Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

OxyNorm 10 mg hard capsules

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each capsule contains 9 mg of oxycodone as 10 mg of oxycodone hydrochloride.
For the full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Hard capsule.

OxyNorm hard capsules 10 mg are white/beige, printed ONR 10.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

For the treatment of severe pain.

4.2 Posology and method of administration

Posology

Adults:
OxyNormcapsules should be taken at 4-6 hourly intervals. The dose should be adjusted to the intensity of the pain and the sensitivity of the individual patient. The patient's previous history of analgesic requirements should also be taken into account when determining the dose.

The usual starting dose for debilitated elderly patients, opioid naïve patients or patients presenting with severe pain uncontrolled with weaker opioids is 5 mg 4-6 hourly. The dose should then be carefully titrated, every day if necessary, to achieve pain relief. Generally, the lowest effective dose for analgesia should be selected. If higher doses are necessary, increases should be made in 25-50% increments where possible. The correct dosage for any individual patient is that which controls the pain with no or tolerable side effects throughout the dosage interval. The need for escape medication more than twice a day indicates that the dosage of ***OxyNorm***capsules should be increased.

Transferring patients between oral and parenteral oxycodone:
The dose should be based on the following ratio: 2 mg of oral oxycodone is equivalent to 1 mg of parenteral oxycodone. It must be emphasised that this is a guide to the dose required. Inter-patient variability requires that each patient is carefully titrated to the appropriate dose.

Conversion from oral morphine:
Patients receiving oral morphine before oxycodone therapy should have their daily dose based on the following ratio: 10 mg of oral oxycodone is equivalent to 20 mg of oral morphine. It must be emphasised that this is a guide to the dose of ***OxyNorm***capsules required. Inter-patient variability requires that each patient is carefully titrated to the appropriate dose.

Elderly patients:
A dose adjustment is not usually necessary in elderly patients.
Controlled pharmacokinetic studies in elderly patients (aged over 65 years) have shown that compared with younger adults the clearance of oxycodone is only slightly reduced. No untoward adverse drug reactions were seen based on age, therefore adult doses and dosage intervals are appropriate.

Non-malignant pain:

Treatment with oxycodone should be short and intermittent to minimise the risk of dependence. The need for continued treatment should be assessed at regular intervals. Patients should not usually require more than 160 mg per day. For the long-term treatment of severe pain prolonged release formulations of oxycodone are available.

Cancer-related pain:
Patients should be titrated up to a dose which achieves pain relief unless unmanageable adverse drug reactions prevent this.

Patients with renal or hepatic impairment:
Unlike morphine preparations, the administration of oxycodone does not result in significant levels of active metabolites. However, the plasma concentration of oxycodone in this patient population may be increased compared with patients having normal renal or hepatic function. The dose initiation should follow a conservative approach in these patients. The recommended adult starting dose should be reduced by 50% (for example a total daily dose of 10 mg orally in opioid naïve patients), and each patient should be titrated to adequate pain control according to their clinical situation.

Adults under 20 years and paediatric population:
Not recommended.

Method of administration:
Oral use.
The capsules should be swallowed whole with water.

Duration of treatment:
Oxycodone should not be used longer than necessary.

Discontinuation of treatment:
When a patient no longer requires therapy with oxycodone, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal.

4.3 Contraindications

Hypersensitivity to oxycodone or to any of the excipients listed in section 6.1.
Oxycodone must not be used in any situation where opioids are contraindicated: severe respiratory depression with hypoxia, elevated carbon dioxide levels in the blood (hypercarbia), head injury, paralytic ileus, acute abdomen, delayed gastric emptying, severe chronic obstructive lung disease, severe bronchial asthma, cor pulmonale, known sensitivity to morphine or other opioids.

4.4 Special warnings and precautions for use

The major risk of opioid excess is respiratory depression.

