

Olanzapine

Lupilan

5 mg and 10 mg Orodispersible Tablet ANTIPSYCHOTIC

Formulation:

Each orodispersible tablet contains:

Olanzapine.....5 mg
Olanzapine.....10 mg

Product Description:

Yellow coloured, round, flat face beveled edge tablets with characteristic flavour, debossed with "D5" on one side and "CO" on other side

Yellow coloured, round, flat face beveled edge tablets with characteristic flavour, debossed with "D10" on one side and "CO" on other side

Pharmacodynamics / Pharmacokinetics:

Pharmacodynamics

Pharmacotherapeutic group: Diazepines, oxazepines and thiazepines. *ATC code:* N05A H03. Olanzapine is an antipsychotic, anti-manic, and mood stabilising agent that demonstrates a broad pharmacologic profile across a number of receptor systems. In preclinical studies, olanzapine exhibited a range of receptor affinities (Ki <100nM) for serotonin 5HT2A/2C, 5HT3, 5HT6; dopamine D1, D2, D3, D4, D5; cholinergic muscarinic receptors M1-M5; α1 adrenergic; and histamine H1 receptors. Animal behavioural studies with olanzapine indicated 5HT, dopamine, and cholinergic antagonism, consistent with the receptor-binding profile. Olanzapine demonstrated a greater *in vitro* affinity for serotonin 5HT2 than dopamine D2 receptors and greater 5HT2 than D2 activity in *in vivo* models. Electrophysiological studies demonstrated that olanzapine selectively reduced the firing of mesolimbic (A10) dopaminergic neurons, while having little effect on the striatal (A9) pathways involved in motor function. Olanzapine reduced a conditioned avoidance response, a test indicative of antipsychotic activity, at doses below those producing catalepsy, an effect indicative of motor side effects. Unlike some other antipsychotic agents, olanzapine increases response in an 'anxiolytic' test. In a single oral dose (10 mg) Positron Emission Tomography (PET) study in healthy volunteers, olanzapine produced a higher 5HT2A than dopamine D2 receptor occupancy. In addition, a Single Photon Emission Computed Tomography (SPECT) imaging study in schizophrenic patients revealed that olanzapine-responsive patients had lower striatal D2 occupancy than some other antipsychotic- and risperidone-responsive patients, while being comparable to clozapine-responsive patients. In two of two placebo- and two of three comparator-controlled trials with over 2,900 schizophrenic patients presenting with both positive and negative symptoms, olanzapine was associated with statistically significantly greater improvements in negative as well as positive symptoms.

In a multinational, double-blind, comparative study of schizophrenia, schizoaffective and related disorders, which included 1,481 patients with varying degrees of associated depressive symptoms (baseline mean of 16.6 on the Montgomery-Asberg Depression Rating Scale), a prospective secondary analysis of baseline to endpoint mood score change demonstrated a statistically significant improvement (*P* = 0.001) favouring olanzapine (-6.0) versus haloperidol (-3.1). In patients with a manic or mixed episode of bipolar disorder, olanzapine demonstrated superior efficacy to placebo and valproate semisodium (divalproex) in reduction of manic symptoms over 3 weeks. Olanzapine also demonstrated comparable efficacy results to haloperidol in terms of the proportion of patients in symptomatic remission from mania and depression at 6 and 12 weeks. In a co-therapy study of patients treated with lithium or valproate for a minimum of 2 weeks, the addition of olanzapine 10 mg (co-therapy with lithium or valproate) resulted in a greater reduction in symptoms of mania than lithium or valproate monotherapy after 6 weeks. In a 12-month recurrence prevention study in manic episode patients who achieved remission on olanzapine and were then randomised to olanzapine or placebo, olanzapine demonstrated statistically significant superiority over placebo on the primary endpoint of bipolar recurrence. Olanzapine also showed a statistically significant advantage over placebo in terms of preventing either recurrence into mania or recurrence into depression. In a second 12-month recurrence prevention study in manic episode patients who achieved remission with a combination of olanzapine and lithium and were then randomised to olanzapine or lithium alone, olanzapine was statistically non-inferior to lithium on the primary endpoint of bipolar recurrence (olanzapine 30.0%, lithium 38.3%; *P* = 0.055). In an 18-month co-therapy study in manic or mixed episode patients stabilised with olanzapine plus a mood stabiliser (lithium or valproate), long-term olanzapine cotherapy with lithium or valproate was not statistically significantly superior to lithium or valproate alone in delaying bipolar recurrence, defined according to syndromic (diagnostic) criteria.

