, liver function tests abnormal, rectal hemorrhage, ulcerative stomatitis; *rare:* aphthous stomatitis, bloody diarrhea, bulimia, cardiospasm, cholelithiasis, duodenitis, enteritis, esophagitis, fecal impactions, fecal incontinence, gum hemorrhage, hematemesis, hepatitis, ileitis, ileus, intestinal obstruction, jaundice, melena, mouth ulceration, peptic ulcer, salivary gland enlargement, sialadenitis, stomach ulcer, stomatitis, tongue discoloration, tongue edema, tooth caries.

Endocrine System: *rare:* diabetes mellitus, goiter, hyperthyroidism, hypothyroidism, thyroiditis.

Hemic and Lymphatic Systems: *infrequent:* anemia, leukopenia, lymphadenopathy, purpura; *rare:* abnormal erythrocytes, basophilia, bleeding time increased, eosinophilia, hypochromic anemia, iron deficiency anemia, leukocytosis, lymphedema, abnormal lymphocytes, lymphocytosis, microcytic anemia, monocytosis, normocytic anemia, thrombocythemia, thrombocytopenia.

Metabolic and Nutritional: *frequent:* weight gain; *infrequent:* edema, peripheral edema, SGOT increased, SGPT increased, thirst, weight loss; *rare:* alkaline phosphatase increased, bilirubinemia, BUN increased, creatinine phosphokinase increased, dehydration, gamma globulins increased, gout, hypercalcemia, hypercholesteremia, hyperglycemia, hyperkalemia, hyperphosphatemia, hypocalcemia, hypoglycemia, hypokalemia, hyponatremia, ketosis, lactic dehydrogenase increased, non-protein nitrogen (NPN) increased.

Musculoskeletal System: *frequent:* arthralgia; *infrequent:* arthritis, arthrosis; *rare:* bursitis, myositis, osteoporosis, generalized spasm, tenosynovitis, tetany.

Nervous System: *frequent:* emotional lability, vertigo; *infrequent:* abnormal thinking, alcohol abuse, ataxia, dystonia, dyskinesia, euphoria, hallucinations, hostility, hypertonia, hypesthesia, hypokinesia, incoordination, lack of emotion, libido increased, manic reaction, neurosis, paralysis, paranoid reaction; *rare:* abnormal gait, akinesia, antisocial reaction, aphasia, choreoathetosis, circumoral paresthesias, convulsion, delirium, delusions, diplopia, drug dependence, dysarthria, extrapyramidal syndrome, fasciculations, grand mal convulsion, hyperalgesia, hysteria, manic-depressive reaction, meningitis, myelitis, neuralgia, neuropathy, nystagmus, peripheral neuritis, psychotic depression, psychosis, reflexes decreased, reflexes increased, stupor, torticollis, trismus, withdrawal syndrome.

Respiratory System: *infrequent:* asthma, bronchitis, dyspnea, epistaxis, hyperventilation, pneumonia, respiratory flu; *rare:* emphysema, hemoptysis, hiccups, lung fibrosis, pulmonary edema, sputum increased, stridor, voice alteration.

Skin and Appendages: *frequent:* pruritus; *infrequent:* acne, alopecia, contact dermatitis, dry skin, ecchymosis, eczema, herpes simplex, photosensitivity, urticaria; *rare:* angioedema, erythema nodosum, erythema multiforme, exfoliative dermatitis, fungal dermatitis, furunculosis, herpes zoster, hirsutism, maculopapular rash, seborrhea, skin discoloration, skin hypertrophy, skin ulcer, sweating decreased, vesiculobullous rash.

Special Senses: *frequent:* tinnitus; *infrequent:* abnormality of accommodation, conjunctivitis, ear pain, eye pain, keratoconjunctivitis, mydriasis, otitis media; *rare:* amblyopia, anisocoria, blepharitis, cataract, conjunctival edema, corneal ulcer, deafness, exophthalmos, eye hemorrhage, glaucoma, hyperacusis, night blindness, otitis externa, parosmia, photophobia ptosis, retinal hemorrhage, taste loss, visual field defect.