Caution must be exercised when administering oxycodone to the debilitated elderly; patients with severely impaired pulmonary function, impaired hepatic or renal function; patients with myxoedema, hypothyroidism, Addison's disease, toxic psychosis, adrenocortical insufficiency, prostate hypertrophy, head injury (due to the risk of raised intracranial pressure), convulsive disorders, delirium tremens, disorders of consciousness, hypotension, hypovolaemia. Use with caution in opioid dependent patients, diseases of the biliary tract, biliary or ureteric colic, pancreatitis, obstructive and inflammatory bowel disorders, chronic obstructive airways disease, reduced respiratory reserve, alcoholism or patients taking benzodiazepines, other CNS depressants (including alcohol) or MAO inhibitors. In patients in whom caution is required, a reduction in dosage may be advisable.

Risk from concomitant use of sedative medicines such as benzodiazepines or related drugs:
Concomitant use of opioids, including oxycodone and sedative medicines such as benzodiazepines or related drugs may result in sedation, respiratory depression, coma and death. Because of these risks, concomitant prescribing with these sedative medicines should be reserved for patients for whom alternative treatment options are not possible. If a decision is made to prescribe oxycodone concomitantly with sedative medicines, the lowest effective dose should be used, and the duration of treatment should be as short as possible.

The patients should be followed closely for signs and symptoms of respiratory depression and sedation. In this respect, it is strongly recommended to inform patients and their caregivers to be aware of these symptoms (see section 4.5).

OxyNormcapsules should not be used where there is a possibility of paralytic ileus occurring. Should paralytic ileus be suspected or occur during use, ***OxyNorm***capsules should be discontinued immediately (see section 4.3).

OxyNorm should be used with caution pre-operatively and within the first 12-24 hours post-operatively.

As with all opioid preparations, patients about to undergo additional pain relieving procedures (e.g. surgery, plexus blockade) should not receive ***OxyNorm***capsules for six hours prior to the intervention. If further treatment with ***OxyNorm***capsules is indicated then the dosage should be adjusted to the new post-operative requirement.

As with all opioid preparations, oxycodone products should be used with caution following abdominal surgery as opioids are known to impair intestinal motility and should not be used until the physician is assured of normal bowel function.

The patient may develop tolerance to the drug with chronic use and require progressively higher doses to maintain pain control. Prolonged use of this product may lead to physical dependence and a withdrawal syndrome may occur upon abrupt cessation of therapy. When a patient no longer requires therapy with oxycodone, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. Withdrawal symptoms may include yawning, mydriasis, lacrimation, rhinorrhoea, tremor, hyperhidrosis, anxiety, agitation, convulsions and insomnia.

Opioids are not first-line therapy for chronic non-malignant pain, nor are they recommended as the only treatment. Opioids should be used as part of a comprehensive treatment programme involving other medications and treatment modalities. Patients with chronic non-malignant pain should be assessed and monitored for addiction and substance abuse. There must be frequent contact between physician and patient so that dosage adjustments can be made. It is strongly recommended that the physician defines treatment outcomes in accordance with pain management guidelines. The physician and patient can then agree to discontinue treatment if these objectives are not met.

Hyperalgesia that will not respond to a further dose increase of oxycodone may occur, particularly in high doses. An oxycodone dose reduction or change to an alternative opioid may be required.

Opioids, such as oxycodone hydrochloride, may influence the hypothalamic-pituitary-adrenal or – gonadal axes. Some changes that can be seen include an increase in serum prolactin, and decreases in plasma cortisol and testosterone. Clinical symptoms may manifest from these hormonal changes.

Oxycodone has an abuse profile similar to other strong opioid agonists and may be sought and abused by people with latent or manifest addiction disorders. There is potential for development of psychological dependence (addiction) to opioid analgesics, including oxycodone. ***OxyNorm***capsules should be used with particular care in patients with a history of alcohol or drug abuse.

The capsules should be swallowed whole, and not chewed or crushed. Abuse of oral dosage forms by parenteral administration can be expected to result in serious adverse events, which may be fatal.