Paediatric population

The experience in adolescents (ages 13 to 17 years) is limited to short-term efficacy data in schizophrenia (6 weeks) and mania associated with bipolar I disorder (3 weeks), involving less than 200 adolescents. Olanzapine was used as a flexible dose starting with 2.5 and ranging up to 20 mg/day. During treatment with olanzapine, adolescents gained significantly more weight compared with adults. The magnitude of changes in fasting total cholesterol, LDL cholesterol, triglycerides, and prolactin were greater in adolescents than in adults. There are no data on maintenance of effect and limited data on long-term safety.

Pharmacokinetics

Olanzapine orodispersible tablet is bioequivalent to olanzapine coated tablets, with similar rate and extent of absorption. Olanzapine orodispersible tablets may be used as an alternative to olanzapine coated tablets. Olanzapine is well absorbed after oral administration, reaching peak plasma concentrations within 5 to 8 hours. The absorption is not affected by food. Absolute oral bioavailability relative to intravenous administration has not been determined. Olanzapine is metabolised in the liver by conjugative and oxidative pathways. The major circulating metabolite is the 10-N-glucuronide, which does not pass the blood brain barrier. Cytochromes P450-CYP1A2 and P450-CYP2D6 contribute to the formation of the N-desmethyl and 2-hydroxymethyl metabolites; both exhibited significantly less *in vivo* pharmacological activity than olanzapine in animal studies. The predominant pharmacologic activity is from the parent, olanzapine. After oral administration, the mean terminal elimination half-life of olanzapine in healthy subjects varied on the basis of age and gender. In healthy elderly (65 and over) versus non-elderly subjects, the mean elimination half-life was prolonged (51.8 versus 33.8 hours) and the clearance was reduced (17.5 versus 18.2 L/hr). The pharmacokinetic variability observed in the elderly is within the range for the non-elderly. In 44 patients with schizophrenia >65 years of age, dosing from 5 to 20 mg/day was not associated with any distinguishing profile of adverse events. In female versus male subjects, the mean elimination half-life was somewhat prolonged (36.7 versus 32.3 hours) and the clearance was reduced (18.9 versus 27.3 L/hr). However, olanzapine (5-20 mg) demonstrated a comparable safety profile in female (n = 467) as in male patients (n = 869). In renally impaired patients (creatinine clearance <10 mL/min) versus healthy subjects, there was no significant difference in mean elimination half-life (37.7 versus 32.4 hours) or clearance (21.2 versus 25.0 L/hr). A mass balance study showed that approximately 57% of radiolabelled olanzapine appeared in urine, principally as metabolites. In smoking subjects with mild hepatic dysfunction, mean elimination half-life (39.3 hours) was prolonged and clearance (18.0 L/hr) was reduced analogous to non-smoking healthy subjects (48.8 hours and 14.1 L/hr, respectively). In non-smoking versus smoking subjects (males and females), the mean elimination half-life was prolonged (38.6 versus 30.4 hours) and the clearance was reduced (18.6 versus 27.7 L/hr). The plasma clearance of olanzapine is lower in elderly versus young subjects, in females versus males, and in non-smokers versus smokers. However, the magnitude of the impact of age, gender, or smoking on olanzapine clearance and half-life is small in comparison to the overall variability between individuals. In a study of Caucasians, Japanese, and Chinese subjects, there were no differences in the pharmacokinetic parameters among the three populations. The plasma protein binding of olanzapine was about 93% over the concentration range of about 7 to about 1,000 ng/mL. Olanzapine is bound predominantly to albumin and α1-acid-glycoprotein.

Paediatric population

Adolescents (ages 13 to 17 years): The pharmacokinetics of olanzapine are similar between adolescents and adults. In clinical studies, the average olanzapine exposure was approximately 27% higher in adolescents. Demographic differences between the adolescents and adults include a lower average body weight and fewer adolescents were smokers. Such factors possibly contribute to the higher average exposure observed in adolescents.

