

IRISH MEDICINES BOARD ACTS 1995 AND 2006

MEDICINAL PRODUCTS(CONTROL OF PLACING ON THE MARKET)REGULATIONS,2007

(S.I. No.540 of 2007)

PPA0465/089/001A

Case No: 2058942

The Irish Medicines Board in exercise of the powers conferred on it by the above mentioned Regulations hereby grants to

PCO Manufacturing Limited

Unit 10, Ashbourne Business Park, Rath, Ashbourne, Co. Meath, Ireland

an authorisation, subject to the provisions of the said Regulations, in respect of the product

Zyban 150 mg Prolonged Release Tablets

The particulars of which are set out in Part I and Part II of the attached Schedule. The authorisation is also subject to the general conditions as may be specified in the said Regulations as listed on the reverse of this document.

This authorisation, unless previously revoked, shall continue in force from **09/12/2008**.

Signed on behalf of the Irish Medicines Board this

A person authorised in that behalf by the said Board.

Part II

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Zyban 150 mg Prolonged Release Tablets.

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains bupropion hydrochloride 150mg.

For a full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Prolonged Release Tablet

Product sourced from Belgium and the United Kingdom.

White, film-coated, biconvex, round tablet, printed on one side with 'GX CH7' and plain on the other side.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Zyban tablets are indicated as an aid to smoking cessation in combination with motivational support in nicotine-dependent patients.

4.2 Posology and method of administration

Zyban should be used in accordance with smoking cessation guidelines.

Prescribers should assess the patient's motivation to quit. Smoking cessation therapies are more likely to succeed in those patients whom are motivated to quit and have motivational support.

Zyban tablets should be swallowed whole and not crushed or chewed.

Patients should be treated for 7–9 weeks.

Although discontinuation reactions are not expected with Zyban, a tapering-off period may be considered.

If at seven weeks no effect is seen, treatment should be discontinued.

Use in Adults

It is recommended that treatment is started while the patient is still smoking and a "target stop date" set within the first two weeks of treatment with Zyban, preferably in the second week.

The initial dose is 150mg to be taken daily for six days, increasing on day seven to 150mg twice daily.

There should be an interval of at least 8 hours between successive doses. The maximum single dose must not exceed 150mg and the maximum total daily dose must not exceed 300mg.

Insomnia is a very common adverse event which can be reduced by avoiding bedtime doses of Zyban (provided there is at least 8 hours between doses).

Use in Children and Adolescents

Use in patients under 18 years of age is not recommended as the safety and efficacy of Zyban tablets have not been evaluated in these patients.

Use in Elderly Patients

Zyban should be used with caution in elderly patients. Greater sensitivity in some elderly individuals cannot be ruled out. The recommended dose in the elderly is 150mg once a day.

Use in Patients with Hepatic Insufficiency

Zyban should be used with caution in patients with hepatic impairment.

Because of increased variability in the pharmacokinetics in patients with mild to moderate impairment the recommended dose in these patients is 150mg once a day.

Use in Patients with Renal Insufficiency

Zyban should be used with caution in patients with renal insufficiency. The recommended dose in these patients is 150mg once a day.

4.3 Contraindications

Zyban is contraindicated in patients with hypersensitivity to bupropion or any of the excipients.

Zyban is contraindicated in patients with a current seizure disorder or any history of seizures.

Zyban is contraindicated in patients with a known central nervous system (CNS) tumour.

Zyban is contraindicated in patients who, at any time during treatment, are undergoing abrupt withdrawal from alcohol or any medicinal product known to be associated with risk of seizures on withdrawal (in particular benzodiazepines and benzodiazepine-like agents).

Zyban is contraindicated in patients with a current or previous diagnosis of bulimia or anorexia nervosa.

Zyban is contraindicated for use in patients with severe hepatic cirrhosis.