Concomitant use of alcohol and ***OxyNorm***may increase the undesirable effects of ***OxyNorm***; concomitant use should be avoided.

It should be emphasised that patients, once titrated to an effective dose of a certain opioid, should not be changed to other analgesic preparations without clinical assessment and careful retitration as necessary. Otherwise, a continuous analgesic action is not ensured.

4.5 Interaction with other medicinal products and other forms of interactions

The concomitant use of opioids with sedative medicines such as benzodiazepines or related drugs increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. The dose and duration of concomitant use should be limited (see section 4.4). Drugs which depress the CNS include, but are not limited to: other opioids, gabapentinoids such as pregabalin, anxiolytics, hypnotics and sedatives (incl. benzodiazepines), antipsychotics, antidepressants, phenothiazines, and alcohol. Oxycodone should be used with caution and the dosage may need to be reduced in patients using these medications.

Concomitant administration of oxycodone with serotonin agents, such as a Selective Serotonin Re-uptake Inhibitor (SSRI) or a Serotonin Norepinephrine Re-uptake Inhibitor (SNRI) may cause serotonin toxicity. The symptoms of serotonin toxicity may include mental-status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood

pressure, hyperthermia), neuromuscular abnormalities (e.g., hyperreflexia, incoordination, rigidity), and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhoea). Oxycodone should be used with caution and the dosage may need to be reduced in patients using these medications.

Concomitant administration of oxycodone with anticholinergics or medicines with anticholinergic activity (e.g. tricyclic anti-depressants, antihistamines, antipsychotics, muscle relaxants, anti-Parkinson drugs) may result in increased anticholinergic adverse effects. Oxycodone should be used with caution and the dosage may need to be reduced in patients using these medications.

Monoamine oxidase inhibitors are known to interact with narcotic analgesics, producing CNS excitation or depression associated with hypertensive or hypotensive crisis (see section 4.4). Oxycodone should be used with caution in patients administered MAO-inhibitors or who have received MAO-inhibitors during the last two weeks (see section 4.4).

Alcohol may enhance the pharmacodynamic effects of ***OxyNorm***, concomitant use should be avoided.

Oxycodone is metabolised mainly by CYP3A4, with a contribution from CYP2D6. The activities of these metabolic pathways may be inhibited or induced by various co-administered drugs or dietary elements.

CYP3A4 inhibitors, such as macrolide antibiotics (e.g. clarithromycin, erythromycin and telithromycin), azol-antifungals (e.g. ketoconazole, voriconazole, itraconazole, and posaconazole), protease inhibitors (e.g. boceprevir, ritonavir, indinavir, nelfinavir and saquinavir), cimetidine and grapefruit juice may cause a reduced clearance of oxycodone that could cause an increase of the plasma concentrations of oxycodone. Therefore, the oxycodone dose may need to be adjusted accordingly.

Some specific examples are provided below:

- Itraconazole, a potent CYP3A4 inhibitor, administered 200 mg orally for five days, increased the AUC of oral oxycodone. On average, the AUC was approximately 2.4 times higher (range 1.5 - 3.4).
- Voriconazole, a CYP3A4 inhibitor, administered 200 mg twice-daily for four days (400 mg given as first two doses), increased the AUC of oral oxycodone. On average, the AUC was approximately 3.6 times higher (range 2.7 - 5.6).
- Telithromycin, a CYP3A4 inhibitor, administered 800 mg orally for four days, increased the AUC of oral oxycodone. On average, the AUC was approximately 1.8 times higher (range 1.3 – 2.3).
- Grapefruit Juice, a CYP3A4 inhibitor, administered as 200 ml three times a day for five days, increased the AUC of oral oxycodone. On average, the AUC was approximately 1.7 times higher (range 1.1 – 2.1).

CYP3A4 inducers, such as rifampicin, carbamazepin, phenytoin and St John´s Wort may induce the metabolism of oxycodone and cause an increased clearance of oxycodone that could cause a reduction of the plasma concentrations of oxycodone. The oxycodone dose may need to be adjusted accordingly.

