

PRODUCT MONOGRAPH

^{Pr}VAN-Fluoxetine

10 mg and 20 mg fluoxetine hydrochloride capsules BP

Antidepressant / Antiobsessional / Antibulimic

Manufacturer and Distributor:

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Table of Contents

PART I: HEALTH PROFESSIONAL INFORMATION	3
SUMMARY PRODUCT INFORMATION.....	3
INDICATIONS AND CLINICAL USE	3
CONTRAINDICATIONS	4
WARNINGS AND PRECAUTIONS	5
ADVERSE REACTIONS.....	14
DRUG INTERACTIONS	25
DOSAGE AND ADMINISTRATION	30
OVERDOSAGE	32
ACTION AND CLINICAL PHARMACOLOGY	34
STORAGE AND STABILITY.....	36
DOSAGE FORMS, COMPOSITION AND PACKAGING	36
PART II: SCIENTIFIC INFORMATION.....	38
PHARMACEUTICAL INFORMATION.....	38
CLINICAL TRIALS.....	39
DETAILED PHARMACOLOGY	41
TOXICOLOGY	42
REFERENCES.....	47
PART III: CONSUMER INFORMATION.....	51

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PART I: HEALTH PROFESSIONAL INFORMATION

SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	Nonmedicinal Ingredients
oral	capsules / 10 mg and 20 mg	<p>VAN-Fluoxetine 10 mg and 20 mg contains colloidal anhydrous silica, magnesium stearate, pregelatinised starch and purified talc.</p> <p>The capsule shells contain:</p> <p><u>10 mg</u>: black ink (black iron oxide, butyl alcohol, dehydrated alcohol, isopropyl alcohol, potassium hydroxide, propylene glycol, shellac, strong ammonia solution), FD & C Blue no. 1, gelatin, iron oxide yellow and titanium dioxide.</p> <p><u>20 mg</u>: black ink (black iron oxide, butyl alcohol, dehydrated alcohol, isopropyl alcohol, potassium hydroxide, propylene glycol, shellac, strong ammonia solution), erythrosine, gelatin, indigo carmine, quinoline yellow and titanium dioxide.</p>

INDICATIONS AND CLINICAL USE

Adults

Depression

VAN-Fluoxetine (fluoxetine) are indicated for the symptomatic relief of Major Depressive Disorder (MDD).

Bulimia Nervosa

Fluoxetine capsules have been shown to significantly decrease binge-eating and purging activity when compared with placebo treatment.

Obsessive-Compulsive Disorder

VAN-Fluoxetine are indicated for the symptomatic treatment of obsessive-compulsive disorder (OCD).

The obsessions or compulsions must be experienced as intrusive, markedly distressing, time consuming, or interfering significantly with the person's social or occupational functioning.

The efficacy of fluoxetine capsules in hospitalized patients has not been adequately studied.

Long-term use of VAN-Fluoxetine: The effectiveness of fluoxetine in long-term use in bulimia nervosa (i.e. for more than 16 weeks) and in obsessive-compulsive disorder (i.e. for more than 13 weeks) has not been systematically evaluated in controlled trials. Therefore, the

physician who elects to use VAN-Fluoxetine in these indications for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

Geriatrics (≥60 years of age): Evidence from clinical studies and experience suggests that use in the geriatric population may be associated with differences in safety or effectiveness, and a brief discussion can be found in the appropriate sections (WARNINGS AND PRECAUTIONS, Special Populations, Geriatrics; DOSAGE AND ADMINISTRATION).

Pediatrics (<18 years of age): VAN-Fluoxetine are not indicated for use in patients below the age of 18 years. See WARNINGS AND PRECAUTIONS, General, Potential Association with Behavioural and Emotional Changes, including Self-Harm; see also ADVERSE REACTIONS, Potential for Effects on Growth in Pediatric Patients.

CONTRAINDICATIONS

Hypersensitivity – Fluoxetine is contraindicated in patients with known hypersensitivity to the drug or the excipients of the product. For a complete listing, see DOSAGE FORMS, COMPOSITION AND PACKAGING section.

Monoamine Oxidase Inhibitors - In patients receiving serotonin reuptake inhibitors (SSRIs) in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions (including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma). These reactions have also been reported in patients who have recently discontinued SSRI treatment and then started treatment on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome (e.g., serotonin syndrome). VAN-Fluoxetine should not be used in combination with an MAOI (including the antibiotic linezolid and the thiazine dye methylthioninium chloride (methylene blue) which are less well-known examples of MAOIs) or within 14 days of discontinuing therapy with an MAOI.

Since fluoxetine and its major metabolite have very long elimination half-lives, at least 5 weeks should elapse after discontinuing treatment with fluoxetine before starting an MAOI. Limited reports suggest that intravenously administered dantrolene (Dantrium[®]) or orally administered cyproheptadine (Periactin[®]) may benefit patients experiencing such reactions. See DRUG INTERACTIONS section.

Thioridazine - Thioridazine should not be administered concomitantly with VAN-Fluoxetine or within a minimum of 5 weeks after VAN-Fluoxetine have been discontinued, nor should VAN-Fluoxetine be administered within 2 weeks after thioridazine has been discontinued.

Thioridazine administration alone produces prolongation of the QTc interval, which is associated with serious ventricular arrhythmias, such as torsades de pointes-type arrhythmias, and sudden death. This effect appears to be dose-related.

An *in vivo* study suggests that drugs which inhibit P4502D6 including certain SSRI's such as paroxetine, fluoxetine and fluvoxamine, will elevate plasma levels of thioridazine. Therefore, fluoxetine should not be used in combination with thioridazine. See DRUG INTERACTIONS

section.

WARNINGS AND PRECAUTIONS

General

POTENTIAL ASSOCIATION WITH BEHAVIOURAL AND EMOTIONAL CHANGES, INCLUDING SELF-HARM

Pediatrics - Placebo-Controlled Clinical Trial Data

Recent analyses of placebo-controlled clinical trial safety databases from selective serotonin reuptake inhibitors (SSRIs) and other newer anti-depressants suggests that use of these drugs in patients under the age of 18 may be associated with behavioural and emotional changes, including an increased risk of suicidal ideation and behaviour over that of placebo.

The small denominators in the clinical trial database, as well as the variability in placebo rates, preclude reliable conclusions on the relative safety profiles among these drugs.

Adults and Pediatrics - Additional data

There are clinical trial and post-marketing reports with SSRIs and other newer anti-depressants, in both pediatrics and adults, of severe agitation-type adverse events coupled with self-harm or harm to others. The agitation-type events include: akathisia, agitation, disinhibition, emotional lability, hostility, aggression, depersonalization. In some cases, the events occurred within several weeks of starting treatment.

Rigorous clinical monitoring for suicidal ideation or other indicators of potential for suicidal behaviour is advised in patients of all ages. This includes monitoring for agitation-type emotional and behavioural changes.

An FDA meta-analysis of placebo-controlled clinical trials of antidepressant drugs in adult patients ages 18 to 24 years with psychiatric disorders showed an increased risk of suicidal behavior with antidepressants compared to placebo.

Families and caregivers of patients being treated with VAN-Fluoxetine should be alerted about the need to monitor patients for the emergence of agitation, anxiety, panic attacks, hostility, irritability, hypomania or mania, unusual changes in behaviour, and other symptoms, as well as the emergence of suicidality particularly within several weeks of starting treatment or changing the dose. Such symptoms should be reported immediately to healthcare providers. Such monitoring should include daily observation by families and caregivers.

Discontinuation Symptoms

Patients currently taking SSRIs or newer anti-depressants should NOT be discontinued abruptly, due to risk of discontinuation symptoms. Fluoxetine has only rarely been associated with such symptoms. At the time that a medical decision is made to discontinue an SSRI or other newer anti-depressant drug, a gradual reduction in the dose rather than an abrupt cessation, except for fluoxetine, is recommended. Plasma fluoxetine and norfluoxetine concentrations decrease gradually at the conclusion of therapy which makes dose tapering unnecessary in most patients taking this drug (see WARNINGS AND

PRECAUTIONS, Dependence; and ADVERSE REACTIONS, Adverse Events Subsequent to Discontinuation section; and DOSAGE AND ADMINISTRATION, Discontinuation of Treatment section).

Implications of the Long Elimination Half-Life of Fluoxetine:

Because of the long elimination half-lives of fluoxetine and its major active metabolite norfluoxetine, changes in dose will not be fully reflected in plasma for several weeks, affecting both strategies for titration to final dose and withdrawal from treatment (see ACTION AND CLINICAL PHARMACOLOGY; and DOSAGE AND ADMINISTRATION sections). Even when dosing is stopped, active drug substance will persist in the body for weeks due to the long elimination half-lives of fluoxetine and norfluoxetine. This is of potential consequence when drug discontinuation is required or when drugs are prescribed that might interact with fluoxetine and norfluoxetine following discontinuation of fluoxetine.

Use of Fluoxetine in Pregnant Women: Effects on Newborns:

Results of a number of epidemiological studies of pregnancy outcomes following early maternal exposure to antidepressants have been inconsistent, but there is some evidence of a possible small increase in the risk of cardiac malformations (eg ventricular and septal defects) associated with use of fluoxetine. The mechanism is unknown. The use of VAN-Fluoxetine during pregnancy should be considered only if the potential benefit justifies the potential risk to the fetus taking into account the risks associated with untreated depression.

Post-marketing reports indicate that some neonates exposed to fluoxetine, other SSRIs (selective serotonin reuptake inhibitors), or newer anti-depressants late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. When treating a pregnant woman with VAN-Fluoxetine during the third trimester, the physician should carefully consider the potential risks and benefits of treatment. See WARNINGS AND PRECAUTIONS, Special Populations, Pregnant Women; and DOSAGE AND ADMINISTRATION sections.

Weight Change:

Significant weight loss, especially in underweight depressed patients and the elderly, may be an undesirable result of treatment with VAN-Fluoxetine. VAN-Fluoxetine should be given with caution to patients suffering from anorexia nervosa and only if the expected benefits (e.g. comorbid depression) markedly outweigh the potential weight reducing effect of the drug.

Psychomotor Impairment:

Patients should be cautioned against driving an automobile or performing hazardous tasks until they are reasonably certain that treatment with VAN-Fluoxetine do not affect them adversely.

Allergic Reactions (Rash and Accompanying Events):

During premarketing testing, 7% of 10,782 patients developed various types of rashes and/or urticaria. Among these cases, almost a third were withdrawn from treatment because of the rash and/or systemic signs or symptoms associated with the rash. Clinical findings reported in association with these allergic reactions include rash, fever, leukocytosis, arthralgias, edema, carpal tunnel syndrome, respiratory distress, lymphadenopathy, proteinuria, and mild transaminase elevation. Most patients improved promptly with discontinuation of fluoxetine and/or adjunctive treatment with antihistamines or steroids, and all patients experiencing these

events were reported to recover completely.

In premarketing clinical trials two patients are known to have developed a serious cutaneous systemic illness. In neither patient was there an unequivocal diagnosis, but one was considered to have a leukocytoclastic vasculitis, and the other severe desquamation that was considered variously to be a vasculitis or erythema multiforme. Other patients have had systemic manifestations suggestive of serum sickness.

Since the introduction of fluoxetine, systemic events, possibly related to vasculitis, and including lupus-like syndrome, have developed in patients with rash. Although these events are rare, they may be serious, involving the lung, kidney, or liver. Death has been reported to occur in association with these systemic events.

Anaphylactoid events, including bronchospasm, angioedema, laryngospasm and urticaria alone and in combination, have been reported.

Pulmonary events, including inflammatory processes of varying histopathology and/or fibrosis, have been reported rarely. These events have occurred with dyspnea as the only preceding symptom.

Whether these systemic events and rash have a common underlying cause or are due to different etiologies or pathogenic processes is not known. Furthermore, a specific underlying immunologic basis for these events has not been identified. Upon the appearance of rash or of other possibly allergic phenomena for which an alternative etiology cannot be identified, VAN-Fluoxetine should be discontinued. Particular caution should be exercised in patients with a history of allergic reactions.

Potential for reduced efficacy of tamoxifen with concomitant SSRI use, including Fluoxetine: The antitumor agent tamoxifen is a pro-drug requiring metabolic activation by CYP2D6. Inhibition of CYP2D6 can lead to reduced plasma concentrations of a primary active metabolite (endoxifen). Chronic use of CYP2D6 inhibitors, including certain SSRIs, together with tamoxifen can lead to persistent reduction in levels of endoxifen (see also DRUG INTERACTIONS, Drug-Drug Interactions). Reduced efficacy of tamoxifen has been reported with concomitant usage of some SSRI antidepressants in some studies. When tamoxifen is used for the treatment of breast cancer, prescribers should consider using an alternative antidepressant with little or no CYP2D6 inhibition.

The following additional PRECAUTIONS are listed alphabetically.