Concomitant use of Zyban and monoamine oxidase inhibitors (MAOIs) is contraindicated. At least 14 days should elapse between discontinuation of irreversible MAOIs and initiation of treatment with Zyban. For reversible MAOIs, a 24 period is sufficient.

Zyban is contraindicated in patients with a history of bipolar disorder as it may precipitate a manic episode during the depressed phase of their illness.

4.4 Special warnings and precautions for use***Seizures***

The recommended dose of Zyban should not be exceeded, since bupropion is associated with a dose-related risk of seizure. At doses up to the maximum recommended daily dose (300mg of Zyban daily), the incidence of seizures is approximately 0.1% (1/1,000).

There is an increased risk of seizures occurring with the use of Zyban, which appears to be strongly associated with the presence of predisposing risk factors which lower the seizures threshold. Zyban must not be used in patients with predisposing risk factors unless there is a compelling clinical justification for which the potential medical benefit of smoking cessation outweighs the potential increased risk of seizure. In these patients, a maximum dose of 150mg daily should be considered for the duration of treatment.

All patients should be assessed for predidposing risk factors, which include:

- o history of head trauma
- o diabetes treated with hypoglycaemics or insulin
- o alcohol abuse (*see section 4.3, Contraindications*)
- o diabetes treated with hypoglycaemics or insulin
- o Concomitant administration of other medicinal products known to lower the seizure threshold (e.g. antipsychotics, antidepressants, antimalarials, tramadol, theophylline, systemic steroids, quinolones and sedating antihistamines). For patients prescribed such medicinal products whilst taking Zyban, a maximum dose of 150mg daily for the remainder of their treatment should be considered.

Zyban should be discontinued and not recommenced in patients who experience a seizure while on treatment.

Interactions (*see section, 4.5 Interaction with other medicinal products and other forms of interaction*).

Due to pharmacokinetic interactions plasma levels of bupropion or its metabolites may be altered, which may increase the potential for undesirable effects (e.g. dry mouth, insomnia, seizures). Therefore care should be taken when bupropion is given concomitantly with medicinal products which can induce or inhibit the metabolism of bupropion .

Bupropion inhibits metabolism by cytochrome P450 2D6. Caution is advised when medicinal products metabolised by this enzyme are administered concomitantly.

Neuropsychiatry

Zyban is a centrally-acting noreadrenaline/dopamine reuptake inhibitor and as such the pharmacology resembles that of some antidepressants.

Neuropsychiatric reactions have been reported (*see 4.8 Undesirable Effects*). In particular, psychotic and manic symptomatology have been reported mainly in patients with a known history of psychiatric illness.

Depressed mood may be a symptom of nicotine withdrawal. Depression, rarely including suicidal ideation, has been reported in patients undergoing a smoking cessation attempt.

These symptoms have also been reported during Zyban treatment, and generally occurred early during the treatment course. Clinicians should be aware of the possible emergence of significant depressive symptomatology in patients undergoing a smoking cessation attempt, and should advise patients accordingly.

Data in animals suggest a potential for drug abuse. However, studies on abuse liability in humans and extensive clinical experience show that bupropion has low abuse potential.

Hypersensitivity

Zyban should be discontinued if patients experience hypersensitivity or anaphylactic reactions during treatment. Clinicians should be aware that symptoms may progress or recur following the discontinuation of Zyban and should ensure symptomatic treatment is administered for an adequate length of time (at least one week). Symptoms typically include skin rash, pruritus, urticaria or chest pain but more severe reactions may include angioedema, dyspnoea/bronchospasm, anaphylactic shock, erythema multiforme or Stevens-Johnson Syndrome. Arthralgia, myalgia and fever have also been reported in association with rash and other symptoms suggestive of delayed hypersensitivity. These symptoms may resemble serum sickness (*See 4.8 Undesirable Effects*). In most patients symptoms improved after stopping bupropion and initiating treatment with antihistamine or corticosteroids, and resolved over time.