Some specific examples are provided below:

- St Johns Wort, a CYP3A4 inducer, administered as 300 mg three times a day for fifteen days, reduced the AUC of oral oxycodone. On average, the AUC was approximately 50% lower (range 37-57%).
- Rifampicin, a CYP3A4 inducer, administered as 600 mg once-daily for seven days, reduced the AUC of oral oxycodone. On average, the AUC was approximately 86% lower

Drugs that inhibit CYP2D6 activity, such as paroxetine and quinidine, may cause decreased clearance of oxycodone which could lead to an increase in oxycodone plasma concentrations.

4.6 Fertility, pregnancy and lactation

Use of this medicinal product should be avoided to the extent possible in patients who are pregnant or lactating.
Pregnancy
There are limited data from the use of oxycodone in pregnant women. Infants born to mothers who have received opioids during the last 3 to 4 weeks before giving birth should be monitored for respiratory depression. Withdrawal symptoms may be observed in the newborn of mothers undergoing treatment with oxycodone.
Studies in rats and rabbits with oral doses of oxycodone equivalent to 3 and 47 times an adult human dose of 160 mg/day respectively, did not reveal evidence of harm to the foetus due to oxycodone.
Oxycodone penetrates the placenta. Oxycodone should not be used during pregnancy and labour due to impaired uterine contractility and the risk of neonatal respiratory depression.
Breast-feeding
Oxycodone may be secreted in breast milk and may cause respiratory depression in the newborn.
Oxycodone should therefore not be used in breastfeeding mothers.

4.7 Effects on ability to drive and use machines

Oxycodone may impair the ability to drive and use machines. Oxycodone may modify patients' reactions to a varying extent depending on the dosage and individual susceptibility. If affected, patients should not drive or operate machinery.

4.8 Undesirable effects

The most commonly reported adverse reactions are nausea and constipation, both occurring in approximately 25 to 30 % of patients. If nausea or vomiting are troublesome, oxycodone may be combined with an antiemetic. Constipation should be anticipated as with any strong opioid, and treated appropriately with laxatives. Should opioid related adverse events persist, they should be investigated for an alternative cause.

Adverse drug reactions are typical of full opioid agonists, and tend to reduce with time, with the exception of constipation. Anticipation of adverse drug reactions and appropriate patient management can improve acceptability.

The most serious adverse reaction, as with other opioids, is respiratory depression (see Overdose section). This is most likely to occur in elderly, debilitated or opioid-intolerant patients.

Adverse drug reactions seen during clinical trials and from spontaneous reports are listed below.

The following frequency categories form the basis for classification of the undesirable effects:

Term	Frequency
Very common	≥ 1/10
Common	≥ 1/100 to <1/10
Uncommon	≥ 1/1,000 to <1/100
Rare	≥1/10,000 to <1/1,000
Very rare	<1/10,000
Not known	Cannot be estimated from the available data

	Very Common	Common	Uncommon	Rare	Not known
Immune system disorders			hypersensitivity		anaphylactic responses
Endocrine disorders			syndrome of inappropriate antidiuretic hormone secretion (SIADH)		
Metabolism and nutrition disorders		decreased appetite	dehydration, weight fluctuation		
Psychiatric disorders		abnormal dreams, abnormal thinking, anxiety,	agitation, depersonalisation, affect lability, euphoric mood, hallucinations, decreased libido, drug dependence (see section 4.4)		aggression