Bone Fracture Risk

Epidemiological studies show an increased risk of bone fractures following exposure to some antidepressants, including SSRIs/SNRIs. The risks appear to be greater at the initial stages of treatment, but significant increased risks were also observed at later stages of treatment. The possibility of fracture should be considered in the care of patients treated with fluoxetine. Elderly patients and patients with important risk factors for bone fractures should be advised of possible adverse events which increase the risk of falls, such as dizziness and orthostatic hypotension, especially at the early stages of treatment but also soon after withdrawal. Preliminary data from

observational studies show association of SSRIs/SNRIs and low bone mineral density in older men and women. Until further information becomes available, a possible effect on bone mineral density with long term treatment with SSRIs/SNRIs, including fluoxetine, cannot be excluded, and may be a potential concern for patients with osteoporosis or major risk factors for bone fractures.

Carcinogenesis and Mutagenesis

For animal data, see Part II: TOXICOLOGY section.

Cardiovascular

Fluoxetine may be associated with a risk of QTc interval prolongation (see ADVERSE REACTIONS, ECG Findings; DRUG INTERACTIONS; ACTION AND CLINICAL PHARMACOLOGY, Electrocardiography). Rare events of torsade de pointes, ventricular fibrillation, cardiac arrest, and sudden death have been reported with fluoxetine during post-market use (see ADVERSE REACTIONS, Post-Market Adverse Drug Reactions). If sustained, torsade de pointes can progress to ventricular fibrillation and sudden cardiac death.

Fluoxetine should be used with caution in patients with conditions such as congenital long QT syndrome and acquired long QT syndrome. (e.g., due to concomitant use of a drug that prolongs the QT); a family history of QT prolongation; or other clinical conditions that predispose to arrhythmias (e.g., hypokalemia or hypomagnesemia or hypocalcemia) or increased exposure to fluoxetine (e.g., hepatic impairment). Electrocardiogram monitoring may be warranted in patients who are suspected to be at an increased risk of experiencing torsade de pointes, such as cardiac disease (e.g., ischemic heart disease, congestive heart failure, history of arrhythmias) a family history of QT prolongation, recent myocardial infarction, bradyarrhythmias, patients on concomitant medications that prolong the QTc interval or other clinical conditions that predispose to arrhythmias (e.g., acute neurological events, diabetes mellitus, autonomic neuropathy). Female gender and age 65 years or older are risk factors for torsade de pointes.

When drugs that prolong the QTc interval are prescribed, healthcare professionals should counsel their patients concerning the nature and implications of the ECG changes, underlying diseases and disorders that are considered to represent risk factors, demonstrated and predicted drug-drug interactions, symptoms suggestive of arrhythmia, risk management strategies, and other information relevant to the use of the drug.

Fluoxetine has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were systematically excluded from premarketing clinical studies. The mean heart rate was reduced by approximately 3 beats/minute.

Hypokalemia:

Self-induced vomiting often leads to hypokalemia which may lower seizure threshold and/or may lead to cardiac conduction abnormalities. Electrolyte levels of bulimic patients should be assessed prior to initiation of treatment and at regular intervals thereafter.

Concomitant Illness:

Clinical experience with fluoxetine in patients with concomitant systemic illness is limited and it should be used cautiously in such patients, especially those with diseases or conditions that could affect metabolism or hemodynamic responses.

Dependence

Discontinuation of Treatment with fluoxetine (Post-Marketing and Clinical Trials):

When discontinuing treatment, patients should be monitored for symptoms which may be associated with discontinuation (e.g. headache, insomnia, paresthesias, nervousness, anxiety, nausea, sweating, numbness, dizziness, jitteriness, asthenia or other symptoms which may be of clinical significance).

Fluoxetine has been only rarely associated with such symptoms. Plasma fluoxetine and norfluoxetine concentrations decrease gradually at the conclusion of therapy, which makes dose tapering unnecessary in most patients (see WARNINGS AND PRECAUTIONS, General; ADVERSE REACTIONS; and DOSAGE AND ADMINISTRATION sections).

Dependence Liability:

Fluoxetine has not been systematically studied, in animals or humans, for its potential for abuse, tolerance, or physical dependence. Physicians should carefully evaluate patients for history of drug abuse and follow such patients closely, observing them for signs of misuse or abuse of Fluoxetine.

Endocrine and Metabolism

Diabetes:

In patients with diabetes, fluoxetine may alter glycemic control. Hypoglycemia has occurred during therapy with fluoxetine, and hyperglycemia has developed following discontinuation of the drug. As is true with many other types of medication when taken concurrently by patients with diabetes, insulin and/or oral hypoglycemic dosage may need to be adjusted when therapy with fluoxetine is instituted or discontinued.

Hematologic

Abnormal Bleeding:

SSRIs and SNRIs, including fluoxetine, may increase the risk of bleeding events by causing abnormal platelet aggregation. Concomitant use of acetylsalicylic acid (ASA), nonsteroidal anti-inflammatory drugs (NSAIDs), warfarin and other anticoagulants may add to the risk. Case reports and epidemiological studies (case-control and cohort design) have demonstrated an association between use of drugs that interfere with serotonin reuptake and the occurrence of gastrointestinal bleeding. Bleeding events related to SSRIs and SNRIs use have ranged from ecchymoses, hematomas, epistaxis, and petechiae to life-threatening hemorrhages.

Patients should be cautioned about the risk of bleeding associated with the concomitant use of fluoxetine and NSAIDs, ASA, or other drugs that affect coagulation (see DRUG INTERACTIONS, Drugs Affecting Platelet Function). Caution is advised in patients with a history of bleeding disorder or predisposing conditions (e.g. thrombocytopenia).

Hepatic/Biliary/Pancreatic

Hepatic Impairment:

Since clearances of fluoxetine and norfluoxetine may be decreased in patients with impaired liver function including cirrhosis, a lower or less frequent dose should be used in such patients. See ACTION AND CLINICAL PHARMACOLOGY section.

Neurologic

Seizures:

VAN-Fluoxetine should be used with caution in patients with a history of convulsive disorders. The incidence of seizures associated with fluoxetine during clinical trials did not appear to differ from that reported with other marketed antidepressants; however, patients with a history of convulsive disorders were excluded from these trials. Concurrent administration with electroshock therapy should be avoided because of the absence of experience in this area. There have been rare reports of prolonged seizures in patients on fluoxetine receiving ECT treatment.

Serotonin Syndrome /Neuroleptic Malignant Syndrome:

On rare occasions serotonin syndrome or neuroleptic malignant syndrome-like events have occurred in association with treatment with SSRIs, including fluoxetine, particularly when given in combination with other serotonergic and/or neuroleptic drugs. As these syndromes may result in potentially life-threatening conditions, treatment with VAN-Fluoxetine should be discontinued if such events (characterized by clusters of symptoms such as hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, mental status changes including confusion, irritability, extreme agitation progressing to delirium and coma) occur and supportive symptomatic treatment should be initiated. Due to the risk of serotonergic syndrome or neuroleptic malignant syndrome, VAN-Fluoxetine should not be used in combination with MAO inhibitors (including the antibiotic linezolid and the thiazine dye methylthionium chloride (methylene blue) which are less well-known examples of MAOIs) or serotonin-precursors (such as L-tryptophan, oxitriptan) and should be used with caution in combination with other serotonergic drugs (triptans, certain tricyclic antidepressants, lithium, tramadol, St. John's Wort) due to the risk of serotonergic syndrome (see CONTRAINDICATIONS and DRUG INTERACTIONS).

Ophthalmologic

Glaucoma:

As with other SSRIs/SNRIs, fluoxetine can cause mydriasis and should be used with caution in patients with raised intraocular pressure or those with narrow-angle glaucoma.

Psychiatric

Suicide risk:

The possibility of a suicide attempt is inherent in depression and other psychiatric disorders and may persist until significant remission occurs. As with other drugs with similar pharmacological action (antidepressants), isolated cases of suicidal ideation and suicidal behaviors have been reported during fluoxetine therapy or early after treatment discontinuation.

Although a causal role for fluoxetine in inducing such events has not been established, an FDA analysis from pooled studies of antidepressants in psychiatric disorders found an increased risk for

suicidal ideation and/or suicidal behaviors in pediatric and young adult (<25 years of age) patients compared to placebo.

Close supervision of high-risk patients should accompany drug therapy and consideration should be given to the possible need for hospitalization. Physicians should encourage patients of all ages to report any new or worsened distressing thoughts or feelings occurring at any time. In order to minimize the opportunity for overdose, prescriptions for fluoxetine should be written for the smallest quantity of drug consistent with good patient management.

Because of the well established comorbidity between depression and other psychiatric disorders, the same precautions observed when treating patients with depression should be observed when treating patients with other psychiatric disorders (see WARNINGS AND PRECAUTIONS: General: Potential Association with Behavioral and Emotional Changes, Including Self-Harm section).

Activation of Mania/Hypomania:

During premarketing clinical trials in a patient population comprised primarily of unipolar depressed patients, hypomania or mania occurred in approximately 1% of fluoxetine treated patients. The incidence in a general patient population which might also include bipolar depressives is unknown. The likelihood of hypomanic or manic episodes may be increased at the higher dosage levels. Such reactions require a reduction in dosage or discontinuation of the drug.

A major depressive episode may be the initial presentation of bipolar disorder. Patients with bipolar disorder may be at an increased risk of experiencing manic episodes when treated with antidepressants alone. Therefore, the decision to initiate symptomatic treatment of depression should only be made after patients have been adequately assessed to determine if they are at risk for bipolar disorder.

Electroconvulsive Therapy (ECT):

There are no clinical studies to support the safety and efficacy of combined use of ECT and fluoxetine. There have been rare reports of prolonged seizures in patients on fluoxetine receiving ECT treatment.

Renal

Severe Renal Impairment:

Since fluoxetine is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. However, until an adequate number of patients with severe renal impairment have been evaluated in the course of chronic treatment, fluoxetine should be used with caution in such patients.

Hyponatremia:

Several cases of hyponatremia (some with serum sodium lower than 110 mmol/L) have been reported. The hyponatremia appeared to be reversible when fluoxetine was discontinued. Although these cases were complex with varying possible etiologies, some were possibly due to the syndrome of inappropriate antidiuretic hormone secretion (SIADH). The majority of these occurrences have been in older patients and in patients taking diuretics or who were otherwise volume depleted.

In two 6-week controlled studies in patients ≥ 60 years of age, 10 of 323 fluoxetine patients and 6 of 327 placebo recipients had a lowering of serum sodium below the reference range; this difference was not statistically significant. The lowest observed concentration of sodium in a fluoxetine treated patient was 129 mmol/L. The observed decreases were not clinically significant.

Special Populations

Fertility, Pregnant Women and Newborns:

Male Fertility:

Animal data have shown that VAN-Fluoxetine at levels in excess of the maximum tolerable dose may affect sperm quality (See Part II: TOXICOLOGY, Subchronic Studies, and Reproduction and Impairment of Fertility Studies). In human case reports, some reversible changes in sperm quality have been reported with some SSRIs, including VAN-Fluoxetine. An impact on human fertility has not been observed.

Pregnant Women and Newborns:

There are no adequate and well-controlled clinical studies on the use of fluoxetine in pregnant women. VAN-Fluoxetine should not be administered to pregnant women or those intending to become pregnant unless in the opinion of the treating physician, the expected benefits to the patient markedly outweigh the possible hazards to the fetus or the child.

See also: WARNINGS AND PRECAUTIONS, Use of Fluoxetine in Pregnant Women: Effects on Newborns, and DOSAGE AND ADMINISTRATION sections.

Possible Risk of Cardiovascular Malformations following first trimester exposure to SSRIs

Results of a number of epidemiological studies of pregnancy outcomes following early maternal exposure to antidepressants have been inconsistent, with some finding no increased risk of malformations with fluoxetine exposure, while others have found a small increased risk for cardiovascular malformations (eg ventricular and septal defects) in infants with first trimester exposure to fluoxetine compared to those not exposed. The mechanism is unknown. Overall, the data suggest that the potential risk of having an infant with a cardiovascular malformation following maternal exposure to fluoxetine is less than 2/100 compared with an expected rate for such defects of approximately 1/100 in the general population. The use of VAN-Fluoxetine during pregnancy should be considered only if the potential benefit justifies the potential risk to the fetus taking into account the risks associated with untreated depression.

Complications following late third trimester exposure to SSRIs

Post-marketing reports indicate that some neonates exposed to fluoxetine, other SSRIs (selective serotonin reuptake inhibitors), or newer anti-depressants late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding

difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and other newer anti-depressants or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (see CONTRAINDICATIONS, Monoamine Oxidase Inhibitors). When treating a pregnant woman with VAN-Fluoxetine during the third trimester, the physician should carefully consider the potential risks and benefits of treatment (see DOSAGE AND ADMINISTRATION section).

