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- acting aggressive, being angry, or violent
- acting on dangerous impulses
- an extreme increase in activity and talking (mania)
- other unusual changes in behavior or mood

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- **Not all antidepressant medicines prescribed for children are FDA approved for use in children.** Talk to your child's healthcare provider for more information.

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

DURAMED PHARMACEUTICALS, INC.
Subsidiary of Barr Pharmaceuticals, Inc.
Pomona, New York 10970

B08-0718 Rev. 6/07

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anomalies in rats or rabbits at doses 20 times the human dose. There are no adequate and well-controlled studies in pregnant women. Surmontil should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

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

Geriatric Use
Clinical studies of Surmontil® (trimipramine maleate) were not adequate to determine whether subjects aged 65 and over respond differently from younger subjects.

The pharmacokinetics of trimipramine were not substantially altered in the elderly (see CLINICAL PHARMACOLOGY).

Surmontil is known to be substantially excreted by the kidney. Clinical circumstances, some of which may be more common in the elderly, such as hepatic or renal impairment, should be considered (see PRECAUTIONS — General).

Greater sensitivity (e.g., confusional states, sedation) of some older individuals cannot be ruled out (see ADVERSE REACTIONS). In general, dose selection for an elderly patient should be cautious, usually starting at a lower dose (see DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS
Note: The pharmacological similarities among the tricyclic antidepressants require that each of the reactions be considered when Surmontil is administered. Some of the adverse reactions included in this listing have not in fact been reported with Surmontil.

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

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

Neurological
Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion.

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

Allergic
Skin rash, ptechieae, urticaria, itching, photosensitization, edema of face and tongue.

Hematologic
Bone-marrow depression including agranulocytosis, eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal
Nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

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.

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

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

DOSAGE AND ADMINISTRATION
Dosage should be initiated at a low level and increased gradually, noting carefully the clinical response and any evidence of intolerance.

Lower dosages are recommended for elderly patients and adolescents. Lower dosages are also recommended for outpatients as compared to hospitalized patients who will be under close supervision. It is not possible to prescribe a single dosage schedule of Surmontil that will be therapeutically effective in all patients. The physical psychodynamic factors contributing to depressive symptomatology are very complex; spontaneous remissions or exacerbations of depressive symptoms may occur with or without drug therapy. Consequently, the recommended dosage regimens are furnished as a guide which may be modified by factors such as the age of the patient, chronicity and severity of the disease, medical condition of the patient, and degree of psychotherapeutic support.

Most antidepressant drugs have a lag period of ten days to four weeks before a therapeutic response is noted. Increasing the dose will not shorten this period but rather increase the incidence of adverse reactions.

Usual Adult Dose
Outpatients and Office Patients—Initially, 75 mg/day in divided doses, increased to 150 mg/day. Dosages over 200 mg/day are not recommended. Maintenance therapy is in the range of 50 to 150 mg/day. For convenient therapy and to facilitate patient compliance, the total dosage requirement may be given at bedtime.

Hospitalized Patients—Initially, 100 mg/day in divided doses. This may be increased gradually in a few days to 200 mg/day, depending upon individual response and tolerance. If improvement does not occur in 2 to 3 weeks, the dose may be increased to the maximum recommended dose of 250 to 300 mg/day.

Adolescent and Geriatric Patients—Initially, a dose of 50 mg/day is recommended, with gradual increments up to 100 mg/day, depending upon patient response and tolerance.

Maintenance—Following remission, maintenance medication may be required for a longer period of time, at the lowest dose that will maintain remission. Maintenance therapy is preferably administered as a single dose at bedtime. To minimize relapse, maintenance therapy should be continued for about three months.

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 any 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. Plasma drug levels may not reflect the severity of the poisoning. Therefore, monitoring of plasma drug levels alone 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 has been associated with an increased incidence of seizures. A QRS duration of ≥ 0.16 seconds has been associated with an increased incidence of ventricular dysrhythmias. 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 pCO₂ < 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 (e.g., 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 (e.g., 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 child and adult overdosages are similar. It is strongly recommended that the physician contact the local poison control center for specific pediatric treatment.

*Poisindex® Toxicologic Management. Topic: Antidepressants, Tricyclic Micromedex Inc. Vol. 85.

HOW SUPPLIED
Surmontil® (trimipramine maleate) Capsules
25 mg — Opaque blue and yellow capsule in bottles of 100.
Printed OP and 718
50 mg — Opaque blue and orange capsule in bottles of 100.
Printed OP and 719.
100 mg — Opaque blue and white capsule in bottles of 100.
Printed OP and 720
Store at 20°-25°C (68°-77°F) [See USP Controlled Room Temperature].
Keep bottles tightly closed.
Dispense in a tight container.

Medication Guide
Antidepressant Medicines, Depression and other Serious Mental Illnesses, and Suicidal Thoughts or Actions

Read the Medication Guide that comes with you or your family member's antidepressant medicine. This Medication Guide is only about the risk of suicidal thoughts and actions with antidepressant medicines. **Talk to your, or your family member's, healthcare provider about:**

- all risks and benefits of treatment with antidepressant medicines
- all treatment choices for depression or other serious mental illness

What is the most important information I should know about antidepressant medicines, depression and other serious mental illnesses, and suicidal thoughts or actions?

1. **Antidepressant medicines may increase suicidal thoughts or actions in some children, teenagers, and young adults within the first few months of treatment.**
2. **Depression and other serious mental illnesses are the most important causes of suicidal thoughts and actions. Some people may have a particularly high risk of having suicidal thoughts or actions.** These include people who have (or have a family history of) bipolar illness (also called manic-depressive illness) or suicidal thoughts or actions.
3. **How can I watch for and try to prevent suicidal thoughts and actions in myself or a family member?**
 - Pay close attention to any changes, especially sudden changes, in mood, behaviors, thoughts, or feelings. This is very important when an antidepressant medicine is started or when the dose is changed.
 - Call the healthcare provider right away to report new or sudden changes in mood, behavior, thoughts, or feelings.
 - Keep all follow-up visits with the healthcare provider as scheduled. Call the healthcare provider between visits as needed, especially if you have concerns about symptoms.

Call a healthcare provider right away if you or your family member has any of the following symptoms, especially if they are new, worse, or worry you:

- thoughts about suicide or dying
- attempts to commit suicide
- new or worse depression
- new or worse anxiety
- feeling very agitated or restless
- panic attacks
- trouble sleeping (insomnia)
- new or worse irritability
- acting aggressive, being angry, or violent
- acting on dangerous impulses
- an extreme increase in activity and talking (mania)
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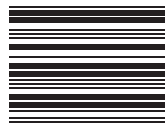
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