Indication:

Adults

Olanzapine is indicated for the treatment of schizophrenia. Olanzapine is effective in maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. Olanzapine is also indicated for the treatment of moderate to severe manic episode. In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder.

Recommended Dose:

Adults

Schizophrenia: The recommended starting dose for olanzapine is 10 mg/day.

Manic episode: The starting dose is 15 mg as a single daily dose in monotherapy or 10 mg daily in combination therapy. Preventing recurrence in bipolar disorder: The recommended starting dose is 10 mg/day. For patients who have been receiving olanzapine for treatment of manic episode, continue therapy for preventing recurrence at the same dose. If a new manic, mixed, or depressive episode occurs, olanzapine treatment should be continued (with dose optimisation as needed), with supplementary therapy to treat mood symptoms, as clinically indicated.

During treatment for schizophrenia, manic episode, and recurrence prevention in bipolar disorder, daily dosage may subsequently be adjusted on the basis of individual clinical status within the range 5-20 mg/day. An increase to a dose greater than the recommended starting dose is advised only after appropriate clinical reassessment and should generally occur at intervals of not less than 24 hours.

Paediatric population

Olanzapine is not recommended for use in children and adolescents below 18 years of age due to a lack of data on safety and efficacy. A greater magnitude of weight gain, lipid and prolactin alterations has been reported

Elderly

A lower starting dose (5 mg/day) is not routinely indicated but should be considered for those 65 and over when clinical factors warrant.

Renal and/or hepatic impairment

A lower starting dose (5 mg) should be considered for such patients. In cases of moderate hepatic insufficiency (cirrhosis, Child-Pugh

class A or B), the starting dose should be 5 mg and only increased with caution.

Gender

The starting dose and dose range need not be routinely altered for female patients relative to male patients.

Smokers

The starting dose and dose range need not be routinely altered for non-smokers relative to smokers.

When more than one factor is present which might result in slower metabolism (female gender, geriatric age, non-smoking status), consideration should be given to decreasing the starting dose. Dose escalation, when indicated, should be conservative in such patients.

Mode of Administration:

Olanzapine can be given without regard for meals, as absorption is not affected by food.

Gradual tapering of the dose should be considered when discontinuing olanzapine.

OLANZAPINE orodispersible tablet should be placed in the mouth, where it will rapidly disperse in saliva, so it can be easily swallowed. Removal of the intact orodispersible tablet from the mouth is difficult. Since the orodispersible tablet is fragile, it should be taken immediately on opening the blister. Alternatively, it may be dispersed in a full glass of water or other suitable beverage (orange juice, apple juice, milk, or coffee) immediately before administration.

Contraindication:

Hypersensitivity to the active substance or to any of the excipients.

Patients with known risk of narrow-angle glaucoma.

Warnings and Precautions:

During antipsychotic treatment, improvement in the patient's clinical condition may take several days to some weeks. Patients should be closely monitored during this period.

Dementia-related psychosis and/or behavioural disturbances

Olanzapine is not approved for the treatment of dementia-related psychosis and/or behavioural disturbances and is not recommended for use in this particular group of patients because of an increase in mortality and the risk of cerebrovascular accident. In placebo-controlled clinical trials (6-12 weeks duration) of elderly patients (mean age 78 years) with dementia-related psychosis and/or disturbed behaviours, there was a 2-fold increase in the incidence of death in olanzapine treated patients compared to patients treated with placebo (3.5% vs. 1.5%, respectively). The higher incidence of death was not associated with olanzapine dose (mean daily dose 4.4 mg) or duration of treatment.

Risk factors that may predispose this patient population to increased mortality include age > 65 years, dysphagia, sedation, malnutrition and dehydration, pulmonary conditions (e.g., pneumonia, with or without aspiration), or concomitant use of benzodiazepines. However, the incidence of death was higher in olanzapine-treated than in placebo-treated patients independent of these risk factors. In the same clinical trials, cerebrovascular adverse events (e.g., stroke, transient ischaemic attack), including fatalities, were reported. There was a 3-fold increase in CVAE in patients treated with olanzapine compared to patients treated with placebo (1.3% vs. 0.4%, respectively). All olanzapine-treated and placebo-treated patients who experienced a cerebrovascular event had pre-existing risk factors. Age > 75 years and vascular/mixed type dementia were identified as risk factors for CVAE in association with olanzapine treatment. The efficacy of olanzapine was not established in these trials.