Risk of PPHN and exposure to SSRIs (including fluoxetine):

Exposure during late pregnancy to SSRIs, including fluoxetine, may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1-2 per 1,000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective case-control study of 377 women whose infants were born with PPHN and 836 women whose infants were born healthy, the risk for developing PPHN was approximately six-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. A study of 831,324 infants born in Sweden in 1997-2005 found a PPHN risk ratio of 2.4 (95% CI 1.2-4.3) associated with patient-reported maternal use of SSRIs in “early pregnancy” and a PPHN risk ratio of 3.6 (95% CI 1.2-8.3) associated with a combination of patient-reported maternal use of SSRIs in “early pregnancy” and an antenatal SSRI prescription in “later pregnancy”.

Nursing Women:

Lactation:

Fluoxetine and its metabolites are excreted in breast milk, and have been observed to reach high levels in the plasma of nursing infants. Women who are taking VAN-Fluoxetine should not breast feed unless, in the opinion of the treating physician, breast feeding is necessary, in which case the infant should be closely monitored.

In one breast milk sample, the concentration of fluoxetine plus norfluoxetine was 70.4 ng/mL. The concentration in the mother's plasma was 295.0 ng/mL. No adverse effects on the infant were reported. In another case, a 6-week infant, nursed by a mother on fluoxetine, developed crying, decreased sleep, vomiting and watery stools. The breast milk showed concentrations of 69 ng/mL for fluoxetine and 90 ng/mL for norfluoxetine. In the infant's plasma, the concentrations of fluoxetine and norfluoxetine on the second day of feeding were 340 and 208 ng/mL, respectively.

Pediatrics (<18 years of age):

VAN-Fluoxetine are not indicated for use in patients below the age of 18 years. See WARNINGS AND PRECAUTIONS, General, Potential Association with Behavioural and Emotional Changes, including Self-Harm. See also ADVERSE REACTIONS, Potential for Effects on Growth in Pediatric Patients.

Geriatrics (≥60 years of age):

Evaluation of patients over the age of 60 who received fluoxetine 20 mg daily revealed no unusual pattern of adverse events relative to the clinical experience in younger patients. These data are however insufficient to rule out possible age-related differences during chronic use, particularly in elderly patients who have concomitant systemic illnesses or who are receiving concomitant drugs. See INDICATIONS AND CLINICAL USE, and DOSAGE AND ADMINISTRATION sections.

ADVERSE REACTIONS

Adverse Drug Reaction Overview

Commonly Observed Adverse Events

In clinical trials, the most commonly observed adverse events associated with the use of fluoxetine and not seen at an equivalent incidence among placebo treated patients were: central nervous system complaints, including headache, nervousness, insomnia, drowsiness, fatigue or asthenia, anxiety, tremor, and dizziness or lightheadedness; gastrointestinal complaints, including nausea, diarrhea, dry mouth and anorexia; and excessive sweating.

Adverse Events Leading to Discontinuation of Treatment

Fifteen percent of approximately 4,000 patients who received fluoxetine in North American clinical trials discontinued treatment due to an adverse event. The more common events causing discontinuation from depression trials in adults and elderly, included: psychiatric, primarily nervousness, anxiety, and insomnia; digestive, primarily nausea; nervous system, primarily dizziness, asthenia, and headaches; skin, primarily rash and pruritus.

In obsessive compulsive disorder studies, 12.1% of fluoxetine treated patients discontinued treatment early because of adverse events. Anxiety and rash, at incidences of less than 2%, were the most frequently reported events. In bulimia nervosa studies, 10.2% of fluoxetine treated patients discontinued treatment early because of adverse events. Insomnia, anxiety and rash, at incidences of less than 2%, were the most frequently reported events.

Adverse Events Subsequent to Discontinuation

Symptoms associated with discontinuation of fluoxetine have been reported in clinical trials and post-marketing (e.g. headache, insomnia, paresthesias, nervousness, anxiety, nausea, sweating, numbness, dizziness, jitteriness, asthenia, or other symptoms which may be of clinical significance). The majority of these are mild and self-limiting. Fluoxetine has been only rarely associated with such symptoms. Plasma fluoxetine and norfluoxetine concentrations decrease gradually at the conclusion of therapy, which makes dose tapering unnecessary in most patients. See WARNINGS AND PRECAUTIONS, General; and DOSAGE AND ADMINISTRATION sections.

Serious Adverse Reactions

Suicidal thoughts and acts are far more common among depressed patients than in the general population. It is estimated that suicide is 22 to 36 times more prevalent in depressed persons than in the general population. A comprehensive meta-analysis of pooled data from 17 double blind clinical trials in patients with major depressive disorder compared fluoxetine (n=1765) with a tricyclic antidepressant (n=731) or placebo (n=569), or both. The pooled incidence of emergence of substantial suicidal ideation was 1.2% for fluoxetine, 2.6% for placebo, and 3.6% for tricyclic antidepressants.

In countries where the drug has already been marketed, the following potentially serious adverse reactions have been reported; interactions with MAO inhibitors and possibly other drugs, allergic reactions, cardiovascular reactions, syndrome of inappropriate ADH secretion, and grand mal seizure. Death and life-threatening events have been associated with some of these reactions, although causal relationship to fluoxetine has not necessarily been established.

Post-marketing experience also confirms the profile of adverse reactions commonly reported during clinical trials with fluoxetine including allergic skin reactions.

Clinical Trial Adverse Drug Reactions

Because clinical trials are conducted under very specific conditions the adverse drug reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.

Multiple doses of fluoxetine had been administered to 10,782 patients with various diagnoses in US clinical trials as of May 8, 1995. Adverse events were recorded by clinical investigators using descriptive terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a limited (i.e., reduced) number of standardized event categories.

Adults

In the tables and tabulations that follow, COSTART Dictionary terminology has been used to

classify reported adverse events. The stated frequencies represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. It is important to emphasize that events reported during therapy were not necessarily caused by it.

The prescriber should be aware that the figures in the tables and tabulations cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and nondrug factors to the side effect incidence rate in the population studied.

Table 1: Treatment-Emergent Adverse Events Incidence in Fluoxetine versus Placebo Trials Listed by Indication

<i>Percentage of Patients Reporting Event</i>								
Body System/ Adverse Event	DEPRESSION * (Adults)		DEPRESSION (Elderly)		OCD*		BULIMIA*	
	Fluoxetine (N=1728)	Placebo (N=975)	Fluoxetine (N=335)	Placebo (N=336)	Fluoxetine (N=266)	Placebo (N=89)	Fluoxetine (N=450)	Placebo (N=267)
Nervous System								
Headache	--	--	28	24	--	--	--	--
Nervousness	14	9	12	7	14	15	11	5
Insomnia	16	9	18	12	28	22	33	13
Somnolence	13	6	9	6	17	7	13	5
Anxiety	12	7	13	8	14	7	15	9
Tremor	10	3	8	4	9	1	13	1
Dizziness	--	--	11	10	--	--	--	--
Libido, decreased	3	0	--	--	11	2	5	1
Abnormal dreams	1	1	--	--	5	2	5	3
Digestive System								
Nausea	21	9	17	7	26	13	29	11
Diarrhea	--	--	14	9	--	--	--	--
Dry mouth	10	7	7	5	12	3	9	6
Anorexia	11	2	11	2	17	10	8	4
Dyspepsia	7	5	11	5	10	4	10	6
Constipation	--	--	7	6	--	--	--	--
Flatulence	--	--	7	2	--	--	--	--
Skin and Appendages								
Sweating	8	3	7	3	7	0	8	3

<i>Percentage of Patients Reporting Event</i>								
Body System/ Adverse Event	DEPRESSION * (Adults)		DEPRESSION (Elderly)		OCD*		BULIMIA*	
	Fluoxetine (N=1728)	Placebo (N=975)	Fluoxetine (N=335)	Placebo (N=336)	Fluoxetine (N=266)	Placebo (N=89)	Fluoxetine (N=450)	Placebo (N=267)
Rash	4	3	--	--	6	3	4	4
Body as a Whole								
Asthenia	9	5	13	10	15	11	21	9
Flu syndrome	3	4	--	--	10	7	8	3
Back Pain	--	--	7	9	--	--	--	--
Abdominal Pain	--	--	6	6	--	--	--	--
Myalgia	--	--	3	5	--	--	--	--
Respiratory System								
Rhinitis	--	--	9	14	--	--	--	--
Pharyngitis	3	3	--	--	11	9	10	5
Sinusitis	1	4	3	7	5	2	6	4
Yawn	--	--	--	--	7	--	11	--
Cardiovascular System								
Vasodilatation	3	2	--	--	5	0	2	1
Urogenital System								
Abnormal Ejaculation [†]	--	--	--	--	7	--	7	--
Impotence [†]	2	--	--	--	--	--	7	--

[†]Denominator used was for males only (N= 690 Fluoxetine depression; N=410 placebo depression; N=116 Fluoxetine OCD; N=43 placebo OCD; N=14 Fluoxetine bulimia; N=1 placebo bulimia).

-- Incidence less than 1%

* The most common treatment-emergent adverse events associated with the use of fluoxetine (incidence of at least 5% for fluoxetine and at least twice that for placebo within at least one of the indications) for the treatment of depression, OCD, and bulimia in US controlled clinical trials.

Table 2 enumerates treatment-emergent adverse events that occurred in 2% or more patients treated with fluoxetine and with incidence greater than placebo who participated in US controlled clinical trials comparing fluoxetine with placebo in the treatment of depression, OCD, or bulimia. Table 2 provides combined data for the pool of studies that are provided separately by indication in Table 1.

Table 2: Combined Treatment-Emergent Adverse Events Incidence for Patients Treated with Fluoxetine versus Placebo

<i>Percentage of patients reporting event</i>		
	Depression, OCD, and bulimia combined	
Body System/Adverse Event *	Fluoxetine (N=2444)	Placebo (N=1331)
Body as a Whole		
Headache	21	20
Asthenia	12	6
Flu syndrome	5	4
Fever	2	1
Cardiovascular System		
Vasodilatation	3	1
Palpitation	2	1
Digestive System		
Nausea	23	10
Diarrhea	12	8
Anorexia	11	3
Dry mouth	10	7
Dyspepsia	8	5
Flatulence	3	2
Vomiting	3	2
Metabolic and Nutritional Disorders		
Weight loss	2	1
Nervous System		
Insomnia	20	11
Anxiety	13	8
Nervousness	13	9
Somnolence	13	6
Dizziness	10	7
Tremor	10	3
Libido decreased	4	--
Respiratory System		
Pharyngitis	5	4
Yawn	3	--
Skin and Appendages		
Sweating	8	3
Rash	4	3
Pruritus	3	2
Special Senses		
Abnormal vision	3	1

* Included are events reported by at least 2% of patients taking fluoxetine, except the following events, which had an incidence on placebo > fluoxetine (depression, OCD, and bulimia combined): abdominal pain, abnormal dreams, accidental injury, back pain, chest pain, constipation, cough increased, depression (includes suicidal thoughts), dysmenorrhea, gastrointestinal disorder, infection, myalgia, pain, paresthesia, rhinitis, sinusitis, thinking abnormal.

-- Incidence less than 1%.

Table 3 lists the adverse events associated with discontinuation of fluoxetine treatment (incidence at least twice that for placebo and at least 1% for fluoxetine in clinical trials collecting only a primary event associated with discontinuation) in depression, OCD, and bulimia. For symptoms associated with discontinuation of fluoxetine in clinical trials and post-marketing, see ADVERSE REACTION: Post-Market Adverse Drug Reactions section.

Table 3: Adverse Events Associated with Discontinuation of Fluoxetine Treatment

Depression, OCD, and Bulimia Combined (N=1108)	Depression (N=392)	OCD (N=266)	Bulimia (N=450)
--	--	Anxiety (2%)	--
Insomnia (1%)	--	--	Insomnia (2%)
--	Nervousness (1%)	--	--
--	--	Rash (1%)	--

Male and Female Sexual Dysfunction with SSRIs

Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences.

Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance, cited in product labeling, are likely to underestimate their actual incidence. In patients enrolled in depression, OCD, and bulimia placebo-controlled clinical trials, decreased libido was the only sexual side effect reported by at least 2% of patients taking fluoxetine (4% fluoxetine, < 1% placebo). There have been spontaneous reports in women taking fluoxetine of orgasmic dysfunction, including anorgasmia.

There are no adequate and well-controlled studies examining sexual dysfunction with fluoxetine treatment. Symptoms of sexual dysfunction occasionally persisting after discontinuation of fluoxetine treatment have been observed in spontaneous reports. Priapism has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects.

Treatment-Emergent Adverse Events

Following is a list of all treatment-emergent adverse events reported at any time by individuals taking fluoxetine in US clinical trials (10,782 patients) except: (1) those listed in the body or footnotes of Tables 1 or 2 above or elsewhere in labelling; (2) those for which the COSTART terms were uninformative or misleading; (3) those events for which a causal relationship to fluoxetine use was considered remote; and (4) events occurring in only 1 patient treated with fluoxetine and which did not have a substantial probability of being acutely life-threatening.

Events are further classified within body system categories and enumerated in order of decreasing frequency using the following definitions: frequent adverse events are defined as

those occurring on 1 or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in less than 1/100 but at least 1/1,000 patients; rare events are those occurring in less than 1/1,000 patients.