Hypertension

In clinical practice, hypertension, which in some cases may be severe (*see 4.8 Undesirable Effects*) and require acute treatment, has been reported in patients receiving bupropion alone and in combination with nicotine replacement therapy. This has been observed in patients with and without pre-existing hypertension. A baseline blood pressure should be obtained at the start of treatment with subsequent monitoring, especially in patients with pre-existing hypertension. Consideration should be given to discontinuation of Zyban if a clinically significant increase in blood pressure is observed.

Limited clinical trial data suggest that higher smoking cessation rates may be achieved by the combination use of Zyban together with Nicotine Transdermal Systems (NTS). However, a higher rate of treatment-emergent hypertension was noted in the combination therapy group. If combination therapy with a NTS is used, caution must be exercised and weekly monitoring of blood pressure is recommended. Prior to initiation of combination therapy prescribers should consult the prescribing information of the relevant NTS.

Specific patient groups

Elderly – Clinical experience with bupropion has not identified any differences in tolerability between elderly and other adult patients. However, greater sensitivity of some elderly individuals cannot be ruled out. Elderly patients are more likely to have decreased renal function, hence 150 mg once a day is the recommended dose in these patients.

Hepatically-impaired - Bupropion is extensively metabolised in the liver to active metabolites, which are further metabolised. No statistically significant differences in the pharmacokinetics of bupropion were observed in patients with mild to moderate hepatic cirrhosis compared with healthy volunteers, but bupropion plasma levels showed a higher variability between individual patients. Therefore Zyban should be used with caution in patients with mild to moderate hepatic impairment and 150mg once a day is the recommended dose in these patients.

All patients with hepatic impairment should be closely monitored for possible undesirable effects (e.g., insomnia, dry mouth, seizures) that could indicate high drug or metabolite levels.

Renally-impaired - Patients with impaired renal function were not studied. Bupropion is mainly excreted into urine as its metabolites. Therefore 150 mg once a day is the recommended dose in patients with renal impairment, as bupropion and its metabolites may accumulate in such patients to a greater extent than usual. The patient should be closely monitored for possible undesirable effects that could indicate high drug or metabolite levels.

4.5 Interaction with other medicinal products and other forms of interaction

In patients receiving medicinal products known to lower seizure threshold, Zyban must only be used if there is a compelling clinical justification for which the potential medical benefit of smoking cessation outweighs the increased risk of seizure (see 4.4 *Special Warnings and Precautions for Use*)

The effect of bupropion on other medicinal products:

Although not metabolised by the CYP2D6 isoenzyme, bupropion and its main metabolite, hydroxybupropion, inhibit the CYP2D6 pathway, as shown by in vitro studies. In a human pharmacokinetic study, co-administration of bupropion hydrochloride and desipramine to healthy volunteers known to be extensive metabolisers of the CYP2D6 isoenzyme resulted in large (2- to 5-fold) increases in the C_{max} and AUC of desipramine. Inhibition of CYP2D6 was present for at least 7 days after the last dose of bupropion hydrochloride.

Although not formally studied, concomitant therapy with medicinal products with narrow therapeutic indices that are predominantly metabolised by CYP2D6 should be initiated at the lower end of the dose range of the concomitant medicinal product. Such medicinal products include certain antidepressants (e.g. desipramine, imipramine, paroxetine), antipsychotics (e.g. risperidone, thioridazine), beta-blockers (e.g. metoprolol), and Type 1C antiarrhythmics (e.g. propafenone, flecainide) should be initiated at the lower end of the dose range of the concomitant medicinal product. If Zyban is added to the treatment regimen of a patient already receiving a medicinal product metabolised by CYP2D6, the need to decrease the dose of the original medicinal product should be considered, particularly for those concomitant medicinal products with a narrow therapeutic index. In these cases the expected benefit of treatment with Zyban should be carefully considered compared with the potential risks.