Parkinson's disease

The use of olanzapine in the treatment of dopamine agonist associated psychosis in patients with Parkinson's disease is not recommended. In clinical trials, worsening of Parkinsonian symptomatology and hallucinations were reported very commonly and more frequently than with placebo, and olanzapine was not more effective than placebo in the treatment of psychotic symptoms. In these trials, patients were initially required to be stable on the lowest effective dose of anti-Parkinsonian medicinal products (dopamine agonist) and to remain on the same anti-Parkinsonian medicinal products and dosages throughout the study. Olanzapine was started at 2.5 mg/day and titrated to a maximum of 15 mg/day based on investigator judgement.

Neuroleptic Malignant Syndrome (NMS)

NMS is a potentially life-threatening condition associated with antipsychotic medicinal products. Rare cases reported as NMS have also been received in association with olanzapine. Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. If a patient develops signs and symptoms indicative of NMS, or presents with unexplained high fever without additional clinical manifestations of NMS, all antipsychotic medicines, including olanzapine must be discontinued.

Hyperglycaemia and diabetes

Hyperglycaemia and/or development or exacerbation of diabetes, occasionally associated with ketoacidosis or coma, has been reported rarely, including some fatal cases. In some cases, a prior increase in body weight has been reported, which may be a predisposing factor. Appropriate clinical monitoring is advisable in accordance with utilised antipsychotic guidelines. Patients treated with any antipsychotics, including OLANZAPINE should be observed for signs and symptoms of hyperglycaemia (such as polydipsia, polyuria, polyphagia, and weakness) and patients with diabetes mellitus or with risk factors for diabetes mellitus should be monitored regularly for worsening of glucose control. Weight should be monitored regularly.

Lipid alterations

Undesirable alterations in lipids have been observed in olanzapine-treated patients in placebo-controlled clinical trials. Lipid alterations should be managed as clinically appropriate, particularly in dyslipidemic patients and in patients with risk factors for the development of lipid disorders. Patients treated with any antipsychotic agents, including OLANZAPINE should be monitored regularly for lipids in accordance with utilised antipsychotic guidelines.

Anticholinergic activity

While olanzapine demonstrated anticholinergic activity *in vitro*, experience during the clinical trials revealed a low incidence of related events. However, as clinical experience with olanzapine in patients with concomitant illness is limited, caution is advised when prescribing for patients with prostatic hypertrophy, or paralytic ileus and related conditions.

Hepatic function

Transient, asymptomatic elevations of hepatic aminotransferases, alanine transferase (ALT) and aspartate transferase (AST) have been seen commonly, especially in early treatment. Caution should be exercised and follow-up organised in patients with elevated ALT and/or AST, in patients with signs and symptoms of hepatic impairment, in patients with pre-existing conditions associated with limited hepatic functional reserve, and in patients who are being treated with potentially hepatotoxic medicines. In cases where hepatitis (including hepatocellular, cholestatic or mixed liver injury) has been diagnosed, olanzapine treatment should be discontinued.

Neutropenia

Caution should be exercised in patients with low leucocyte and/or neutrophil counts for any reason, in patients receiving medicines known to cause neutropenia, in patients with a history of drug-induced bone marrow depression/toxicity, in patients with bone marrow depression caused by concomitant illness, radiation therapy or chemotherapy and in patients with hypereosinophilic conditions or with myeloproliferative disease. Neutropenia has been reported commonly when olanzapine and valproate are used concomitantly.

Discontinuation of treatment

Acute symptoms such as sweating, insomnia, tremor, anxiety, nausea, or vomiting have been reported very rarely (<0.01%) when olanzapine is stopped abruptly.

QT interval

In clinical trials, clinically meaningful QTc prolongations (Fridericia QT correction [QTcF] 500 milliseconds [msec] at any time post-baseline in patients with baseline QTcF <500 msec) were uncommon (0.1% to 1%) in patients treated with olanzapine, with no significant differences in associated cardiac events compared to placebo. However, as with other antipsychotics, caution should be exercised when olanzapine is prescribed with medicines known to increase QTc interval, especially in the elderly, in patients with congenital long QT syndrome, congestive heart failure, heart hypertrophy, hypokalaemia or hypomagnesaemia.

