

Size: 12-3/8 x 8-1/4 Folds to:1-3/8 x 1-3/8 Type Size: 6.25pt. Nortriptyline Hydrochloride Oral Solution USP 2/7/05 P.O.# 0400031 Side A

Nortriptyline Hydrochloride Oral Solution, USP

Rx only

DESCRIPTION

Suicidality in Children and Adolescents

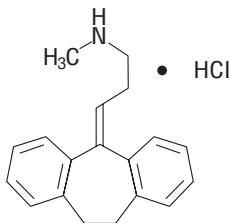
Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in short term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of Nortriptyline Hydrochloride Oral Solution or any other antidepressant 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. Nortriptyline hydrochloride 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.

Nortriptyline Hydrochloride, USP is 1-propanamine, 3-(10, 11-dihydro-5H-dibenzo [a,d] cyclohepten-5-ylidene)-N-methyl, hydrochloride. Its molecular weight is 299.8, and its molecular formula is C₁₉H₂₁N•HCl.

The oral solution contains nortriptyline hydrochloride equivalent to 10 mg/5 mL (38.0 μmol) of the base and 4% alcohol. It also contains benzoic acid, flavors, sorbitol, and water.

The structural formula is as follows:



ACTIONS

The mood elevating mechanism of tricyclic antidepressants is at present unknown. Nortriptyline hydrochloride is not a monoamine oxidase inhibitor. It inhibits the activity of such diverse agents as histamine, 5-hydroxytryptamine, and acetylcholine. It increases the pressor effect of norepinephrine but blocks the pressor response of phenethylamine. Studies suggest that nortriptyline hydrochloride interferes with the transport, release, and storage of catecholamines. Operant conditioning techniques in rats and pigeons suggest that nortriptyline hydrochloride has a combination of stimulant and depressant properties.

INDICATIONS

Nortriptyline hydrochloride is indicated for the relief of symptoms of depression. Endogenous depressions are more likely to be alleviated than are other depressive states.

CONTRAINDICATIONS

The concurrent use of nortriptyline hydrochloride or other tricyclic antidepressants with a monoamine oxidase (MAO) inhibitor is contraindicated. Hyperpyretic crises, severe convulsions, and fatalities have occurred when similar tricyclic antidepressants were used in such combinations. It is advisable to discontinue the MAO inhibitor at least 2 weeks before treatment with nortriptyline hydrochloride is to be started.

Patients hypersensitive to nortriptyline hydrochloride should not be given the drug.

Cross-sensitivity between nortriptyline hydrochloride and other dibenzazepines is a possibility.

Nortriptyline hydrochloride is contraindicated during the acute recovery period after myocardial infarction.

WARNINGS

Clinical Worsening and Suicide Risk

Patients with major depressive disorder (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 Major Depressive Disorder (MDD) and other psychiatric disorders.

Pooled analyses of short-term placebo-controlled trials of 9 antidepressant drugs (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 trials in other psychiatric indications (obsessive compulsive disorder 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 co-morbid 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.

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 major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either 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.

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.

Families and caregivers of pediatric patients being treated with antidepressants for major depressive disorder 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 nortriptyline hydrochloride should be written for the smallest quantity 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 nortriptyline hydrochloride is not approved for use in treating bipolar depression.

Patients with cardiovascular disease should be given nortriptyline hydrochloride only under close supervision because of the tendency of the drug to produce sinus tachycardia and to prolong the conduction time. Myocardial infarction, arrhythmia, and strokes have occurred. The antihypertensive action of guanethidine and similar agents may be blocked. Because of its anticholinergic activity, nortriptyline hydrochloride should be used with great caution in patients who have glaucoma or a history of urinary retention. Patients with a history of seizures should be followed closely when nortriptyline hydrochloride is administered, because this drug is known to lower the convulsive threshold. Great care is required if nortriptyline hydrochloride is given to hyperthyroid patients or to those receiving thyroid medication, because cardiac arrhythmias may develop.

Nortriptyline hydrochloride may impair the mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a car; therefore, the patient should be warned accordingly.