The effect of other medicinal products on bupropion:

In vitro findings indicate that bupropion is metabolised to its major active metabolite hydroxybupropion primarily by the cytochrome P450 CYP2B6 (see 5.2 Pharmacokinetic Properties). Care should therefore be exercised when Zyban is co-administered with medicinal products known to affect the CYP2B6 isoenzyme (e.g.: orphenadrine, cyclophosphamide, ifosfamide).

Since bupropion is extensively metabolised, caution is advised when bupropion is co-administered with medicinal products known to induce metabolism (e.g. carbamazepine, phenytoin) or inhibit metabolism (e.g. valproate), as these may affect its clinical efficacy and safety.

Nicotine, administered transdermally by patches did not affect the pharmacokinetics of bupropion and its metabolites.

Other interactions:

Smoking is associated with an increase in CYP1A2 activity. After cessation of smoking, reduced clearance of medicinal products metabolised by this enzyme may occur. This may result in increased plasma levels of these medicinal products, which may be particularly important for those primarily metabolised by CYP1A2 with narrow therapeutic windows (e.g. theophylline, tacrine and clozapine). The clinical consequences of smoking cessation on other medicinal products that are partially metabolised by CYP1A2 (e.g. imipramine, olanzapine, clomipramine and fluvoxamine) are unknown. In addition, limited data indicate that the metabolism of flecainide or pentazocine may also be induced by smoking.

Administration of Zyban to patients receiving levodopa or amantadine concurrently should be undertaken with caution. Limited clinical data suggest a higher incidence of undesirable effects (e.g. nausea, vomiting and neuropsychiatric events including excitement, restlessness and postural tremor) in patients receiving concurrent administration of bupropion and levodopa or amantadine.

Concomitant use of Zyban with other medicinal products metabolised by the CYP2D6 isoenzyme has not been formally studied. Therefore, concomitant therapy with medicinal products predominantly metabolised by this isoenzyme with narrow therapeutic indices.

Bupropion did not influence the pharmacokinetics of lamotrigine or its glucuronide metabolite when administered concomitantly.

Although clinical data do not identify a pharmacokinetic interaction between bupropion and alcohol, there have been rare reports of adverse neuropsychiatric events or reduced alcohol tolerance in patients drinking alcohol during Zyban treatment. The consumption of alcohol during Zyban treatment should be minimised or avoided.

Since monoamine oxidase A and B inhibitors also enhance the catecholaminergic pathways, by a different mechanism from bupropion, concomitant use of Zyban and monoamine oxidase inhibitors (MAOIs) is contraindicated (*see section 4.3 Contraindications*) as there is an increase possibility of adverse reactions from their co-administration. At least 14 days should elapse between discontinuation of irreversible MAOIs and initiation of treatment with Zyban. For reversible MAOIs, a 24 hour period is sufficient.

4.6 Pregnancy and lactation

The safety of Zyban for use in human pregnancy has not been established.

Evaluation of experimental animal studies does not indicate direct or indirect harmful effects with respect to the development of the embryo or foetus, the course of gestation and peri-natal or post-natal development. Exposure in animals was, however, similar to the systemic exposure achieved in humans at the maximum recommended dose. The potential risk in humans is unknown.

Pregnant women should be encouraged to quit smoking without the use of pharmacotherapy. Zyban should not be used in pregnancy.

As bupropion and its metabolites are excreted in human breast milk mothers should be advised not to breast feed while taking Zyban.

4.7 Effects on ability to drive and use machines

As with other CNS acting drugs bupropion may affect ability to perform tasks that require judgement or motor and cognitive skills. Zyban has also been reported to cause dizziness and lightheadedness. Patients should therefore exercise caution before driving or use of machinery until they are reasonably certain Zyban does not adversely affect their performance.

4.8 Undesirable effects

The list below provides information on the undesirable effects identified from clinical experience, categorised by incidence and body system. It is important to note that smoking cessation is often associated with nicotine withdrawal symptoms (e.g. agitation, insomnia, tremor, sweating), some of which are also recognised as adverse events associated with Zyban. In addition, depressed mood, a symptom of nicotine withdrawal, rarely including suicidal ideation may occur during a smoking cessation attempt.