Thromboembolism

Temporal association of olanzapine treatment and venous thromboembolism has very rarely (< 0.01%) been reported. A causal relationship between the occurrence of venous thromboembolism and treatment with olanzapine has not been established. However, since patients with schizophrenia often present with acquired risk factors for venous thromboembolism, all possible risk factors of VTE e.g., immobilisation of patients, should be identified and preventive measures undertaken.

General CNS activity

Given the primary CNS effects of olanzapine, caution should be used when it is taken in combination with other centrally acting medicines and alcohol. As it exhibits *in vitro* dopamine antagonism, olanzapine may antagonise the effects of direct and indirect dopamine agonists.

Seizures

Olanzapine should be used cautiously in patients who have a history of seizures or are subject to factors which may lower the seizure threshold. Seizures have been reported to occur rarely in patients when treated with olanzapine. In most of these cases, a history of seizures or risk factors for seizures was reported.

Tardive dyskinesia

In comparator studies of one year or less duration, olanzapine was associated with a statistically significant lower incidence of treatment-emergent dyskinesia. However, the risk of tardive dyskinesia increases with long-term exposure, and therefore if signs or symptoms of tardive dyskinesia appear in a patient on olanzapine, a dose reduction or discontinuation should be considered. These symptoms can temporally deteriorate or even arise after discontinuation of treatment.

Postural hypotension

Postural hypotension was infrequently observed in the elderly in olanzapine clinical trials. As with other antipsychotics, it is recommended that blood pressure is measured periodically in patients over 65 years.

Sudden cardiac death

In postmarketing reports with olanzapine, the event of sudden cardiac death has been reported in patients with olanzapine. In a retrospective observational cohort study, the risk of presumed sudden cardiac death in patients treated with olanzapine was approximately twice the risk in patients not using antipsychotics. In the study, the risk of olanzapine was comparable to the risk of atypical antipsychotics included in a pooled analysis.

Paediatric population

Olanzapine is not indicated for use in the treatment of children and adolescents. Studies in patients aged 13-17 years showed various adverse reactions, including weight gain, changes in metabolic parameters and increases in prolactin levels. Long-term outcomes associated with these events have not been studied and remain unknown.

Phenylalanine

OLANZAPINE Orodispersible tablet contains aspartame, which is a source of phenylalanine may be harmful for people with phenylketonuria.

Interactions with Other Medicaments:

Paediatric population

Interaction studies have only been performed in adults.

Potential Interactions Affecting Olanzapine



Since olanzapine is metabolised by CYP1A2, substances that can specifically induce or inhibit this isoenzyme may affect the pharmacokinetics of olanzapine.

Induction of CYP1A2

The metabolism of olanzapine may be induced by smoking and carbamazepine, which may lead to reduced olanzapine concentrations. Only slight to moderate increase in olanzapine clearance has been observed. The clinical consequences are likely to be limited, but clinical monitoring is recommended and an increase of olanzapine dose may be considered if necessary.

Inhibition of CYP1A2

Fluvoxamine, a specific CYP1A2 inhibitor, has been shown to significantly inhibit the metabolism of olanzapine. The mean increase in olanzapine C_{max} following fluvoxamine was 54% in female non-smokers and 77% in male smokers. The mean increase in olanzapine AUC was 52% and 108%, respectively. A lower starting dose of olanzapine should be considered in patients who are using fluvoxamine or any other CYP1A2 inhibitors, such as ciprofloxacin. A decrease in the dose of olanzapine should be considered if treatment with an inhibitor of CYP1A2 is initiated.

Decreased bioavailability

Activated charcoal reduces the bioavailability of oral olanzapine by 50 to 60% and should be taken at least 2 hours before or after olanzapine. Fluoxetine (a CYP2D6 inhibitor), single doses of antacid (aluminium, magnesium) or cimetidine have not been found to significantly affect the pharmacokinetics of olanzapine.