Excessive consumption of alcohol in combination with nortriptyline therapy may have a potentiating effect, which may lead to the danger of increased suicidal attempts or overdose, especially in patients with histories of emotional disturbances or suicidal ideation.

Use in Pregnancy—Safe use of nortriptyline hydrochloride during pregnancy and lactation has not been established; therefore, when the drug is administered to pregnant patients, nursing mothers, or women of childbearing potential, the potential benefits must be weighed against the possible hazards. Animal reproduction studies have yielded inconclusive results.

PRECAUTIONS

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 nortriptyline hydrochloride and should counsel them in its appropriate use. A patient Medication Guide

About Using Antidepressants in Children and Teenagers is available for nortriptyline hydrochloride. 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.

Patients should be advised of the following issues and asked to alert their prescribers if these occur while taking nortriptyline hydrochloride.

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.

Pediatric Use—Safety and effectiveness in the pediatric population have not been established (see **BOX WARNING** and **WARNING—Clinical Worsening and Suicide Risk**). Anyone considering the use of nortriptyline hydrochloride in a child or adolescent must balance the potential risks with the clinical need.

General: The use of nortriptyline hydrochloride in schizophrenic patients may result in exacerbation of the psychosis or may activate latent schizophrenic symptoms. If the drug is given to overactive or agitated patients, increased anxiety and agitation may occur. In manic-depressive patients, nortriptyline hydrochloride may cause symptoms of the manic phase to emerge.

Troublesome patient hostility may be aroused by the use of nortriptyline hydrochloride. As may happen with other drugs of its class, epileptiform seizures may accompany its administration.

When it is essential, the drug may be administered concurrently with electroconvulsive therapy, although the hazards may be increased. Discontinue the drug for several days, if possible, prior to elective surgery.

The possibility of a suicidal attempt by a depressed patient remains after the initiation of treatment; in this regard, it is important that the least possible quantity of drug be dispensed at any given time.

Both elevation and lowering of blood sugar levels have been reported.

A case of significant hypoglycemia has been reported after the addition of nortriptyline (125mg/day) in a type II diabetic patient maintained on chlorpropamide (250 mg/day).

Drug Interactions: Steady-state serum concentrations of tricyclic antidepressants are reported to fluctuate significantly when cimetidine is either added or deleted from the drug regimen. Serious anticholinergic symptoms (severe dry mouth, urinary retention, blurred vision) have been associated with elevations in the serum levels of tricyclic antidepressants when cimetidine is added to the drug regimen. In addition, higher-than expected steady-state serum concentrations of tricyclic antidepressants have been observed when therapy is initiated in patients already taking cimetidine.

In well-controlled patients undergoing concurrent therapy with cimetidine, a decrease in the steady-state serum concentrations of tricyclic antidepressants may occur when cimetidine therapy is discontinued. The therapeutic efficacy of tricyclic antidepressants may be compromised in these patients when cimetidine is discontinued. Several of the tricyclic antidepressants have been cited in these reports.

There have been greater than 2-fold increases in previously stable plasma levels of other antidepressants, including nortriptyline, when fluoxetine hydrochloride has been administered in combination with these agents. Fluoxetine and its active metabolite, norfluoxetine, have long half-lives (4 to 16 days for norfluoxetine), that may affect strategies during conversion from one drug to the other.

Administration of reserpine during therapy with a tricyclic antidepressant has been shown to produce a "stimulating" effect in some depressed patients.

Close supervision and careful adjustment of the dosage are required when nortriptyline hydrochloride is used with other anticholinergic drugs or sympathomimetic drugs.

The patient should be informed that the response to alcohol may be exaggerated.

Drugs Metabolized by P450IID6—A subset (3% to 10%) of the population has reduced activity of certain drug metabolizing enzymes such as the cytochrome P450 isoenzyme P450IID6. Such individuals are referred to as "poor metabolizers" of drugs such as debrisoquin, dextromethorphan, and the tricyclic antidepressants. These individuals may have higher than expected plasma concentrations of tricyclic antidepressants when given usual doses. In addition, certain drugs that are metabolized by this isoenzyme, including many antidepressants (tricyclic antidepressants, selective serotonin reuptake inhibitors, and others), may inhibit the activity of this isoenzyme, and thus may make normal metabolizers resemble poor metabolizers with regard to concomitant therapy with other drugs metabolized by this enzyme system, leading to drug interactions.