	Very Common	Common	Uncommon	Rare	Not known
		confusional state, depression, insomnia, nervousness			
Nervous system disorders	somnolence, dizziness, headache	tremor, lethargy	amnesia, convulsion, hyperkinesia, hypertonia, hypoaesthesia, hypotonia, involuntary muscle contractions, speech disorder, stupor, paraesthesia, dysgeusia, syncope		hyperalgesia
Eye disorders			lacrimation disorder, miosis , visual impairment		
Ear and labyrinth disorders			tinnitus, vertigo		
Cardiac disorders			palpitations (in the context of withdrawal syndrome)		
Vascular disorders			vasodilatation	hypotension, orthostatic hypotension	
Respiratory, thoracic and mediastinal disorders		dyspnoea, bronchospasm	rhinitis, epistaxis, hiccup, voice alteration, respiratory depression		
Gastrointestinal disorders	constipation, nausea, vomiting	abdominal pain, diarrhoea, dry mouth, dyspepsia	dysphagia, flatulence, gastritis, mouth ulceration, eructation, gastrointestinal disorders, ileus, stomatitis		dental caries
Hepatobiliary disorders			hepatic enzyme increased		biliary colic, cholestasis
Skin and subcutaneous tissue disorders	pruritus	rash, hyperhidrosis	dry skin	urticaria	
Renal and urinary disorders		urinary disorders	urinary retention		
Reproductive system and breast disorders			erectile dysfunction, hypogonadism		amenorrhoea
General disorders and administration site conditions		asthenia, fever, fatigue	chills, chest pain, drug withdrawal syndrome, gait disturbance, malaise, oedema, peripheral oedema, drug tolerance, thirst		drug withdrawal syndrome neonatal

Tolerance may occur in patients treated with oxycodone, although this has not been a significant problem in the clinical trial programme. Patients requiring marked dose escalation should have their pain control regimen carefully reviewed.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie

4.9 Overdose

Acute overdose with oxycodone can be manifested by respiratory depression, somnolence progressing to stupor or coma, hypotonia, miosis, bradycardia, hypotension, pulmonary oedema and death.

Treatment of oxycodone overdose: A patent airway must be maintained. The pure opioid antagonists such as naloxone are specific antidotes against symptoms from opioid overdose. Other supportive measures should be employed as needed.

In the case of massive overdose, administer naloxone 0.8 mg intravenously. Repeat at 2-3 minute intervals as necessary, or by an infusion of 2 mg in 500 ml of normal saline or 5% dextrose (0.004 mg/ml).

The infusion should be run at a rate related to the previous bolus doses administered and should be in accordance with the patient's response. However, because the duration of action of naloxone is relatively short, the patient must be carefully monitored until spontaneous respiration is reliably reestablished.

For less severe overdose, administer naloxone 0.2 mg intravenously followed by increments of 0.1 mg every 2 minutes if required.

Naloxone should not be administered in the absence of clinically significant respiratory or circulatory depression secondary to oxycodone overdose. Naloxone should be administered cautiously to persons who are known, or suspected, to be physically dependent on oxycodone. In such cases, an abrupt or complete reversal of opioid effects may precipitate pain and an acute withdrawal syndrome.

Gastric contents may need to be emptied as this can be useful in removing unabsorbed drug.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Natural opium alkaloids
ATC code: N02A A05
Oxycodone is a full opioid agonist with no antagonist properties and has an affinity for kappa, mu and delta opiate receptors in the brain and spinal cord. The therapeutic effect is mainly analgesic, anxiolytic, antitussive and sedative. The mechanism of action involves CNS opioid receptors for endogenous compounds with opioid-like activity.

Gastrointestinal System
Opioids may induce spasm of the sphincter of Oddi.

Endocrine System
See section 4.4

Other Pharmacological Effects
In vitro and animal studies indicate various effects of natural opioids, such as morphine, on components of the immune system; the clinical significance of these findings is unknown. Whether oxycodone, a semi-synthetic opioid, has immunological effects similar to morphine is unknown.

5.2 Pharmacokinetic properties

Absorption
After administration of ***OxyNorm***capsules, peak oxycodone plasma concentrations are observed after approximately 1 hour (range 0.5 – 5.0 hours). Plasma concentrations increase in a dose linear manner for the 5-20 mg dosage range.

Oxycodone has a high absolute bioavailability of up to 87% following oral administration.

Distribution
Oxycodone is distributed throughout the entire body. Approximately 45% is bound to plasma protein.