Potential for Olanzapine to Affect Other Medicinal Products

Olanzapine may antagonise the effects of direct and indirect dopamine agonists. Olanzapine does not inhibit the main CYP450 isoenzymes *in vitro* (e.g., 1A2, 2D6, 2C9, 2C19, 3A4). Thus, no particular interaction is expected, as verified through *in vivo* studies, where no inhibition of metabolism of the following active substances was found: tricyclic antidepressants (representing mostly CYP2D6 pathway), warfarin (CYP2C9), theophylline (CYP1A2), or diazepam (CYP3A4 and 2C19). Olanzapine showed no interaction when co-administered with lithium or biperiden. Therapeutic monitoring of valproate plasma levels did not indicate that valproate dosage adjustment is required after the introduction of concomitant olanzapine.

General CNS activity

Caution should be exercised in patients who consume alcohol or receive medicinal products that can cause central nervous system depression. The concomitant use of olanzapine with anti-Parkinsonian medicinal products in patients with Parkinson's disease and dementia is not recommended.

QTc interval

Caution should be used if olanzapine is being administered concomitantly with medicinal products known to increase QTc interval.

Pregnancy and Lactation:

Pregnancy

There are no adequate and well-controlled studies in pregnant women. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with olanzapine. Nevertheless, because human experience is limited, olanzapine should be used in pregnancy only if the potential benefit justifies the potential risk to the foetus. Spontaneous reports have been very rarely received on tremor, hypertonia, lethargy and sleepiness, in infants born to mothers who had used olanzapine during the 3rd trimester.

Breast feeding

In a study in breast feeding, healthy women, olanzapine was excreted in breast milk. Mean infant exposure (mg/kg) at steady-state was estimated to be 1.8% of the maternal olanzapine dose (mg/kg). Patients should be advised not to breast feed an infant if they are taking olanzapine.

Undesirable Effects:

Adults

The most frequently (seen in 1% of patients) reported adverse reactions associated with the use of olanzapine in clinical trials were somnolence, weight gain, eosinophilia, elevated prolactin, cholesterol, glucose and triglyceride levels, glucosuria, increased appetite, dizziness, akathisia, parkinsonism, dyskinesia, orthostatic hypotension, anticholinergic effects, transient asymptomatic elevations of hepatic aminotransferases, rash, asthenia, fatigue and oedema. The following table lists the adverse reactions and laboratory investigations observed from spontaneous reporting and in clinical trials. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The frequency terms listed are defined as follows: Very common (10%), common (1% and <10%), uncommon (0.1% and <1%), rare (0.01% and <0.1%), very rare (<0.01%), not known (cannot be estimated from the data available).

Blood and the lymphatic system disorders

- Eosinophilia
- Leucopenia
- Neutropenia
- Thrombocytopenia

Immune system disorders

- Allergic reactions

Metabolism and nutrition disorders

- Weight gain
- Elevated cholesterol levels
- Elevated glucose level
- Elevated triglyceride
- Development or exacerbation of diabetes occasionally associated with ketoacidosis or coma, including some fatal cases
- Hypothermia
- Glucosuria
- Increased appetite

Nervous system disorders

- Somnolence
- Dizziness
- Akathisia
- Parkinsonism
- Dyskinesia
- Seizures where in most cases a history of seizures or risk factors for seizures were reported.
- Neuroleptic malignant syndrome
- Dystonia (including oculogyration)
- Tardive dyskinesia
- Discontinuation symptoms

Cardiac disorders

- Bradycardia
- QTc prolongation
- Ventricular tachycardia/fibrillation,
- Sudden death

Vascular disorders

- Orthostatic hypotension
- Thromboembolism (including pulmonary embolism and deep vein thrombosis)

Gastrointestinal disorders

- Mild, transient anticholinergic effects including constipation and dry mouth
- Pancreatitis

Hepato-biliary disorders

- Transient Hepatitis (including asymptomatic elevations of hepatic aminotransferases (ALT, AST), especially in early treatment
- Hepatocellular cholestatic or mixed liver injury

Skin and subcutaneous tissue disorders

- Rash
- Photosensitivity reactions
- Alopecia

Musculoskeletal and connective tissue disorders

- Rhabdomyolysis

Renal and urinary disorders

- Urinary incontinence
- Urinary hesitation

Reproductive system and breast disorders

- Priapism

General disorders and administration site conditions

- Asthenia
- Fatigue
- Oedema

Investigations

- Elevated plasma prolactin levels
- High creatine phosphokinase
- Increased total bilirubin
- Increased alkaline phosphatase

Clinically significant weight gain was observed across all baseline Body Mass Index (BMI) categories. Following short-term treatment (median duration 47 days), weight gain 7% of baseline body weight was very common (22.2 %); 15 % was common (4.2 %); and 25 % was uncommon (0.8 %). Patients gaining 7 %, 15 % and 25 % of their baseline body weight with long-term exposure (at least 48 weeks) were very common (64.4 %, 31.7 % and 12.3 % respectively).