Body as a Whole

Frequent: chills

Infrequent: chills and fever, face edema, feeling abnormal, intentional overdose, malaise, pelvic pain, suicide attempt.

Rare: abdominal syndrome acute, hypothermia, intentional injury, neuroleptic malignant syndrome*, photosensitivity reaction.

characterized by the clustering of clinical features of changes in mental state and neuromuscular activity, in combination with autonomic nervous system dysfunction.

Cardiovascular System

Frequent: hemorrhage, hypertension.

Infrequent: angina pectoris, arrhythmia, congestive heart failure, hypotension, migraine, myocardial infarct, postural hypotension, syncope, tachycardia, vascular headache.

Rare: atrial fibrillation, bradycardia, cerebral embolism, cerebral ischemia, cerebrovascular accident, extrasystoles, heart arrest, heart block, pallor, peripheral vascular disorder, phlebitis, shock, thrombophlebitis, thrombosis, vasospasm, ventricular arrhythmia, ventricular extrasystoles, ventricular fibrillation.

Digestive System

Frequent: increased appetite, nausea and vomiting.

Infrequent: aphthous stomatitis, cholelithiasis, colitis, dysphagia, eructation, esophagitis, gastritis, gastroenteritis, glossitis, gum hemorrhage, hyperchlorhydria, increased salivation, liver function tests abnormal, melena, mouth ulceration, nausea/vomiting/diarrhea, stomach ulcer, stomatitis, thirst.

Rare: biliary pain, bloody diarrhea, cholecystitis, duodenal ulcer, enteritis, esophageal ulcer, fecal incontinence, gastrointestinal hemorrhage, hematemesis, hemorrhage of colon, hepatitis, intestinal obstruction, liver fatty deposit, oesophageal pain, pancreatitis, peptic ulcer, rectal hemorrhage, salivary gland enlargement, stomach ulcer hemorrhage, tongue edema.

Endocrine System

Infrequent: hypothyroidism

Rare: diabetic acidosis, diabetes mellitus.

Hemic and Lymphatic System

Infrequent: anemia, ecchymosis.

Rare: blood dyscrasia, hypochromic anemia, leukopenia, lymphedema, lymphocytosis, petechia, purpura, thrombocytopenia, thrombocytopenia.

Metabolic and Nutritional

Frequent: weight gain.

* Neuroleptic malignant syndrome is the COSTART term which best captures serotonin syndrome.

Infrequent: dehydration, generalized edema, gout, hypercholesteremia, hyperlipemia, hypokalemia, peripheral edema.

Rare: alcohol intolerance, alkaline phosphatase increased, BUN increased, creatine phosphokinase increased, hyperkalemia, hyperuricemia, hypocalcemia, iron deficiency anemia, SGPT increased.

Musculoskeletal System

Infrequent: arthritis, bone pain, bursitis, leg cramps, tenosynovitis.

Rare: arthrosis, chondrodystrophy, myasthenia, myopathy, myositis, osteomyelitis, osteoporosis, rheumatoid arthritis.

Nervous System

Frequent: abnormal movement/tremor[†], agitation, amnesia, confusion, emotional lability, fatigue[‡], headache, sleep abnormalities[§].

Infrequent: abnormal gait, acute brain syndrome, akathisia, apathy, balance disorder, bruxism, CNS depression, CNS stimulation, depersonalization, euphoria, hallucinations, hostility, hyperkinesia, hypertonia, hypesthesia, incoordination, libido increased, neuralgia, neuropathy, neurosis, paranoid reaction, personality disorder^{**}, psychosis, vertigo.

Rare: abnormal electroencephalogram, antisocial reaction, circumoral paresthesia, coma, delusions, dysarthria, dystonia, extrapyramidal syndrome, foot drop, hyperesthesia, neuritis, paralysis, reflexes decreased, reflexes increased, stupor.

Respiratory System

Infrequent: asthma, epistaxis, hiccup, hyperventilation.

Rare: apnea, atelectasis, cough decreased, emphysema, hemoptysis, hypoventilation, hypoxia, larynx edema, lung edema, pneumothorax, stridor.

Skin and Appendages

Infrequent: acne, alopecia, contact dermatitis, eczema, maculopapular rash, skin discoloration, skin ulcer, vesiculobullous rash.

Rare: furunculosis, herpes zoster, hirsutism, petechial rash, psoriasis, purpuric rash, pustular rash, seborrhea.

Special Senses

Frequent: ear pain, taste perversion, tinnitus.

Infrequent: conjunctivitis, dry eyes, mydriasis, photophobia.

Rare: blepharitis, deafness, diplopia, exophthalmos, eye hemorrhage, glaucoma, hyperacusis, iritis, parosmia, scleritis, strabismus, taste loss, visual field defect.

[†] COSTART group term **abnormal movement/tremor** includes the independent terms: *frequent:* tremor; *infrequent:* ataxia, buccoglossal, myoclonus; *rare:* twitching.

[‡] COSTART group term **fatigue** includes the independent terms: *frequent:* asthenia, somnolence.

[§] COSTART group term **sleep abnormalities** includes the independent terms: *frequent:* insomnia; *rare:* abnormal dreams.

^{**} Personality disorder is the COSTART term for designating non-aggressive objectionable behavior.

Urogenital System

Frequent: gynaecological bleeding^{††}, sexual dysfunction^{††‡‡}, urinary frequency.

Infrequent: abortion^{††}, albuminuria, amenorrhoea^{††}, breast enlargement, breast pain, cystitis, dysuria, female lactation^{††}, fibrocystic breast^{††}, hematuria, leukorrhoea^{††}, menorrhagia^{††}, metrorrhagia^{††}, nocturia, polyuria, urinary incontinence, urinary retention, urinary urgency.

Rare: breast engorgement, glycosuria, hypomenorrhoea^{††}, kidney pain, oliguria, priapism^{††}, uterine fibroids enlarged^{††}.

ECG Findings:

In a placebo-controlled clinical trial in major depressive disorder, fluoxetine titrated to doses in the range of 40-80 mg/day was associated with a statistically significant placebo-adjusted mean change from baseline in the Fridericia-corrected QT interval ($QTcF=QT/RR^{0.33}$) of 8.6 ms (90% CI 4.5, 12.6). See WARNINGS AND PRECAUTIONS, Cardiovascular; DRUG INTERACTIONS; ACTION AND CLINICAL PHARMACOLOGY, Electrocardiography.

Special Populations: (only Adverse Events that are different from the above events are listed under special populations)

Pediatrics (<18 years of age):

Frequent: epistaxis

Potential for Effects on Growth in Pediatric Patients

VAN-Fluoxetine are not indicated for use in patients below the age of 18 years (see WARNINGS AND PRECAUTIONS, General, Potential Association with Behavioural and Emotional Changes, including Self-Harm).

Decreased weight gain and a lesser gain in height have been observed in association with the use of fluoxetine in children and adolescent patients. After 19 weeks of treatment in a clinical trial, pediatric subjects treated with fluoxetine (n=88) were recorded as gaining an average of 1.1 cm less in height than subjects treated with placebo (n=75). However, the study was not designed for a rigorous assessment of growth (e.g., heights were recorded to the nearest rounded inch), and thus a definite interpretation of this finding was compromised. This is exemplified by the reported outcome of a loss in height for 17 of the patients. Notwithstanding these limitations, an attenuation of height gain with acute fluoxetine treatment cannot be excluded. (See also PART II: TOXICOLOGY, Juvenile Toxicology Study). Fluoxetine treatment was also associated with a decrease in serum alkaline phosphatase levels in this study. Limited evidence is available concerning the longer-term effects of fluoxetine on the development and maturation of children and adolescent patients. Height and weight should be monitored periodically in pediatric patients receiving fluoxetine.

^{††} Adjusted for gender

^{‡‡} COSTART group term **sexual dysfunction** includes the independent terms: *frequent:* impotence, libido decreased; *infrequent:* anorgasmia, delayed or absent ejaculation.

Post-Market Adverse Drug Reactions

Voluntary reports of adverse events temporally associated with fluoxetine that have been received since market introduction and that may have no causal relationship with the drug include the following: aplastic anemia, atrial fibrillation, bone fractures, cardiac arrest, cataract, cerebral vascular accident, cholestatic jaundice, confusion, dyskinesia (including, for example, a case of buccal-lingual-masticatory syndrome with involuntary tongue protrusion reported to develop in a 77-year-old female after 5 weeks of fluoxetine therapy and which completely resolved over the next few months following drug discontinuation), eosinophilic pneumonia, epidermal necrolysis, erythema multiforme, erythema nodosum, exfoliative dermatitis, gastrointestinal bleeding^{§§}, galactorrhea, gynecomastia, heart arrest, hepatic failure/necrosis, hyperprolactinemia, hypoglycemia, immune-related hemolytic anemia, kidney failure, memory impairment, misuse/abuse, movement disorders developing in patients with risk factors including drugs associated with such events and worsening of preexisting movement disorders, neuroleptic malignant syndrome-like events, optic neuritis, pancreatitis, pancytopenia, priapism, pulmonary embolism, pulmonary hypertension, QT prolongation, serotonin syndrome (a range of signs and symptoms that can rarely, in most severe cases, resemble neuroleptic malignant syndrome), Stevens-Johnson syndrome, sudden unexpected death, suicidal ideation, thrombocytopenia, thrombocytopenic purpura, vaginal bleeding after drug withdrawal, ventricular tachycardia (including torsades de pointes-type arrhythmias and ventricular fibrillation) and violent behaviours.

^{§§} Includes: esophageal varices hemorrhage, gingival and mouth bleeding, hematemesis, hematochezia, hematomas [intraabdominal, peritoneal], hemorrhage [anal, esophageal, gastric, gastrointestinal (upper and lower), haemorrhoidal, peritoneal, rectal], hemorrhagic diarrhoea and enterocolitis, hemorrhagic diverticulitis, hemorrhagic gastritis, melaena, and ulcer hemorrhage [esophageal, gastric, duodenal]

DRUG INTERACTIONS

Serious Drug Interactions

Monoamine Oxidase Inhibitors: See CONTRAINDICATIONS

Thioridazine: See CONTRAINDICATIONS

Overview

Fluoxetine, like some other agents that are metabolized by the P4502D6 system, inhibits the activity of this isoenzyme. Therefore, co-therapy with medications that are predominantly metabolized by the P4502D6 system and that have a relatively narrow therapeutic index (e.g. flecainide, encainide, vinblastine, carbamazepine and tricyclic antidepressants) should be initiated at the low end of the dose range if a patient is receiving fluoxetine concurrently, or has taken it in the previous 5 weeks. If fluoxetine is added to the treatment regimen of a patient already receiving a drug metabolized by P4502D6, the need for decreased dose of the original medication should be considered. The aforementioned drugs with a narrow therapeutic index represent the greatest concern.

Other drugs that have demonstrated increased plasma values or magnified effects when co-administered with fluoxetine include: phenytoin, antipsychotics, benzodiazepines, thioridazine (see CONTRAINDICATIONS), St. John's Wort and warfarin.

As fluoxetine is highly bound to plasma proteins, co-administration with another drug which is also highly bound (e.g. warfarin, digitoxin) may result in adverse effects due to an increase in plasma levels of either unbound drug.

There are little data available on the concomitant use of fluoxetine and alcohol.

Drug-Drug Interactions

QTc-Prolonging Drugs: Pharmacokinetic and pharmacodynamic studies of fluoxetine combined with other medicinal products that prolong the QT interval have not been performed. An additive effect of fluoxetine and these medicinal products cannot be excluded. Therefore, co-administration of fluoxetine with medicinal products that have a clear QT interval prolonging effect is discouraged. Drugs that have been associated with QTc interval prolongation and/or torsade de pointes include, but are not limited to, the examples in the following list. Chemical/pharmacological classes are listed if some, although not necessarily all, class members have been implicated in QTc prolongation and/or torsade de pointes:

- Class IA antiarrhythmics (e.g., quinidine, procainamide, disopyramide);
- Class III antiarrhythmics (e.g., amiodarone, sotalol, ibutilide, dronedarone);
- Class 1C antiarrhythmics (e.g., flecainide, propafenone);
- antipsychotics (e.g., chlorpromazine, pimozide, haloperidol, droperidol, ziprasidone);
- antidepressants (e.g., citalopram, venlafaxine, tricyclic/tetracyclic antidepressants e.g., amitriptyline, imipramine, maprotiline);
- opioids (e.g. methadone);
- macrolide antibiotics and analogues (e.g., erythromycin, clarithromycin, telithromycin, tacrolimus);
- quinolone antibiotics, (e.g., moxifloxacin levofloxacin, ciprofloxacin);
- antimalarials (e.g., quinine, chloroquine);
- azole antifungals (e.g., ketoconazole, fluconazole, voriconazole);
- domperidone;
- 5-HT₃ receptor antagonists (e.g., dolasetron, ondansetron);
- tyrosine kinase inhibitors (e.g., vandetanib, sunitinib, nilotinib, lapatinib);
- histone deacetylase inhibitors (e.g., vorinostat);
- beta-2 adrenoceptor agonists (e.g., salmeterol, formoterol).