Biotransformation
Oxycodone is metabolized in the liver via CYP3A4 and CYP2D6 to noroxycodone, oxymorphone and noroxymorphone, which are subsequently glucuronidated. Noroxycodone and noroxymorphone are the major circulating metabolites. Noroxycodone is a weak mu opioid agonist. Noroxymorphone is a potent mu opioid agonist; however, it does not cross the blood-brain barrier

to a significant extent. Oxymorphone is a potent mu opioid agonist but is present at very low concentrations following oxycodone administration. None of these metabolites are thought to contribute significantly to the analgesic effect of oxycodone.

Elimination
The plasma elimination half-life is approximately 4.5 hours. The active drug and its metabolites are excreted in both urine and faeces.

When compared to normal subjects, patients with mild to severe hepatic dysfunction may have higher plasma concentrations of oxycodone and noroxycodone, and lower plasma concentrations of oxymorphone. There may be an increase in the elimination half-life of oxycodone, and this may be accompanied by an increase in drug effects.

When compared to normal subjects, patients with mild to severe renal dysfunction may have higher plasma concentrations of oxycodone and its metabolites. There may be an increase in the elimination half-life of oxycodone, and this may be accompanied by an increase in drug effects.

5.3 Preclinical safety data

Reproductive and Developmental Toxicology
Oxycodone had no effect on fertility or early embryonic development in male and female rats at doses as high as 8 mg/kg/day. Also, oxycodone did not induce any malformations in rats at doses as high as 8 mg/kg/day or in rabbits at doses as high as 125 mg/kg/day. Dose-related increases in developmental variations (increased incidences of extra (27) presacral vertebrae and extra pairs of ribs) were observed in rabbits when the data for individual foetuses were analysed. However, when the same data were analysed using litters as opposed to individual foetuses, there was no dose-related increase in developmental variations although the incidence of extra presacral vertebrae remained significantly higher in the 125 mg/kg/day group compared to the control group. Since this dose level was associated with severe pharmacotoxic effects in the pregnant animals, the foetal findings may have been a secondary consequence of severe maternal toxicity.

In a prenatal and postnatal development study in rats, maternal body weight and food intake parameters were reduced for doses ≥2 mg/kg/day compared to the control group. Body weights were lower in the F1 generation from maternal rats in the 6 mg/kg/day dosing group.

Genotoxicity
The results of *in vitro* and *in vivo* studies indicate that the genotoxic risk of oxycodone to humans is minimal or absent at the systemic oxycodone concentrations that are achieved therapeutically. Oxycodone was not genotoxic in a bacterial mutagenicity assay or genotoxic in an *in vivo* micronucleus assay in the mouse. Oxycodone was genotoxic in the *in vitro* mouse lymphoma assay in the presence of rat liver S9 metabolic activation at dose levels greater than 25 µg/mL and two *in vitro* chromosomal aberrations assays with human lymphocytes provided equivocal results.

Carcinogenicity
Carcinogenicity was evaluated in a 2-year oral gavage study conducted in Sprague-Dawley rats. Oxycodone did not increase the incidence of tumours in male and female rats at doses up to 6 mg/kg/day. The doses were limited by opioid-related pharmacological effects of oxycodone.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Cellulose, microcrystalline
Magnesium stearate
Titanium dioxide (E171)
Iron oxide (E 172)
Indigo carmine (E132)
Sodium laurilsulfate
Gelatin

The capsules are printed with ink containing shellac, iron oxide (E172), and propylene glycol.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

Do not store above 25^{o}C.

6.5 Nature and contents of container

PVdC coated PVC blister packs with aluminium backing foil.
Polypropylene containers with polyethylene lids.
Pack size: 10, 28, 30, 56, 112 capsules.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

No special requirements.

7 MARKETING AUTHORISATION HOLDER

Mundipharma Pharmaceuticals Limited
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8 MARKETING AUTHORISATION NUMBER

PA1688/006/005

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

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10 DATE OF REVISION OF THE TEXT

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