Mean increases in fasting lipid values (total cholesterol, LDL cholesterol, and triglycerides) were greater in patients without evidence of lipid dysregulation at baseline.

Observed for fasting normal levels at baseline (<5.17 mmol/L) which increased to high (6.2 mmol/L). Changes in total fasting cholesterol levels from borderline at baseline (5.17 - <6.2 mmol/L) to high (6.2 mmol/L) were very common.

Observed for fasting normal levels at baseline (<5.56 mmol/L) which increased to high (7 mmol/L). Changes in fasting glucose from borderline at baseline (5.56 - <7 mmol/L) to high (7 mmol/L) were very common.

Observed for fasting normal levels at baseline (<1.69 mmol/L) which increased to high (2.26 mmol/L). Changes in fasting triglycerides from borderline at baseline (1.69 mmol/L - <2.26 mmol/L) to high (2.26 mmol/L) were very common.

In clinical trials, the incidence of Parkinsonism and dystonia in olanzapine-treated patients was numerically higher, but not statistically significantly different from placebo. Olanzapine-treated patients had a lower incidence of parkinsonism, akathisia and dystonia compared with titrated doses of haloperidol. In the absence of detailed information on the pre-existing history of individual acute and tardive extrapyramidal movement disorders, it cannot be concluded at present that olanzapine produces less tardive dyskinesia and/or other tardive extrapyramidal syndromes. Acute symptoms such as sweating, insomnia, tremor, anxiety, nausea and vomiting have been reported when olanzapine is stopped abruptly. In clinical trials of up to 12 weeks, plasma prolactin concentrations exceeded the upper limit of normal range in approximately 30% of olanzapine treated patients with normal baseline prolactin value. In the majority of these patients the elevations were generally mild, and remained below two times the upper limit of normal range. Generally in olanzapine-treated patients, potentially associated breast- and menstrual related clinical manifestations (e.g. amenorrhoea, breast enlargement, galactorrhea in females, and gynaecomastia/breast enlargement in males) were uncommon. Potentially associated sexual function-related adverse reactions (e.g. erectile dysfunction in males and decreased libido in both genders) were commonly observed.

Long-term exposure (at least 48 weeks)

The proportion of patients who had adverse, clinically significant changes in weight gain, glucose, total/LDL/HDL cholesterol or triglycerides increased over time adult patients who completed 9-12 months of therapy, the rate of increase in mean blood glucose slowed after approximately 6 months.

Additional information on special populations

In clinical trials in elderly patients with dementia, olanzapine treatment was associated with the use of olanzapine in this patient group were abnormal gait and falls, pneumonia, increased body temperature, lethargy, erythema, visual hallucinations and urinary incontinence were observed commonly. In clinical trials in patients with drug-induced (dopamine agonist) psychosis associated with Parkinson's disease, worsening of Parkinsonian symptomatology and hallucinations were reported very commonly and more frequently than with placebo. In one clinical trial in patients with bipolar mania, valproate combination therapy with olanzapine resulted in an incidence of neutropenia of 4.1%, a potential contributing factor could be high plasma valproate levels. Olanzapine administered with lithium or valproate resulted in increased levels (10%) of tremor, dry mouth, increased appetite, and weight gain. Speech disorder was also reported commonly. During treatment with olanzapine in combination with lithium or divalproex, an increase of 7% from baseline body weight occurred in 17.4% of patients during acute treatment (up to 6 weeks). Long-term olanzapine treatment (up to 12 months) for recurrence prevention in patients with bipolar disorder was associated with an increase of 7% from baseline body weight in 39.9% of patients.