Urogenital System: *infrequent:* amenorrhea, breast pain, cystitis, dysuria, hematuria, menorrhagia, nocturia, pyuria, polyuria, urinary incontinence, urinary retention, urinary urgency, vaginitis; *rare:* abortion, breast atrophy, breast enlargement, endometrial disorder, epididymitis, female lactation, fibrocystic breast, kidney calculus, kidney pain, leukorrhea, mastitis, metrorrhagia, nephritis, oliguria, salpingitis, urethritis, urinary casts, uterine spasm, urolith, vaginal hemorrhage, vaginal moniliasis.

Postmarketing Reports

Voluntary reports of adverse events in patients taking paroxetine that have been received since market introduction and not listed above that may have no causal relationship with the drug include acute pancreatitis, elevated liver function tests (the most severe cases were deaths due to liver necrosis, and grossly elevated transaminases associated with severe liver dysfunction), Guillain-Barré syndrome, toxic epidermal necrolysis, priapism, syndrome of inappropriate ADH secretion, symptoms suggestive of prolactinemia and galactorrhea, neuroleptic malignant syndrome-like events; extrapyramidal symptoms which have included akathisia, bradykinesia, cogwheel rigidity, dystonia, hypertonia, oculogyric crisis which has been associated with concomitant use of pimozide, tremor and trismus; serotonin syndrome, associated in some cases with concomitant use of serotonergic drugs and with drugs which may have impaired paroxetine metabolism (symptoms have included agitation, confusion, diaphoresis, hallucinations, hyperreflexia, myoclonus, shivering, tachycardia and tremor), status epilepticus, acute renal failure, pulmonary hypertension, allergic alveolitis, anaphylaxis, eclampsia, laryngismus, optic neuritis, porphyria, ventricular fibrillation, ventricular tachycardia (including torsade de pointes), thrombocytopenia, hemolytic anemia, events related to impaired hematopoiesis

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(including aplastic anemia, pancytopenia, bone marrow aplasia, and agranulocytosis), and vasculitic syndromes (such as Henoch-Schönlein purpura).

There has been a case report of an elevated phenytoin level after 4 weeks of paroxetine and phenytoin coadministration. There has been a case report of severe hypotension when paroxetine was added to chronic metoprolol treatment.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class: Paroxetine is not a controlled substance.

Physical and Psychologic Dependence: Paroxetine has not been systematically studied in animals or humans for its potential for abuse, tolerance or physical dependence. While the clinical trials did not reveal any tendency for any drug-seeking behavior, 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, patients should be evaluated carefully for history of drug abuse, and such patients should be observed closely for signs of PEXEVA® (paroxetine mesylate) misuse or abuse (e.g., development of tolerance, incrementations of dose, drug-seeking behavior).

OVERDOSAGE

Human Experience: Since the introduction of paroxetine in the U.S., 342 spontaneous cases of deliberate or accidental overdose during paroxetine treatment have been reported worldwide (circa 1999). These include overdoses with paroxetine alone and in combination with other substances. Of these, 48 cases were fatal and, of the fatalities, 17 appeared to involve paroxetine alone. Eight fatal cases which documented the amount of paroxetine ingested were generally confounded by the ingestion of other drugs or alcohol or the presence of significant comorbid conditions. Of 145 non-fatal cases with known outcome, most recovered without sequelae. The largest known ingestion involved 2000 mg of paroxetine (33 times the maximum recommended daily dose) in a patient who recovered.

Commonly reported adverse events associated with paroxetine overdose include somnolence, coma, nausea, tremor, tachycardia, confusion, vomiting, and dizziness. Other notable signs and symptoms observed with overdoses involving paroxetine (alone or with other substances) include mydriasis, convulsions (including status epilepticus), ventricular dysrhythmias (including torsade de pointes), hypertension, aggressive reactions, syncope, hypotension, stupor, bradycardia, dystonia, rhabdomyolysis, symptoms of hepatic dysfunction (including hepatic failure, hepatic necrosis, jaundice, hepatitis, and hepatic steatosis), serotonin syndrome, manic reactions, myoclonus, acute renal failure, and urinary retention.

Overdosage Management: Treatment should consist of those general measures employed in the management of overdose with any drugs effective in the treatment of MDD.

Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. General supportive and symptomatic measures are also recommended. Induction of emesis is not recommended. Gastric lavage with a large-bore orogastric tube with appropriate airway protection, if needed, may be indicated if performed soon after ingestion, or in symptomatic patients.