Concomitant use of tricyclic antidepressants with other drugs metabolized by cytochrome P450IID6 may require lower doses than usually prescribed for either the tricyclic antidepressant or the other drug. Therefore, co-administration of tricyclic antidepressants with other drugs that are metabolized by this isoenzyme, including other antidepressants, phenothiazines, carbamazepine, and Type IC antiarrhythmics (eg, propafenone, flecainide, and encainide), or that inhibit this enzyme (eg, quinidine), should be approached with caution.

Size: 12-3/8 x 8-1/4 Folds to:1-3/8 x 1-3/8 Type Size: pt. Side B

Geriatric Use—Confusional states following tricyclic antidepressant administration have been reported in the elderly (see Adverse Reactions). Higher plasma concentrations of the active nortriptyline metabolite 10-hydroxynortriptyline have been reported in elderly patients (see Plasma Levels under Dosage and Administration). Lower than usual dosages are recommended for elderly patients (see Elderly Patients under Dosage and Administration).

ADVERSE REACTIONS

NOTE: Included in the following list are a few adverse reactions that have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of these reactions be considered when nortriptyline is administered.

Cardiovascular—Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric—Confusional states (especially in the elderly), with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia, panic, nightmares; hypomania; exacerbation of psychosis.

Neurologic—Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alteration of EEG patterns; tinnitus.

Anticholinergic—Dry mouth and, rarely, associated sublingual adenitis or gingivitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic—Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue), drug fever, cross-sensitivity with other tricyclic drugs.

Hematologic—Bone-marrow depression, including agranulocytosis; aplastic anemia; eosinophilia; purpura, thrombocytopenia.

Gastrointestinal—Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue, constipation, paralytic ileus.

Endocrine—Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels; syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other—Jaundice (simulating obstructive); altered liver function, hepatitis, and liver necrosis; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness, fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms—Though these are not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

OVERDOSAGE

Deaths may occur from overdosage with this class of drugs. Multiple drug ingestion (including alcohol) is common in deliberate tricyclic antidepressant overdose. As the management is complex and changing, it is recommended that the physician contact a poison control center for current information on treatment. Signs and symptoms of toxicity develop rapidly after tricyclic antidepressant overdose; therefore, hospital monitoring is required as soon as possible.

Manifestations—Critical manifestations of overdose include: cardiac dysrhythmias, severe hypotension, convulsions, and CNS depression, including coma. Changes in the electrocardiogram, particularly in QRS axis or width, are clinically significant indicators of tricyclic antidepressant toxicity.

Other signs of overdose may include: confusion, disturbed concentration, transient visual hallucinations, dilated pupils, agitation, hyperactive reflexes, stupor, drowsiness, muscle rigidity, vomiting, hypothermia, hyperpyrexia, or many of the symptoms listed under ADVERSE REACTIONS.

Management

General: Obtain an ECG and immediately initiate cardiac monitoring. Protect the patient's airway, establish an intravenous line and initiate gastric decontamination. A minimum of six hours of observation with cardiac monitoring and observation for signs of CNS or respiratory depression, hypotension, cardiac dysrhythmias and/or conduction blocks, and seizures is necessary. If signs of toxicity occur at any time during this period, extended monitoring is required. There are case reports of patients succumbing to fatal dysrhythmias late after overdose; these patients had clinical evidence of significant poisoning prior to death and most received inadequate gastrointestinal decontamination. Monitoring of plasma drug levels should not guide management of the patient.

Gastrointestinal Decontamination: All patients suspected of tricyclic antidepressant overdose should receive gastrointestinal decontamination. This should include large volume gastric lavage followed by activated charcoal. If consciousness is impaired, the airway should be secured prior to lavage. Emesis is contraindicated.