Paediatric population

Olanzapine is not indicated for the treatment of children and adolescent patients below 18 years. Although no clinical studies designed to compare adolescents to adults have been conducted, data from the adolescent trials were compared to those of the adult trials.

Clinically significant weight gain (7%) appears to occur more frequently in the adolescent population compared to adults with comparable exposures. The magnitude of weight gain and the proportion of adolescent patients who had clinically significant weight gain were greater with long-term exposure (at least 24 weeks) than with short-term exposure. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The frequency terms listed are defined as follows: Very common (10%), common (1% and <10%).

Metabolism and nutrition disorders

Very common: Weight gain, elevated triglyceride levels, increased appetite.

Common: Elevated cholesterol levels.

Nervous system disorders

Very common: Sedation (including: hypersomnia, lethargy, somnolence).

Gastrointestinal disorders

Common: Dry mouth.

Hepato-biliary disorders

Very common: Elevations of hepatic aminotransferases (ALT/AST)

Investigations

Very common: Decreased total bilirubin increased GGT, elevated plasma prolactin levels.

Following short-term treatment (median duration 22 days), weight gain 7% of baseline body weight (kg) was very common (40.6 %); 15% of baseline body weight was common (7.1 %) and 25% was common (2.5 %). With long-term exposure (at least 24 weeks), 89.4 % gained 7 %, 55.3 % gained 15 % and 29.1 % gained 25% of their baseline body weight.

Observed for fasting normal levels at baseline (<1.016 mmol/L) which increased to high (1.467 mmol/L) and changes in fasting triglycerides from borderline at baseline (1.016 mmol/L - <1.467 mmol/L) to high (1.467 mmol/L).

Changes in total fasting cholesterol levels from normal at baseline (<4.39 mmol/L) to high (5.17 mmol/L) were observed commonly. Changes in total fasting cholesterol levels from borderline at baseline (4.39 - <5.17 mmol/L) to high (5.17 mmol/L) were very common. Elevated plasma prolactin levels were reported in 47.4% of adolescent patients.

Overdose and treatment:

Signs and Symptoms

Very common symptoms in overdose (>10% incidence) include tachycardia, agitation/aggressiveness, dysarthria, various extrapyramidal symptoms, and reduced level of consciousness ranging from sedation to coma. Other medically significant sequelae of overdose include delirium, convulsion, coma, possible neuroleptic malignant syndrome, respiratory depression, aspiration, hypertension or hypotension, cardiac arrhythmias (<2% of overdose cases), and cardiopulmonary arrest. Fatal outcomes have been reported for acute overdoses as low as 450 mg, but survival has also been reported following acute overdose of approximately 2 g of oral olanzapine.

Management of Overdose

There is no specific antidote for olanzapine. Induction of emesis is not recommended. Standard procedures for management of overdose may be indicated (i.e., gastric lavage, administration of activated charcoal). The concomitant administration of activated charcoal was shown to reduce the oral bioavailability of olanzapine by 50 to 60%. Symptomatic treatment and monitoring of vital organ function should be instituted according to clinical presentation, including treatment of hypotension and circulatory collapse and support of respiratory function. Do not use epinephrine, dopamine, or other sympathomimetic agents with beta-agonist activity, since beta stimulation may worsen hypotension. Cardiovascular monitoring is necessary to detect possible arrhythmias.

Close medical supervision and monitoring should continue until the patient recovers.

Storage Condition:

Store below 25°C. Protect from light and moisture.

Caution:

Foods, Drugs, Devices and Cosmetics Act prohibits dispensing without prescription.

Availability:

- 5mg Orodispersable Tablet: Alu/Alu Blister pack x 10's (Box of 30's)
- 10mg Orodispersable Tablet: Alu/Alu Blister pack x 10's (Box of 30's)

Manufactured by: Jubilant Generics Limited

Village Sikandarpur Bhainswal, Roorkee- Dehradun Highway, Bhagwanpur, Roorkee, District Haridwar, Uttarakhand 247 661, India

Imported by: MedEthix, Inc.

6/F RFM Corporate Center Pioneer St. Mandaluyong City, Philippines

Distributed by: Multicare Pharmaceuticals Philippines Inc.

26th Floor Rufino Tower, 6784 Ayala Avenue, Makati City, 1229, Philippines