Drugs that Affect Electrolytes: The concomitant use of fluoxetine with drugs that can disrupt electrolyte levels is discouraged. Drugs that decrease electrolyte levels include, but are not limited to, the following: loop, thiazide, and related diuretics; laxatives and enemas; amphotericin B; high dose corticosteroids.

The above lists of potentially interacting drugs are not comprehensive. (See also sections WARNINGS AND PRECAUTIONS, Cardiovascular; ADVERSE REACTIONS, ECG Findings & Post-Market Drug Reactions, ACTION AND CLINICAL PHARMACOLOGY, Electrocardiography).

Monoamine Oxidase Inhibitors: Combined use of VAN-Fluoxetine and MAO inhibitors (including the antibiotic linezolid and the thiazine dye methylthioninium chloride (methylene blue) which are less well-known examples of MAOIs) is contraindicated due to the potential for serious reactions with features resembling serotonin syndrome or neuroleptic malignant syndrome (See CONTRAINDICATIONS; WARNINGS AND PRECAUTIONS, Serotonin

Syndrome/Neuroleptic Malignant Syndrome).

Thioridazine: Potential Interactions with Thioridazine (see also CONTRAINDICATIONS): In a study of 19 healthy male subjects, which included 6 slow and 13 rapid hydroxylators of debrisoquin, a single 25 mg oral dose of thioridazine produced a 2.4-fold higher C_{max} and a 4.5-fold higher AUC for thioridazine in the slow hydroxylators compared to the rapid hydroxylators. The rate of debrisoquin hydroxylation is felt to depend on the level of cytochrome P4502D6 isozyme activity. Thus, this study suggests that drugs which inhibit P4502D6, such as certain SSRIs, including fluoxetine, will produce elevated plasma levels of thioridazine.

Thioridazine administration produces a dose-related prolongation of the QTc interval which is associated with serious ventricular arrhythmias, such as torsades de pointes-type arrhythmias, and sudden death. This risk is expected to increase with fluoxetine-induced inhibition of thioridazine metabolism. Due to the risk of serious ventricular arrhythmias and sudden death potentially associated with elevated plasma levels of thioridazine, thioridazine should not be concomitantly administered, nor within a minimum of 5 weeks after fluoxetine has been discontinued, nor should fluoxetine be administered within 2 weeks after thioridazine has been discontinued (see CONTRAINDICATIONS).

Drugs Affecting Platelet Function (e.g., NSAIDs, ASA and other anticoagulants): Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID, ASA or other anticoagulants may potentiate the risk of bleeding.

Altered anticoagulant effects, including increased bleeding, have been reported when SSRIs or SNRIs are coadministered with warfarin. Patients receiving warfarin therapy should be carefully monitored when fluoxetine is initiated or discontinued [see WARNINGS AND PRECAUTIONS, Hematologic, Abnormal Bleeding].

Drugs Tightly Bound to Plasma Protein: Because fluoxetine is highly bound to plasma protein, the administration of fluoxetine to a patient taking another drug which is tightly bound to protein (e.g. warfarin, digitoxin) may cause a shift in plasma concentrations potentially resulting in an adverse effect. Conversely, adverse effects may result from displacement of protein bound fluoxetine by other tightly bound drugs.

Drugs Metabolized by P4502D6 Isoenzyme: Approximately 3 to 10% of the normal population has a genetic defect that leads to reduced levels of activity of the cytochrome P450 isoenzyme P4502D6. Such individuals have been referred to as "poor metabolizers" of drugs such as debrisoquine, dextrometorphan, sparteine, tricyclic antidepressants (e.g. nortriptyline, amitriptyline, imipramine, and desipramine), phenothiazine neuroleptics (e.g. perphenazine and thioridazine) and Type 1C antiarrhythmics (e.g. propafenone and flecainide).

Conversely, approximately 90 to 97% of the normal population do not have this genetic defect, and are known as "extensive metabolizers". Fluoxetine, like other agents that are metabolized by the P4502D6 system, inhibits the activity of this isoenzyme, and thus may make normal "extensive" metabolizers resemble "poor metabolizers". Therapy with medications that are

predominantly metabolized by the P4502D6 system and that have a relatively narrow therapeutic index (e.g. flecainide, encainida, vinblastine, carbamazepine and tricyclic antidepressants) should be initiated at the low end of the dose range if a patient is receiving fluoxetine concurrently, or has taken it in the previous 5 weeks.

If fluoxetine is added to the treatment regimen of a patient already receiving a drug metabolized by P4502D6 the need for decreased dose of the original medication should be considered. The aforementioned drugs with a narrow therapeutic index represent the greatest concern.

Tamoxifen: Pharmacokinetic interaction between CYP2D6 inhibitors and tamoxifen, showing a 65-75% reduction in plasma levels of one of the more active forms of the tamoxifen, i.e. endoxifen, has been reported in the literature. Reduced efficacy of tamoxifen has been reported with concomitant usage of some SSRI antidepressants in some studies. As a reduced effect of tamoxifen cannot be excluded, co-administration with potent CYP2D6 inhibitors (including fluoxetine) should whenever possible be avoided (see WARNINGS AND PRECAUTIONS).

Impact of CYP2D6 Inhibition on Fluoxetine Metabolism: Both the pharmacokinetic properties and relative proportion of metabolites of fluoxetine may be affected by a patient's CYP2D6 pharmacogenetic phenotype, or by a number of different drugs known to inhibit the CYP2D6 enzyme.

Drugs Metabolized by Cytochrome P4503A4: In an *in vivo* interaction study involving co-administration of fluoxetine with single doses of terfenadine (a cytochrome P4503A4 substrate), no increase in plasma terfenadine concentrations occurred with concomitant fluoxetine. In addition, *in vitro* studies have shown ketoconazole, a potent inhibitor of P4503A4 activity, to be at least 100 times more potent than fluoxetine or norfluoxetine as an inhibitor of the metabolism of several substrates for this enzyme, including astemizole, cisapride, and midazolam. These data indicate that fluoxetine's extent of inhibition of cytochrome P4503A4 activity is not likely to be of clinical significance.

Tricyclic Antidepressants: In two studies, previously stable plasma levels of imipramine and desipramine have increased greater than 2 to 10-fold when fluoxetine has been administered in combination. This influence may persist for three weeks or longer after fluoxetine is discontinued. Thus, the dose of tricyclic antidepressant (TCA) may need to be reduced and plasma TCA concentrations may need to be monitored temporarily when fluoxetine is coadministered or has been recently discontinued. See WARNINGS AND PRECAUTIONS; and ACTION AND CLINICAL PHARMACOLOGY, Accumulation and Slow Elimination sections.

Lithium: There have been reports of both increased and decreased lithium levels when lithium was used concomitantly with fluoxetine. Cases of lithium toxicity have been reported. Lithium levels should be monitored when these drugs are administered concomitantly.

Tryptophan: Five patients receiving fluoxetine in combination with tryptophan experienced adverse reactions, including agitation, restlessness and gastrointestinal distress.

Benzodiazepines: The half-life of concurrently administered diazepam may be prolonged in some patients.

Coadministration of alprazolam and fluoxetine has resulted in increased alprazolam plasma concentrations and in further psychomotor performance decrement due to increased alprazolam levels. Consideration should be given to monitoring of clinical status. Experience with the use of fluoxetine in combination with other CNS-active drugs is limited and caution is advised if such concomitant medication is required.

Alcohol: The concomitant use of fluoxetine and alcohol on cognitive and psychomotor effects in depressed, panic disorder or OCD patients is not known and is not recommended.

St. John's Wort: In common with other SSRI's, pharmacodynamic interactions between fluoxetine and the herbal remedy St. John's Wort may occur and may result in an increase in undesirable effects.

Antipsychotics: Elevation of blood levels of haloperidol and clozapine and in some cases, clinical manifestations of toxicity have been observed with coadministration of fluoxetine. Consideration should be given to monitoring of clinical status.

Serotonergic Drugs: Based on the mechanism of action of fluoxetine and the potential for serotonin syndrome, caution is advised when fluoxetine is coadministered with other drugs or agents that may affect the serotonergic neurotransmitter systems, such as tryptophan, triptans, serotonin reuptake inhibitors, linezolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, fentanyl and its analogues, dextromethorphan, tapentadol, meperidine, methadone, pentazocine or St. John's Wort (see WARNINGS AND PRECAUTIONS, Serotonin Syndrome/Neuroleptic Malignant Syndrome).

Triptans (5HT₁ agonists): There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of a selective serotonin reuptake inhibitor (SSRI) and the 5HT₁ agonist, sumatriptan. If concomitant treatment with triptan and an SSRI (e.g. fluoxetine, fluvoxamine, paroxetine, sertraline, or citalopram) is clinically warranted, appropriate observation of the patient is advised. The possibility of such interactions should also be considered if other 5HT₁ agonists are to be used in combination with SSRIs (see WARNINGS AND PRECAUTIONS, Serotonin Syndrome/Neuroleptic Malignant Syndrome).

Phenytoin: In patients on stable, maintenance doses of phenytoin, plasma phenytoin concentrations increased substantially and symptoms of phenytoin toxicity appeared (nystagmus, diplopia, ataxia and CNS depression) following initiation of concomitant fluoxetine treatment.

Carbamazepine: Patients on stable doses of phenytoin and carbamazepine have developed elevated plasma anticonvulsant concentrations and clinical anticonvulsant toxicity following initiation of concomitant fluoxetine treatment. Consideration should be given to monitoring of clinical status when fluoxetine treatment is initiated in these patients.

Drug-Food Interactions

Absorption of fluoxetine is not affected by food.

Drug-Herb Interactions

Interactions with Fluoxetine and herbal remedy St. John's Wort may occur (see Drug-Drug Interactions section).

Drug-Laboratory Interactions

Interactions with laboratory tests have not been established.

Drug-Lifestyle Interactions

Interaction with lifestyle interactions have not been established.

DOSAGE AND ADMINISTRATION

Dosing Considerations

VAN-Fluoxetine (fluoxetine) are not indicated for use in children under 18 year of age (see WARNINGS AND PRECAUTIONS: General: Potential Association with Behavioural and Emotional Changes, Including Self-Harm).

General

During maintenance therapy, the dosage should be kept at the lowest effective level.

Dose Adjustment

Since it may take up to four or five weeks to reach steady-state plasma levels of fluoxetine, sufficient time should be allowed to elapse before dosage is gradually increased. Higher dosages are usually associated with an increased incidence of adverse reactions.

Switching Patients to a Tricyclic Antidepressant (TCA)

Dosage of a TCA may need to be reduced and plasma TCA concentrations may need to be monitored temporarily when fluoxetine is coadministered or has been recently discontinued (see DRUG INTERACTIONS: Tricyclic Antidepressants section).

Switching Patients to or from A Monoamine Oxidase Inhibitor (MAOI)

At least 14 days should elapse between discontinuation of an MAOI and initiation of therapy with VAN-Fluoxetine. In addition, at least 5 weeks, perhaps longer, should be allowed after stopping VAN-Fluoxetine before starting MAOI (see CONTRAINDICATIONS section).

Discontinuation of Treatment

When dosing is stopped, active drug substances will persist in the body for weeks. This should be borne in mind when starting or stopping treatment. Dosage tapering is unnecessary in most patients.

Despite its long-half life, symptoms associated with the discontinuation of fluoxetine capsules have been reported in clinical trials and post-marketing. Patients should be monitored for these and other symptoms when discontinuing treatment, regardless of the indication for which VAN-Fluoxetine are being prescribed. Fluoxetine has been only rarely associated with such symptoms. Plasma fluoxetine and norfluoxetine concentrations decrease gradually at the conclusion of therapy, which makes dose tapering unnecessary in most patients (See WARNINGS AND PRECAUTIONS and ADVERSE REACTIONS).

Adults:

Depression

Initial Adult Dosage: The usual initial dosage is 20 mg administered once daily in the morning. A gradual dose increase should be considered only after a trial period of several weeks if the expected clinical improvement does not occur. Dosage should not exceed a maximum of 80 mg per day since clinical experience with doses above 80 mg per day is very limited.

Long Term: The efficacy of fluoxetine in maintaining an antidepressant response for up to 38 weeks following 12 weeks of open-label acute treatment (50 weeks total) was demonstrated in a placebo-controlled trial. The usefulness of the drug in patients receiving VAN-Fluoxetine for extended periods should be reevaluated periodically (see Part II: CLINICAL TRIALS section).

Bulimia Nervosa

Adult Dosage: The recommended dosage is 60 mg per day, although studies show that lower doses may also be efficacious. Electrolyte levels should be assessed prior to initiation of treatment.

Obsessive-Compulsive Disorder

A dose range of 20 mg/day to 60 mg/day is recommended for the treatment of obsessive-compulsive disorder.