Activated charcoal should be administered. Due to the large volume of distribution of this drug, forced diuresis, dialysis, hemoperfusion and exchange transfusion are unlikely to be of benefit. No specific antidotes for paroxetine are known.

A specific caution involves patients who are taking or have recently taken paroxetine who might ingest excessive quantities of a tricyclic antidepressant. In such a case, accumulation of the parent tricyclic and/or an active metabolite may increase the possibility of clinically significant sequelae and extend the time needed for close medical observation (see Drugs Metabolized by Cytochrome CYP2D6 under PRECAUTIONS).

In managing overdose, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center for additional information on the treatment of any overdose. Telephone numbers for certified poison control centers are listed in the *Physicians' Desk Reference* (PDR).

DOSAGE AND ADMINISTRATION

MDD

Usual Initial Dosage: PEXEVA® (paroxetine mesylate) should be administered as a single daily dose with or without food, usually in the morning. The recommended initial dose is 20 mg/day. Patients were dosed in a range of 20 to 50 mg/day in the clinical trials demonstrating the effectiveness of paroxetine in the treatment of MDD. As with all drugs effective in the treatment of MDD, the full effect may be delayed. Some patients not responding to a 20 mg dose may benefit from dose increases, in 10 mg/day increments, up to a maximum of 50 mg/day. Dose changes should occur 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 paroxetine should remain on it. It is generally agreed that acute episodes of MDD require several months or longer of sustained pharmacologic therapy. Whether the dose needed to induce remission is identical to the dose needed to maintain and/or sustain euthymia is unknown.

Systematic evaluation of the efficacy of paroxetine has shown that efficacy is maintained for periods of up to 1 year with doses that averaged about 30 mg.

Obsessive Compulsive Disorder

Usual Initial Dosage: PEXEVA® (paroxetine mesylate) should be administered as a single daily dose with or without food, usually in the morning. The recommended dose of paroxetine 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 paroxetine 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). 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: PEXEVA® (paroxetine mesylate) should be administered as a single daily dose with or without food, usually in the morning. The target dose of paroxetine in the treatment of PD 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 paroxetine. 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 PD assigned to paroxetine demonstrated a lower relapse rate compared to patients on placebo (see CLINICAL PHARMACOLOGY.) PD 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.

Generalized Anxiety Disorder

Usual Initial Dosage: Paroxetine should be administered as a single daily dose with or without food, usually in the morning. In clinical trials the effectiveness of paroxetine 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 paroxetine for periods of up to 24 weeks in patients with GAD who had responded while taking paroxetine 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.

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Special Populations

Treatment of Pregnant Women During the Third Trimester: Neonates exposed to paroxetine and other SSRIs or SNRIs late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding (see PRECAUTIONS). 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, 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 a MAOI and initiation of paroxetine therapy. Similarly, at least 14 days should be allowed after stopping paroxetine before starting an MAOI.

Discontinuation of Treatment with Paroxetine: Symptoms associated with discontinuation of paroxetine have been reported (see PRECAUTIONS). Patients should be monitored for these symptoms when discontinuing treatment, regardless of the indication for which paroxetine 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.

HOW SUPPLIED

Tablets:

Film-coated, modified-oval tablets as follows:

10 mg white tablets with the inscription POT 10 on one side.

NDC 68968-2010-1 Bottles of 30

20 mg dark orange tablets with the inscription POT 20 on one side. The tablets are scored on both sides.

NDC 68968-2020-1 Bottles of 30

30 mg yellow tablets with the inscription POT 30 on one side.

NDC 68968-2030-1 Bottles of 30

40 mg rose tablets with the inscription POT 40 on one side.

NDC 68968-2040-1 Bottles of 30

Protect from Humidity.

Store at 25°C (77°F); excursions permitted to 15°-30°C (59° and 86°F)
(see USP Controlled Room Temperature)

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Rx only

Medication Guide

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

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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 (OCD) 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.

*Prozac® is a registered trademark of Eli Lilly and Company.

†Zoloft® is a registered trademark of Pfizer Pharmaceuticals.

‡Anafranil® is a registered trademark of Mallinckrodt Inc.

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