Undesirable effects are ranked under headings of frequency using the following convention:

- very common: >1/10
- common: >1/100, <1/10
- uncommon: >1/1000, <1/100
- rare: >1/10000, <1/1000

Cardiovascular	Uncommon	Tachycardia, increased blood pressure (sometimes severe), flushing
	Rare	Vasodilation, postural hypotension, syncope, palpitations
CNS	Very common	Insomnia (<i>see section 4.2 Posology and Method of Administration</i>)
	Common	Tremor, concentration disturbance, headache, dizziness, depression (<i>see section 4.4 Special Warnings and Precautions for Use</i>), agitation, anxiety.
	Uncommon	Confusion
	Rare	Seizures (see below), irritability, hostility, hallucinations, depersonalisation, dystonia, ataxia, Parkinsonism, twitching, incoordination, abnormal dreams including nightmares, memory impairment, paraesthesia.
Endocrine and metabolic	Uncommon	Anorexia
	Rare	Blood glucose disturbances

Gastrointestinal	Common	Dry mouth, gastrointestinal disturbance including nausea and vomiting, abdominal pain, constipation
Genitourinary	Rare	Urinary frequency and/or retention
General (body)	Common	Fever
	Uncommon	Chest pain, asthenia
Hepatobiliary	Rare	Elevated liver enzymes, jaundice, hepatitis
Skin/ hypersensitivity	Common	Rash, pruitus, sweating. Hypersensitivity reactions such as urticaria.
	Rare	More severe hypersensitivity reactions including angioedema, dyspnoea/bronchospasm and anaphylactic shock. Arthralgia, myalgia and fever have also been reported in association with rash and other symptoms suggestive of delayed hypersensitivity. These symptoms may resemble serum sickness. Erythema multiforme and Stevens-Johnson syndrome have also been reported. Exacerbation of psoriasis.
Special senses	Common	Taste disorders
	Uncommon	Tinnitus, visual disturbance.

The incidence of seizures is approximately 0.1% (1/1,000). The most common type of seizures is generalized tonic-clonic seizures, a seizure type which can result in some cases in post-ictal confusion or memory impairment. (See section 4.4. *Special Warnings and Precautions for Use*).

4.9 Overdose

Acute ingestion of doses in excess of 10 times the maximum therapeutic dose has been reported. In addition to those events reported as Undesirable Effects, overdose has resulted in symptoms including drowsiness, hallucinations and loss of consciousness. Although most patients recovered without sequelae, deaths associated with overdoses of bupropion have been reported rarely in patients ingesting massive doses of the drug.

Treatment: In the event of overdose, hospitalisation is advised.

Ensure an adequate airway, oxygenation and ventilation. Gastric lavage may be indicated if performed soon after ingestion. The use of activated charcoal is also recommended. No specific antidote for bupropion is known.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: drugs used in nicotine dependence, ATC code: N07B A02

Bupropion is a selective inhibitor of the neuronal re-uptake of catecholamines (noradrenaline and dopamine) with minimal effect on the re-uptake of indolamines (serotonin) and does not inhibit either monoamine oxidase. The mechanism by which bupropion enhances the ability of patients to abstain from smoking is unknown.

However, it is presumed that this action is mediated by noradrenergic and/or dopaminergic mechanisms.