Special Patient Populations

For any indication:

Use in Pregnant Women

Results of a number of epidemiological studies of pregnancy outcomes following early maternal exposure to antidepressants have been inconsistent, but there is some evidence of a possible small increase in the risk of cardiac malformations (eg ventricular and septal defects) associated with use of fluoxetine. The mechanism is unknown. The use of VAN-Fluoxetine during pregnancy should be considered only if the potential benefit justifies the potential risk to the fetus taking into account the risks associated with untreated depression.

Post-marketing reports indicate that some neonates exposed to fluoxetine, SSRIs or other newer anti-depressants, late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding (see WARNINGS AND PRECAUTIONS). When treating pregnant women with VAN-Fluoxetine during the third trimester, the physician should carefully consider the potential risks and benefits of treatment. The physician may consider tapering fluoxetine in the third trimester.

Use in the Elderly: Fluoxetine was evaluated in depressed elderly patients only at a dosage of 20 mg/day. A lower or less frequent dosage may be effective and should be considered in elderly patients with concurrent disease or on multiple medications.

Use in Children: VAN-Fluoxetine are not indicated for use in children under 18 year of age (see WARNINGS AND PRECAUTIONS: General: Potential Association with Behavioural and Emotional Changes, Including Self-Harm).

Debilitated Patients:

A lower or less frequent dosage should be used in patients with renal and/or hepatic impairment and in those on multiple medications.

OVERDOSAGE

For management of a suspected drug overdose, contact your regional Poison Control Centre.

Signs and Symptoms:

Cases of overdose of fluoxetine alone usually have a mild course. Symptoms of overdose included nausea, vomiting, seizures, cardiovascular dysfunction ranging from asymptomatic arrhythmias (including nodal rhythm and ventricular arrhythmias) or ECG changes indicative of QTc prolongation to cardiac arrest (including very rare cases of Torsade de Pointes), pulmonary dysfunction, and signs of altered CNS status ranging from excitation to coma. Fatalities attributed to overdose of fluoxetine alone have been reported. (Please refer to Human Experience and Animal Experience sections below).

Management of Overdosage:

There are no specific antidotes for fluoxetine capsules.

Treatment should consist of those general measures employed in the management of overdosage with any antidepressant.

Establish and maintain an airway; ensure adequate oxygenation and ventilation.

Cardiac, electrocardiogram, and vital signs monitoring is recommended, along with general symptomatic and supportive measures.

Induction of emesis is not recommended.

Gastric lavage with a large-bore orogastric tube with appropriate airway protection, if needed, may be indicated if performed soon after ingestion, or in symptomatic patients.

Activated charcoal should be considered in treating overdose.

Due to the large volume of distribution of fluoxetine, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit.

A specific caution involves patients who are taking or have recently taken fluoxetine and might ingest excessive quantities of a TCA. In such a case, accumulation of the parent tricyclic and/or an active metabolite may increase the possibility of clinically significant sequelae and extend the time needed for close medical observation.

Fluoxetine-induced seizures which fail to remit spontaneously may respond to diazepam. (see Product Monograph for diazepam).

In managing overdose, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control centre on the treatment of any overdose.

Human Experience:

Worldwide exposure to fluoxetine hydrochloride is estimated to be over 38 million patients (circa 1999). Of the 1578 cases of overdose involving fluoxetine hydrochloride, alone or with other drugs, reported from this population, there were 195 deaths.

Among 633 adult patients who overdosed on fluoxetine hydrochloride alone, 34 resulted in a fatal outcome, 378 completely recovered, and 15 patients experienced sequelae after overdose, including abnormal accommodation, abnormal gait, confusion, unresponsiveness, nervousness, pulmonary dysfunction, vertigo, tremor, elevated blood pressure, impotence, movement disorder, and hypomania. The remaining 206 patients had an unknown outcome. The most common signs and symptoms associated with non-fatal overdose were seizures, somnolence, nausea, tachycardia, and vomiting. The largest known ingestion of fluoxetine hydrochloride in adult patients was 8 grams in a patient who took fluoxetine alone and who subsequently recovered. However, in an adult patient who took fluoxetine alone, an ingestion as low as 520 mg has been associated with lethal outcome, but causality has not been established.

Among pediatric patients (ages 3 months to 17 years), there were 156 cases of overdose involving fluoxetine alone or in combination with other drugs. Six patients died, 127 patients completely recovered, 1 patient experienced renal failure, and 22 patients had an unknown outcome. One of the six fatalities was a 9-year-old boy who had a history of OCD, Tourette's syndrome with tics, attention deficit disorder, and fetal alcohol syndrome. He had been receiving 100 mg of fluoxetine daily for 6 months in addition to clonidine, methylphenidate, and promethazine. Mixed-drug ingestion or other methods of suicide complicated all six overdoses in children that resulted in fatalities. The largest ingestion in pediatric patients was 3 grams which was non-lethal.

Other important adverse events reported with fluoxetine overdose (single and multiple drugs) include coma, delirium, ECG abnormalities (such as QT interval prolongation and ventricular tachycardia, including torsades de pointes-type arrhythmias), hypotension, mania, neuroleptic malignant syndrome-like events, pyrexia stupor, and syncope.

Animal Experience:

Studies in animals do not provide precise or necessarily valid information about the treatment of human overdose.

However, animal experiments can provide useful insights into possible treatment strategies.

The oral median lethal dose in rats and mice was found to be 452 and 248 mg/kg, respectively. Acute high oral doses produced hyper-irritability and convulsions in several animal species.

Among six dogs purposely overdosed with oral fluoxetine, five experienced grand mal seizures. Seizures stopped immediately upon the bolus intravenous administration of a standard veterinary dose of diazepam. In this short-term study, the lowest plasma concentration at which a seizure occurred was only twice the maximum plasma concentration seen in humans taking 80 mg/day, chronically.

In a separate single-dose study, the ECG of dogs given high doses did not reveal prolongation of the PR, QRS, or QT intervals. Tachycardia and an increase in blood pressure were observed. Consequently, the value of the ECG in predicting cardiac toxicity is unknown. Nonetheless, the ECG should ordinarily be monitored in cases of human overdose.

ACTION AND CLINICAL PHARMACOLOGY

Pharmacodynamics

The antidepressant, antiobsessional, and antibulimic actions of fluoxetine are presumed to be linked to its ability to selectively inhibit the neuronal reuptake of serotonin. At clinically relevant doses fluoxetine blocks the uptake of serotonin into human platelets. Antagonism of muscarinic, histaminergic and α_1 -adrenergic receptors has been hypothesized to be associated with various anticholinergic, sedative and cardiovascular effects of classical tricyclic antidepressant drugs. *In vitro* receptor binding studies have demonstrated that fluoxetine binds to these and other membrane receptors [opiate, serotonergic (5-HT₁, 5-HT₂), adrenergic (α_1 , α_2 , β) and dopaminergic] much less potently than do the tricyclic drugs.

Electrocardiography

A double-blind, placebo-controlled, randomised, multiple dose study was performed in two cohorts of healthy adult subjects (CYP2D6 intermediate and extensive metabolizers). In the first cohort, subjects received once-daily oral dosing for 28 days with fluoxetine 20 mg (N = 12) or placebo (N = 4), whilst in the second cohort, subjects received once-daily oral dosing for 28 days with fluoxetine 40 mg (N = 12) or placebo (N = 4). Serial ECG assessments were performed at baseline and on days 1 and 28 of treatment. For the 40 mg fluoxetine treatment (N = 12), the maximal mean difference from placebo in change from time-averaged baseline in QTcF (QT/RR^{0.33}) was 12.005 msec (90% CI 4.412, 19.598) on day 28. For the 20-mg treatment, the corresponding placebo-adjusted increase in the QTcF interval was 4.841 msec (90% CI -4.009, 13.69) (see WARNINGS AND PRECAUTIONS, Cardiovascular; ADVERSE REACTIONS, ECG Findings & Post-Market Adverse Drug Reactions; DRUG INTERACTIONS).

Pharmacokinetics

Absorption, Distribution, Metabolism, and Excretion

Fluoxetine is well absorbed after oral administration. In man, following a single oral 40 mg dose, peak plasma concentrations of fluoxetine from 15 to 55 ng/mL are observed after 6 to 8 hours.

The capsule and oral solution dosage forms of fluoxetine are bioequivalent. Food does not appear to affect the systemic bioavailability of fluoxetine, although it may delay its absorption inconsequentially. Thus, fluoxetine may be administered with or without food.

Fluoxetine is extensively metabolized in the liver to norfluoxetine, and other unidentified metabolites. The pharmacological activity of norfluoxetine, which is formed by demethylation of fluoxetine appears to be similar to that of the parent drug. Norfluoxetine contributes to the long duration of action of fluoxetine. The primary route of elimination appears to be hepatic metabolism to inactive metabolites excreted by the kidney. The elimination half-life of fluoxetine is 4 to 6 days and that of its active metabolite is 4 to 16 days.

Clinical Issues Related to Metabolism/Elimination:

Variability in Metabolism:

The metabolism of fluoxetine, like that of a number of other compounds, including tricyclic antidepressants and some selective serotonin reuptake inhibitors (SSRIs), involves the P4502D6 system. Concomitant therapy with fluoxetine and the aforementioned drugs may lead to clinically significant drug interactions (see DRUG INTERACTIONS section).

Accumulation and Slow Elimination:

The relatively slow elimination of fluoxetine and its active metabolite, norfluoxetine, results in significant accumulation of these active moieties in chronic use. Therefore, it may take up to 1 to 2 months for the active drug substance(s) to disappear from the body. This persistence of active moieties is important to keep in mind when VAN-Fluoxetine are discontinued, or when drugs that are predicted to interact with VAN-Fluoxetine are to be administered soon after its discontinuation (see WARNINGS AND PRECAUTIONS, General, Implications of the Long Elimination Half-Life of Fluoxetine; and DRUG INTERACTIONS sections).

Kinetic Data:

After 30 days of dosing at 20 mg/day, mean plasma concentrations of fluoxetine 79.1 ± 33.4 ng/mL and of norfluoxetine 129 ± 42.0 ng/mL have been observed. Plasma concentrations of fluoxetine (elimination half-life of 1 to 3 days after acute administration and 4 to 6 days after chronic administration) were higher than those predicted by single-dose studies. Norfluoxetine appears to have linear pharmacokinetics. Its mean terminal half-lives after a single dose and multiple doses were 8.6 days and 9.3 days, respectively.

Steady state plasma levels are attained after 4 to 5 weeks of continuous drug administration. Patients receiving fluoxetine at doses of 40 to 80 mg/day over periods as long as 3 years exhibited, on average, plasma concentrations similar to those seen among patients treated for 4 to 5 weeks at the same dose.

Protein Binding:

Approximately 94% of fluoxetine is protein bound. The interaction between fluoxetine and other highly protein bound drugs has not been fully evaluated, but may be important (see DRUG INTERACTIONS section).

Special Populations and Conditions

Age: The effects of age upon the metabolism of fluoxetine have been investigated in a subset of 260 elderly, but otherwise healthy, depressed patients (mean age: 67.4 yr, range 60 to 85 yr) who received 20 mg fluoxetine for 6 weeks. Mean plasma concentrations were found to be 89.5 ± 53.6 ng/mL for fluoxetine and 119 ± 51.3 ng/mL for norfluoxetine. However, the effects of concomitant illness and/or concomitant drugs have not been evaluated.

Hepatic Insufficiency: In patients with cirrhosis, the elimination half-life of fluoxetine was prolonged, with a mean of 7.6 days compared to a range of 2 to 3 days seen in healthy subjects; norfluoxetine half-life was also prolonged, with a mean of 12 days compared to a range of 7 to 9 days in healthy subjects. Fluoxetine should therefore be used with caution in patients with liver disease (see WARNINGS AND PRECAUTIONS, Hepatic; and DOSAGE AND ADMINISTRATION sections).

Renal Insufficiency: In single dose studies, the pharmacokinetics of fluoxetine and norfluoxetine were similar among subjects with all levels of impaired renal function including anephric patients on chronic hemodialysis. However, with chronic administration, additional accumulation of fluoxetine or its metabolites (possibly including some not yet identified) may occur in patients with severely impaired renal function, and the use of a lower or less frequent dose is advised (see WARNINGS AND PRECAUTIONS, Renal; and DOSAGE AND ADMINISTRATION sections).

STORAGE AND STABILITY

Store at room temperature (15°- 30° C).

DOSAGE FORMS, COMPOSITION AND PACKAGING

VAN-Fluoxetine 10 mg contain: 11.18 mg fluoxetine hydrochloride equivalent to 10 mg of fluoxetine, colloidal anhydrous silica, magnesium stearate, pregelatinised starch and purified talc. The capsule shell contains black ink (black iron oxide, butyl alcohol, dehydrated alcohol, isopropyl alcohol, potassium hydroxide, propylene glycol, shellac, strong ammonia solution), FD & C Blue no. 1, gelatin, iron oxide yellow and titanium dioxide.