Cardiovascular: A maximal limb-lead QRS duration of ≥ 0.10 seconds may be the best indication of the severity of the overdose. Intravenous sodium bicarbonate should be used to maintain the serum pH in the range of 7.45 to 7.55. If the pH response is inadequate, hyperventilation may also be used. Concomitant use of hyperventilation and sodium bicarbonate should be done with extreme caution, with frequent pH monitoring. A pH > 7.60 or a $pCO_2 < 20$ mm Hg is undesirable. Dysrhythmias unresponsive to sodium bicarbonate therapy/hyperventilation may respond to lidocaine, bretylium or phenytoin. Type 1A and 1C antiarrhythmics are generally contraindicated (eg, quinidine, disopyramide, and procainamide).

In rare instances, hemoperfusion may be beneficial in acute refractory cardiovascular instability in patients with acute toxicity. However, hemodialysis, peritoneal dialysis, exchange transfusions, and forced diuresis generally have been reported as ineffective in tricyclic antidepressant poisoning.

CNS: In patients with CNS depression, early intubation is advised because of the potential for abrupt deterioration. Seizures should be controlled with benzodiazepines, or if these are ineffective, other anticonvulsants (eg, phenobarbital, phenytoin). Physostigmine is not recommended except to treat life-threatening symptoms that have been unresponsive to other therapies, and then only in consultation with a poison control center.

Psychiatric Follow-up: Since overdosage is often deliberate, patients may attempt suicide by other means during the recovery phase. Psychiatric referral may be appropriate.

Pediatric Management: The principles of management of pediatric and adult overdosages are similar. It is strongly recommended that the physician contact the local poison control center for specific pediatric treatment.

DOSAGE AND ADMINISTRATION

Nortriptyline hydrochloride is not recommended for pediatric patients. Nortriptyline hydrochloride is administered orally in the form of an oral solution. Lower than usual dosages are recommended for elderly patients. The use of lower dosages for outpatients is more important than for hospitalized patients who will be treated under close supervision. The physician should initiate dosage at a low level and increase it gradually, checking the clinical response carefully and noting any evidence of intolerance. Following remission, maintenance medication may be required for a longer period of time at the lowest dose that will maintain remission.

If a patient develops minor side effects, the dosage should be reduced. The drug should be discontinued promptly if adverse effects of a serious nature or allergic manifestations occur.

Usual Adult Dose—25 mg 3 or 4 times daily; dosage should begin at a low level and be increased as required. As an alternate regimen, the total daily dose may be given once a day. When doses above 100 mg daily are administered, plasma levels of nortriptyline should be monitored and maintained in the optimum range of 50 to 150 ng/mL. Doses above 150 mg per day are not recommended.

Elderly Patients—30 to 50 mg/day in divided doses.

Plasma Levels—Optimal responses to nortriptyline have been associated with plasma concentrations of 50 to 150 ng/mL. Higher concentrations may be associated with more adverse experiences. Plasma concentrations are difficult to measure, and physicians should consult with the laboratory professional staff.

Larger plasma concentrations of the active nortriptyline metabolite 10-hydroxy nortriptyline have been reported in older patients. In one case, such a condition was associated with apparent cardiotoxicity despite the fact that nortriptyline concentrations were within the "therapeutic range." Clinical findings should predominate over plasma concentrations as primary determinants of dosage changes.

HOW SUPPLIED

Liquid, Oral Solution:

10 mg*/5 mL—(16 fl oz) NDC 63304-202-01

*Equivalent to base.

Store at 20 - 25° C (68 - 77° F). (See USP Controlled Room Temperature).

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

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

2. How to Try to Prevent Suicidal Thoughts and Actions

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

Whenever an antidepressant is started or its dose is changed, pay close attention to your child.

After starting an antidepressant, your child should generally see his or her healthcare provider:

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

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

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

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

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

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

4. There are Benefits and Risks When Using Antidepressants

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

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

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

For obsessive compulsive disorder in children and teenagers, FDA has approved only fluoxetine (Prozac®)*, sertraline (Zoloft®)*, fluvoxamine, and clomipramine (Anafranil®)*. Your healthcare provider may suggest other antidepressants based on the past experience of your child or other family members.

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

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

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

*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.

Manufactured for:

Ranbaxy Pharmaceuticals Inc.

Jacksonville, FL 32216 USA

by: Ohm Laboratories Inc.

Gloversville, NY 12078

February 2005

FDA-03