5.2 Pharmacokinetic properties

Absorption

After oral administration of 150 mg bupropion hydrochloride as a prolonged release tablet to healthy volunteers, maximum plasma concentrations (C_{max}) of approximately 100 nanograms per ml are observed after about 2.5 to 3 hours. The AUC and C_{max} values of bupropion and its active metabolites hydroxybupropion and threohydrobupropion increase dose proportionally over a dose range of 50-200 mg following single dosing and over a dose range of 300-450 mg/day following chronic dosing. The C_{max} and AUC values of hydroxybupropion are approximately 3 and 14 times higher, respectively, than bupropion C_{max} and AUC values. The C_{max} of threohydrobupropion is comparable with the C_{max} of bupropion, while the AUC of threohydrobupropion is approximately 5 times higher than that of bupropion. Peak plasma levels of hydroxybupropion and threohydrobupropion are reached after about 6 hours following administration of a single dose of bupropion. Plasma levels of erythrohydrobupropion (an isomer of threohydrobupropion, which is also active) are not quantifiable after single dosing with bupropion.

After chronic dosing with bupropion 150 mg bid, the C_{max} of bupropion is similar to values reported after single dosing. For hydroxybupropion and threohydrobupropion, the C_{max} values are higher (about 4 and 7 times respectively) at steady-state than after a single dosing. Plasma levels of erythrohydrobupropion are comparable to steady-state plasma levels of bupropion. Steady-state of bupropion and its metabolites is reached within 5-8 days. The absolute bioavailability of bupropion is not known; excretion data in urine, however, show that at least 87% of the dose of bupropion is absorbed. The absorption of bupropion is not significantly influenced when taken concurrently with food.

Distribution

Bupropion is widely distributed with an apparent volume of distribution of approximately 2000 L. Bupropion, hydroxybupropion and threohydrobupropion bind moderately to plasma proteins (84%, 77% and 42%, respectively).

Bupropion and its active metabolites are excreted in human breast milk. Animal studies show that bupropion and its active metabolites pass the blood-brain barrier and the placenta.

Metabolism

Bupropion is extensively metabolised in humans. Three pharmacologically active metabolites have been identified in plasma: hydroxybupropion and the amino-alcohol isomers, threohydrobupropion and erythrohydrobupropion. These may have clinical importance, as their plasma concentrations are as high or higher than those of bupropion. The active metabolites are further metabolised to inactive metabolites (some of which have not been fully characterised but may include conjugates) and excreted in the urine.

In vitro studies indicate that bupropion is metabolised to its major active metabolite hydroxybupropion primarily by the CYP2B6, while CYP1A2, 2A6, 2C9, 3A4 and 2E1 are less involved. In contrast, formation of threohydrobupropion involves carbonyl reduction but does not involve cytochrome P450 isoenzymes. (See 4.5 Interaction with Other Medicinal Products and Other Forms of Interaction)

The inhibition potential of threohydrobupropion and erythrohydrobupropion towards cytochrome P450 has not been studied.

Bupropion and hydroxybupropion are both inhibitors of the CYP2D6 isoenzyme with K_i values of 21 and 13.3 μM , respectively (*See section, 4.5 Interaction with Other Medicinal Products and Other Forms of Interaction*). Following oral administration of a single 150-mg dose of bupropion, there was no difference in C_{max} , half-life, T_{max} , AUC, or clearance of bupropion or its major metabolites between smokers and non-smokers. Bupropion has been shown to induce its own metabolism in animals following sub-chronic administration. In humans, there is no evidence of enzyme induction of bupropion or hydroxybupropion in volunteers or patients receiving recommended doses of bupropion hydrochloride for 10 to 45 days.

Elimination

Following oral administration of 200mg of ^{14}C -bupropion in humans, 87% and 10% of the radioactive dose were recovered in the urine and faeces, respectively. The fraction of the dose of bupropion excreted unchanged was only 0.5%, a finding consistent with the extensive metabolism of bupropion. Less than 10% of this ^{14}C dose was accounted for in the urine as active metabolites.

The mean apparent clearance following oral administration of bupropion hydrochloride is approximately 200 L/hr and the mean elimination half-life of bupropion is approximately 20 hours.

The elimination half-life of hydroxybupropion is approximately 20 hours. The elimination half-lives for threohydrobupropion and erythrohydrobupropion are longer (37 and 33 hours, respectively).