VAN-Fluoxetine 20 mg contain: 22.36 mg fluoxetine hydrochloride equivalent to 20 mg of fluoxetine, colloidal anhydrous silica, magnesium stearate, pregelatinised starch and purified talc. The capsule shells contain black ink (black iron oxide, butyl alcohol, dehydrated alcohol, isopropyl alcohol, potassium hydroxide, propylene glycol, shellac, strong ammonia solution), erythrosine, gelatin, indigo carmine, quinoline yellow and titanium dioxide.

AVAILABILITY OF DOSAGE FORMS:

VAN-Fluoxetine 10 mg are Opaque green/Opaque green, size '3', hard gelatin capsules containing white to off-white powder, packaged in amber HDPE bottles of 100.

VAN-Fluoxetine 20 mg are Light green opaque/standard yellow opaque, size '3', hard gelatin capsules containing white to off-white powder, packaged in amber HDPE bottles of 100.

PART II: SCIENTIFIC INFORMATION

PHARMACEUTICAL INFORMATION

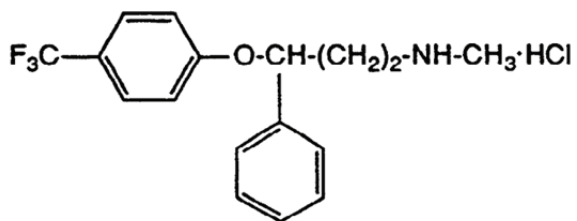
Drug Substance

Proper name: Fluoxetine Hydrochloride

Chemical name: (±)-N-methyl-3-phenyl-3-[(α,α,α-trifluoro-p-tolyl)-oxy]-propylamine hydrochloride

Molecular formula and molecular weight: $C_{17}H_{18}F_3NO \cdot HCl$
345.79

Structural formula:



Physicochemical properties:

Description:	Fluoxetine is white to off-white crystalline solid.	
pKa:	9.5 (66% Dimethylformamide)	
Solubility Profile:	Solvent	mg/mL
	Water	10
	Methylene chloride	10
	Methanol	100

CLINICAL TRIALS

A double blind, balanced, randomized, two-treatment, two-sequence, two-period, single oral dose, crossover comparative bioavailability study of VAN-Fluoxetine 10 mg (Vanc Pharmaceuticals Inc.) versus Prozac[®] capsules 10 mg (fluoxetine hydrochloride, Eli Lilly Canada Inc.) was conducted in 24 normal, healthy, adult, human male subjects under fasting conditions. The results are tabulated below.

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Fluoxetine (1x 10 mg Capsule) From measured data Uncorrected for potency Geometric Mean Arithmetic Mean (CV %) (n=24)				
Parameter	Test*	Reference [†]	% Ratio of Geometric Means	90% Confidence Interval
AUC _{0-72h} (ng.h / mL)	175.347 185.627 (34.7%)	181.582 191.669 (34.9%)	96.6	93.07-100.20
C _{max} (ng / mL)	4.579 4.700 (23.3%)	4.602 4.763 (27.2%)	99.5	95.16-104.03
T _{max} (h) [§]	8.000 (5.000-11.000)	8.250 (6.000-11.000)		

* VAN-Fluoxetine 10 mg (Vanc Pharmaceuticals Inc.)

[†] PROZAC[®] (fluoxetine hydrochloride) capsules 10 mg- Manufactured by Eli Lilly Canada Inc., Toronto, Ontario.

[§] Expressed as the median (range) only

A double blind, balanced, randomized, two-treatment, two-sequence, two-period, single oral dose, crossover comparative bioavailability study of VAN-Fluoxetine 20 mg (Vanc Pharmaceuticals Inc.) versus Prozac[®] capsules 20 mg (fluoxetine hydrochloride, Eli Lilly Canada Inc.) was conducted in 25 normal, healthy, adult, human male subjects under fasting conditions. The results are tabulated below.

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Fluoxetine (1x 20 mg Capsule) From measured data Uncorrected for potency Geometric Mean Arithmetic Mean (CV %) (n=25)				
Parameter	Test *	Reference †	% Ratio of Geometric Means	90% Confidence Interval
AUC _{72h} (ng.h / mL)	394.596 420.170 (39.7%)	397.985 422.257 (37.6%)	99.5	96.32 – 102.72
C _{max} (ng / mL)	11.454 11.743 (23.1%)	11.460 11.736 (22.7 %)	99.7	95.63 – 103.95
T _{max} (h) [§]	7.500 (5.000 – 8.500)	7.000 (5.000 – 8.000)		

* VAN-Fluoxetine 20 mg (Vanc Pharmaceuticals Inc.)

† PROZAC[®] (fluoxetine hydrochloride) capsules 20 mg- Manufactured by Eli Lilly Canada Inc., Toronto, Ontario.

§ Expressed as the median (range) only

The efficacy of fluoxetine was established in 5- and 6- week placebo-controlled clinical trials in depressed outpatients (≥ 18 yr of age), who meet the DSM-III-R criteria for major depressive disorder.

Two, 6-week placebo-controlled clinical trials in depressed elderly patients, who met the DSM-III-R criteria for major depressive disorder (mean age 67.4 yr, range 60 to 85 yr) have shown fluoxetine, 20 mg/day, to be effective.

A study was conducted involving depressed outpatients who had responded (modified HAMD-17 score of ≤ 7 during each of the last 3 weeks of open-label treatment and absence of major depression by DSM-III-R criteria) by the end of an initial 12-week open treatment phase on fluoxetine 20 mg/day. These patients (N=298) were randomized to continuation on double-blind fluoxetine 20 mg/day or placebo. At 38 weeks (50 weeks total), a statistically significantly lower relapse rate (defined as symptoms sufficient to meet a diagnosis of major depression for 2 weeks or a modified HAMD-17 score of ≥ 14 for 3 weeks) was observed for patients taking fluoxetine compared to those on placebo.

DETAILED PHARMACOLOGY

In vitro and *in vivo* studies have shown fluoxetine and norfluoxetine (the major metabolite) to be potent and selective inhibitors of neuronal pre-synaptic reuptake of serotonin. Serotonin released into the synaptic cleft by a nerve impulse is inactivated principally by reuptake into the presynaptic nerve ending where it is metabolized or retained in storage granules. Fluoxetine specifically inhibits the reuptake process, thereby allowing serotonin to remain longer in the synaptic cleft and enhancing the action of the neurotransmitter on synaptic receptors. Fluoxetine has only weak affinity for various receptor systems in receptor binding studies.

A number of behavioural, neuroendocrinologic, and other pharmacologic effects of fluoxetine in experimental animals have been attributed to its enhancement of serotonergic function by inhibition of serotonin uptake. Fluoxetine restored the capacity for acquisition of passive avoidance task in olfactory bulbectomized rats, potentiated 5-hydroxy-tryptophan-induced head twitch in mice, potentiated 5-hydroxytryptophan-induced depression of operant behavior in pigeons, and potentiated the behavioral effect of 5-hydroxytryptophan in rats working on a milk reinforcement schedule. Fluoxetine suppressed REM sleep in rats and cats, and reduced the amount or altered the composition of dietary intake in rats. It also selectively reduced non-protein caloric intake in rats.

Few pharmacologic actions of fluoxetine other than inhibition of serotonin uptake and consequences of that inhibition have been found. For instance, fluoxetine does not antagonize reserpine- or apomorphine-induced hypothermia in mice, and does not reduce immobility in the forced swimming test in rats.

Pharmacokinetics:

Animal and In vitro

Fluoxetine was well absorbed orally and the oral bioavailability of fluoxetine in dogs was 72%.

In dogs given oral doses of 1 to 10 mg/kg fluoxetine for one year, dose dependent increases in fluoxetine and norfluoxetine concentrations were observed in liver, adrenal, and lung.

Norfluoxetine concentrations exceeded fluoxetine concentrations in the tissues, and persisted for a longer period in plasma.

In rats, after a single i.p. dose of 10 mg/kg, the plasma half-life of fluoxetine was 26 hours and that of norfluoxetine, 40 hours. The plasma half-life in dogs dosed orally at 5 to 10 mg/kg for 15 days, was 1 day for fluoxetine and 2.1 to 5.4 days for norfluoxetine.

In vitro, fluoxetine was N-demethylated to norfluoxetine by rat, guinea pig, and rabbit liver microsomes. *In vivo*, fluoxetine was metabolized mainly by N-demethylation in mice, rats, guinea pigs, rabbits, and dogs. The other major metabolite was trifluoro-methylphenol, formed by O-dealkylation, which was excreted as a sulphate or glucuronide conjugate by rats, guinea pigs, and dogs.

Fluoxetine and norfluoxetine were also excreted in the urine unchanged in guinea pigs, rabbits, and dogs. In rats, fluoxetine and norfluoxetine were both further metabolized, so that neither

fluoxetine nor its N-demethylated metabolite was found in the urine. Rats eliminated 16 to 42 percent of the dose in urine as p-trifluoromethylphenol and 8 percent of the dose as hippuric acid in 24 hours.

Safety Pharmacology

In vitro studies have demonstrated that fluoxetine and norfluoxetine inhibit hERG potassium channel and L-type calcium channel, as well as trafficking of the hERG channel to the plasma membrane.

TOXICOLOGY

Acute Toxicity Studies:

Table 4: Toxicity Data of Fluoxetine and Norfluoxetine in Animals

Species	Route	Sex	Fluoxetine LD ₅₀ (mg/kg)	Norfluoxetine LD ₅₀ (mg/kg)
Mouse	Oral	F	248 ± 14	361 ± 14
	I.V.	F	45 ± 1.5	42 ± 3
Rat	Oral	M	467 ± 33	--
		F	437 ± 40	--
	I.V.	M	35 ± 1	--
		F	35 ± 1	35 ± 2
Guinea Pig	Oral	M	> 250	--
Cat	Oral	M/F	> 50	--
Dog	Oral	M/F	> 100	--
Monkey	Oral	M/F	> 50	--

Signs of toxicity included vomiting, anorexia, mydriasis, salivation, tremors, clonic convulsions, hyperirritability and cachexia.

Subchronic/Chronic/Carcinogenicity and Related Toxicity Studies:

Subchronic Toxicity Studies:

Mice (5/sex/dose) were maintained on diets containing ca. 25, 59 and 204 mg/kg/day fluoxetine for 15 days. Thirty and 100% mortality were observed at the middle and high dose, respectively. Significant effects at the two highest doses included: hyperactivity and body weight loss, decrease in spleen weights and phospholipidosis.

Mice were maintained for three months on diets equivalent to ca. 2, 7 or 31 mg/kg/day. Significant effects were essentially limited to high dose mice and included 15% mortality; persistent hyperactivity and decreased body weight gain; slight and reversible increases in alkaline phosphatase and alanine transaminase; decreases in testes, heart, and spleen weights; hypospermatogenesis; reversible pulmonary phospholipidosis.

Pulmonary histiocytosis (phospholipidosis) was the major pathological finding in rats maintained on diets providing average doses of approximately 9, 25 or 74 mg/kg/day for three months. All animals at ca. 74 mg/kg/day died by week 8. Decreased food consumption, weight loss, and

hyperirritability were observed at ca. 25 and 74 mg/kg/day.

Dogs given 5 to 50 mg/kg/day orally for two weeks experienced anorexia, mydriasis and vomiting. Dogs, receiving 50 mg/kg/day exhibited ataxia, tremors and a convulsion in one dog.

Dogs survived oral doses up to 20 mg/kg/day for three months with significant anorexia as the major treatment-related effect. Significant accumulation of both fluoxetine and norfluoxetine occurred in the plasma and tissues. Mydriasis and tremors were observed during the first month.

Monkeys given 10 or 25 mg/kg/day p.o. for two weeks exhibited anorexia and weight loss. One monkey at 25 mg/kg/day exhibited clonic convulsions after six doses. Accumulation of fluoxetine and norfluoxetine was observed after multiple dosing and decreased erythrocyte and white blood cell counts were observed.

Chronic Toxicity Studies:

Fluoxetine was given daily to rats (25/sex/dose) for one year at dietary levels of ca. 0.5, 2.3 and 10.7 mg/kg/day. Physical signs of toxicity were limited to females at the high dose level and consisted of anorexia, chromodacryorrhea and an unusual behaviour first noted during the eighth month of treatment in which the animals walked on their toes with feet extended and backs arched after they had been handled.

Evidence of phospholipidosis was obtained in the lung, liver and adrenal cortex of 24/40 animals at the high dose level and in one rat at the mid-dose level. Phospholipidosis was reversible after two months' withdrawal from treatment. Minimal to slight fat deposition in the liver was prevalent at the mid and high dose levels. Reversible, minimal reticuloendothelial cell hyperplasia was present in the lymph nodes of the high dose level animals.

Dogs (5/sex/dose) received daily oral doses of 1, 4.5, or 20 mg/kg (decreased to 10 mg/kg after 6 months as three females died) of fluoxetine for one year. The toxic effects observed in this study were similar to those of the subchronic study except that phospholipidosis was seen after chronic administration in the lung, liver, adrenals, the inner plexiform layer of the retina, lymph nodes, spleen, and peripheral leukocytes in the animals receiving the high dose. They also showed moderate bradycardia and a moderate decrease in adrenal weight.