Special Patient Groups:

Patients with renal impairment

The effect of renal disease on the pharmacokinetics of bupropion has not been studied. The elimination of the major metabolites of bupropion may be affected by reduced renal function. (*See section, 4.4 Special Warnings and Precautions for Use*).

Patients with hepatic impairment

The pharmacokinetics of bupropion and its active metabolites were not statistically significantly different in patients with mild to moderate cirrhosis when compared to healthy volunteers, although more variability was observed between individual patients (*see section, 4.4 Special Warnings And Precautions for Use*). For patients with severe hepatic cirrhosis, the bupropion C_{max} and AUC were substantially increased (mean difference approximately 70% and 3-fold, respectively) and more variable when compared to the values in healthy volunteers; the mean half-life was also longer (by approximately 40%). For hydroxybupropion, the mean C_{max} was lower (by approximately 70%), the mean AUC tended to be higher (by approximately 30%), the median T_{max} was later (by approximately 20 hrs), and the mean half-lives were longer (by approximately 4-fold) than in healthy volunteers. For threohydrobupropion and erythrohydrobupropion, the mean C_{max} tended to be lower (by approximately 30%), the mean AUC tended to be higher (by approximately 50%), the median T_{max} was later (by approximately 20 hrs), and the mean half-life was longer (by approximately 2-fold) than in healthy volunteers (*see section, 4.3 Contraindications*).

Elderly patients

Pharmacokinetic studies in the elderly have shown variable results. A single dose study showed that the pharmacokinetics of bupropion and its metabolites in the elderly do not differ from those in the younger adults. Another pharmacokinetic study, single and multiple dose, has suggested that accumulation of bupropion and its metabolites may occur to a greater extent in the elderly. Clinical experience has not identified differences in tolerability between elderly and younger patients, but greater sensitivity in older patients cannot be ruled out (*see section, 4.4 Special Warnings and Precautions for Use*).

5.3 Preclinical safety data

In animal experiments bupropion doses several times higher than therapeutic doses in humans caused, amongst others, the following dose-related symptoms: ataxia and convulsions in rats, general weakness, trembling and emesis in dogs and increased lethality in both species. Due to enzyme induction in animals but not in humans, systemic exposures in animals were similar to the systemic exposures seen in humans at the maximum recommended dose.

Liver changes are seen in animal studies but these reflect the action of a hepatic enzyme inducer. At recommended doses in humans, bupropion does not induce its own metabolism. This suggests that the hepatic findings in laboratory animals have only limited importance in the evaluation and risk assessment of bupropion.

Genotoxicity data indicate that bupropion is a weak bacterial mutagen, but not a mammalian mutagen, and therefore is of no concern as a human genotoxic agent. Mouse and rat studies confirm the absence of carcinogenicity in these species.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Microcrystalline cellulose

Hypromellose

Cysteine hydrochloride monohydrate

Magnesium stearate

Film coat

Hypromellose

Macrogol 400

Titanium dioxide (E171)

Carnauba wax (as polish)

Printing ink

Iron oxide black (E172)

Hypromellose

6.2 Incompatibilities

Not applicable.

6.3 Shelf Life

The shelf-life expiry date of this product is the date shown on the container and outer package of the product on the market in the country of origin.

6.4 Special precautions for storage

Do not store above 25°C.

Store in the original package.

6.5 Nature and contents of container

Blister packs containing 60, or 100 tablets contained in an outer cardboard carton.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal of a used medicinal product or waste materials derived from such medicinal product and other handling of the product

No special requirements.

7 MARKETING AUTHORISATION HOLDER

PCO Manufacturing Limited
Unit 10, Ashbourne Business Park
Rath
Ashbourne
Co. Meath
Ireland

8 MARKETING AUTHORISATION NUMBER

PPA 0465/089/001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 13 September 2002

Date of last renewal: 13 September 2007

10 DATE OF REVISION OF THE TEXT

December 2008