Phospholipidosis was only observed in the lung and leukocytes in a few of the dogs at the lowest dose level of 1.0 mg/kg/day. No cardiovascular effects were seen apart from a slight decrease in basal heart rate. All treatment-related effects were reversible during the recovery period in surviving animals.

Discussion on Phospholipidosis: Systemic phospholipidosis was associated with the subchronic and/or chronic administration of fluoxetine to mice, rats and dogs. This effect was associated with the accumulation of norfluoxetine, and to a lesser extent, fluoxetine, in affected tissues. Systemic phospholipidosis was not associated with any adverse effects and was shown to be reversible after the chronic administration of fluoxetine for one year in rats and dogs.

This effect has been demonstrated in animals with a number of other clinically useful cationic

amphiphilic drugs including antidepressants - imipramine, clomipramine, iprindole and other drugs - chlorphentermine, fenfluramine, clozapine, chloroquine, mepacocine, chlorcyclizine, tamoxifen, 4,4'diethylaminoethoxyhexestrol, amiodarone and perhexiline. The significance of this finding for man is not fully understood. It is anticipated that in the clinical use of fluoxetine, the properties of the drug which are associated with phospholipidosis will not result in any untoward effect.

Juvenile Toxicology Study: In a juvenile toxicology study in CD rats, administration of 30 mg/kg of fluoxetine hydrochloride on postnatal days 21 through 90 resulted in increased serum activities of creatine kinase (CK) and aspartate aminotransferase (AST), which were accompanied microscopically by skeletal muscle degeneration, necrosis and regeneration. Femur lengths at 30mg/kg increased to a lesser extent compared with control rats. The dose of 30 mg/kg was associated with severe toxicity in general and exceeded a maximum tolerated dose. A specific effect of fluoxetine on bone development has been reported in mice treated with fluoxetine during the juvenile period. When mice were treated with fluoxetine (5 or 20 mg/kg, ip) for 4 weeks starting at 4 weeks of age, bone formation was reduced resulting in decreased bone mineral content and density. These doses did not affect overall growth (body weight gain or femoral length). The doses administered to juvenile mice in this study are approximately 0.5 and 2 times the MRD for pediatric patients on a body surface basis. Other findings are discussed below in the Reproductive and Impairment of Fertility Studies.

Carcinogenicity Studies:

Rats were maintained for two years at dietary levels equivalent to a time-weighted average dose of ca. 0.45, 2 and 9 mg/kg/day. Age-related observations such as chromodacryorrhea, alopecia, and poor grooming increased at the high dose, especially in females. Weight gain and food consumption were depressed at the high dose and a handling-induced behaviour involving arching of the back and walking on toes was observed primarily in females in this group. Increased tissue levels of fluoxetine and norfluoxetine were observed at all doses, and phospholipidosis was observed primarily at the high dose. There were no significant increases in tumor incidence or animal mortality.

Mice were fed dietary levels of fluoxetine equivalent to ca. 1.2, 4.8 and 12.1 mg/kg/day. The dietary levels were based on the results of the three-month subchronic study. Unexpectedly, high mortality occurred in females receiving the high dose early in the two-year study, necessitating lowering the dose after 30 days. The survival rate of females receiving the high dose was reduced at two years. No major toxicological effects were seen in mice other than a moderate increase in alanine transaminase in males receiving the high dose and slight changes in organ weights. Hepatocellular degeneration, fat deposition in liver, and centrilobular hepatocellular degeneration were observed microscopically at the median and high dose. There was no evidence of phospholipid accumulation in the lung, and no oncogenic response was observed.

A second two-year mouse study using similar doses gave similar results. Survival at two years was reduced in females receiving the high dose. Handling-induced clonic convulsions occurred at all levels in males, and in females, at the high-dose level it was accompanied by a slight increase in liver weight. Minimal-to-moderate fatty change in the liver and hepatocellular cytomegaly were seen in mice from the median- and high-dose levels. There was a dose-

dependent increase in concentrations of fluoxetine and norfluoxetine in lung tissue. There was no evidence of phospholipid accumulation in the lung, and no oncogenic response was observed.

Reproductive and Impairment of Fertility Studies:

Female Wistar rats (30/dose) were given daily oral doses of 2, 5, or 12.5 mg/kg from two weeks prior to mating through gestation or lactation. In a second study, male Wistar rats (40/dose) were maintained on diets approximately equivalent to 1.5, 3.9, or 9.7 mg/kg for 10 weeks prior to mating and through the breeding trial. These treated males were mated with female Wistar rats (40/dose) maintained at the same dietary levels for three weeks prior to mating and throughout lactation. In both studies, a depression in neonatal survival was obtained at the high dose level. No teratogenic effects or adverse effects on fertility or post-natal development were associated with fluoxetine administration.

Impairment of fertility in adult animals at doses up to 12.5mg/kg/day (approximately 1.5 times the MRHD on a mg/m² basis) was not observed

In a juvenile toxicology study, fluoxetine hydrochloride was administered orally to CD rats (30/sex/group) at doses of 0, 3, 10, and 30 mg/kg/day from postnatal days 21 through 91 and evaluated for general clinical observations. Ten rats/sex/group were necropsied on postnatal day 91 and evaluated for changes in clinical chemistry, hematology, femur length, organ weights, and histopathology. Following an approximately 11-week recovery period, sperm assessments were performed in all groups, and microscopic examination of testis and epididymides occurred in the 30mg/kg/day males only.

Plasma levels achieved at 30mg/kg/day were approximately 5 to 8 fold (fluoxetine) and 18 to 20 fold (norfluoxetine), and at 10 mg/kg approximately 2 fold (fluoxetine) and 8 fold (norfluoxetine) higher compared to plasma concentrations usually achieved in pediatric patients.

Administration of 30 mg/kg/day of fluoxetine hydrochloride on postnatal days 21 through 90 resulted in a substantial decrease in body weight gain with concomitant degeneration and necrosis of seminiferous tubules of the testis, epididymal epithelial vacuolation, epididymal sperm granuloma, and immaturity and inactivity of the female reproductive tract.

Findings following an approximately 11-week recovery period in male rats administered 30mg/kg/day, consisted of testicular degeneration, seminiferous tubular sperm microgranulomas, epididymal epithelial cribriform change, epididymal epithelial vacuolation and epididymal sperm granulomas. All of the rats with cribriform change had testicular degeneration, and comparison to the treatment-phase rats indicated that the testicular degeneration was irreversible. In contrast, the reduction in degree and extent of epididymal vacuolation compared to the treatment-phase rats indicates that the vacuolation was reversible.

Sperm assessments in the 30-mg/kg males only indicated an approximately 30% decrease in sperm concentrations without affecting sperm morphology or motility. Decreased fertility was observed in this dose-group. Delays in sexual maturation occurred in the 10-mg/kg/day males and in the 30-mg/kg/day males and females. The significance of these findings in humans is unknown.

Mutagenicity Studies:

The mutagenicity of fluoxetine and its metabolite norfluoxetine was evaluated in a battery of *in vitro* and *in vivo* tests including Ames test, modified Ames test, DNA repair in rat hepatocytes, sister chromatid exchange in Chinese hamster bone marrow assays, and mouse lymphoma assay. Fluoxetine and norfluoxetine were negative in all 5 systems.

Teratology Studies:

Virgin female Fischer 344 rats (25/dose) were bred with untreated control males and were given daily oral (gavage) doses of 2, 5, or 12.5 mg/kg/day fluoxetine on gestation days 6-15; animals were evaluated on gestation day 20. Body weight gains and food consumption were depressed at 12.5 mg/kg/day. Fluoxetine produced no teratogenic effects and no changes in reproductive parameters.

Virgin female Dutch Belted rabbits (15/dose) were artificially inseminated with semen from untreated control males and were given daily oral (gavage) doses of 2.5, 7.5, or 15 mg/kg/day fluoxetine on gestation days 6-18; animals were evaluated on gestation day 28. Maternal toxicity was demonstrated by depressed body weight gains and food consumption at all dose levels in a dose-dependent manner. At the 15 mg/kg/day dose, two rabbits died and three aborted. Resorptions were also increased in this group. There was no evidence of a teratogenic effect.

REFERENCES

1. Altamura AC, Montgomery SA, Wernicke JF. The evidence for 20 mg a day of fluoxetine as the optimal dose in the treatment of depression. *Brit J Psychiatry* 1988; 153:109-112.
2. Aronoff GR, et al. Fluoxetine kinetics and protein binding in normal and impaired renal function. *Clin Pharmacol Ther* 1984; 36:138-144.
3. Bouley M, Fau S, Leplat P, Davrinche P. Fluoxetine and hyponatremia: A case report in the elderly. *J de Pharmacie Clin* 1998; 17:169-174.
4. Beasley C Jr, et al. Fluoxetine and suicide: A meta-analysis of controlled trials of treatment for depression. *Br. Med J* 1991; 303:685-692.
5. Benfield P, Heel RC, Lewis SP. Fluoxetine - a review of its pharmacodynamic and pharmacokinetic properties, and therapeutic efficacy in depressive illness. *Drugs* 1986; 32:481-508.
6. Bergstrom RF, Peyton AL, Lemberger L. Quantification and mechanism of the fluoxetine and tricyclic antidepressant interaction. *Clin Pharmacol Ther* 1992; 51:239-248.
7. Bergstrom RF, Lemberger L, Farid NA, Wolen, RL. Clinical pharmacology and pharmacokinetics of fluoxetine: a review. *Brit J Psychiatry* 1988; 153:47-50.
8. Bremner JD. Fluoxetine in depressed patients: a comparison with imipramine. *J Clin Psychiatry* 1984; 45:414-419.
9. Buff DD, Brenner R, Kirtane SS, Gilboa R. Dysrhythmia associated with fluoxetine treatment in an elderly patient with cardiac disease. *J Clin Psychiatry* 1991;52:174-176.
10. Carillo JA, et al. Pharmacokinetic Interaction of Fluvoxamine and Thioridazine in Schizophrenic Patients. *J Clin Psychopharmacol* 1999;19: 494-499.
11. Chouinard G. A double-blind controlled clinical trial of fluoxetine and amitriptyline in the treatment of outpatients with major depressive disorder. *J Clin Psychiatry* 1985; 46:32-37.
12. Chouinard G, Jones B. No crossover of hypersensitivity between zimelidine and fluoxetine. *Can Med Assoc J* 1984;131:1190.
13. Chouinard G, Sultan S. A case of Parkinson's Disease exacerbated by fluoxetine. *Human Psychopharmacol* 1992;7:63-66.
14. Cooper GL. The safety of fluoxetine - an update. *Brit J Psychiatry* 1988;153:77-86.
15. Droulers A, Bodak N, Oudjhani M et al. Decrease of valproic acid concentration in the blood when coprescribed with fluoxetine. *J Clin Psychopharmacology* 1997;17:139-140.

16. Fabre LF, Putnam HP. A fixed-dose clinical trial of fluoxetine in outpatients with major depression. *J Clin Psychiatry* 1987;48:406-408.
17. Fairweather DB, Kerr JS, Harrison DA et al. A double blind comparison of the effects of fluoxetine and amitriptyline on cognitive function in elderly depressed patients. *Human Psychopharmacology* 1993;8:41-47.
18. Fava M, Herzog D, Hamburg P et al. Long-term use of fluoxetine in bulimia nervosa: a retrospective study. *Ann Clin Psychiat* 1990;2:53-56.
19. Feighner JP. A comparative study of fluoxetine and amitriptyline in patients with major depressive disorder. *J Clin Psychiatry* 1985;46:369-372.
20. Feighner JP, Boyer WF, Meredith CH, Hendrickson G. An overview of fluoxetine in geriatric depression. *Brit J Psychiatry* 1988;153:105-108.
21. Fichter M, Leibl K, Rief W, et al. Fluoxetine versus placebo: a double-blind study with bulimic inpatients undergoing intensive psychotherapy. *Pharmacopsychiatry* 1991;24:1-7.
22. Fisch C. Effect of fluoxetine on the electrocardiogram. *J Clin Psychiatry* 1985;46:42-44.
23. Fluoxetine Bulimia Nervosa Collaborative Study Group: Fluoxetine in the treatment of bulimia nervosa. *Arch Gen Psychiat* 1992;49:139-147.
24. Fuller RW, Perry KW, and Molloy BB. Effect of 3-(p-Trifluoromethyl-phenoxy)-N-Methyl-3-Phenylpropylamine on the depletion of brain serotonin by 4-Chloroamphetamine. *J Pharmacol Exp Ther* 1975;193:796-803.
25. Goldbloom D, Kennedy S. Adverse interaction of fluoxetine and cyprohetadine in two patients with bulimia nervosa. *J Clin Psychiat* 1991; 52:261-262.
26. Halper JP, Mann JJ. Cardiovascular effects of antidepressant medications. *Brit J Psychiatry* 1988;153:87-98.
27. Hartigan-Go K, et al. Concentration-related pharmacodynamic effects of thioridazine and its metabolites in humans. *Clin Pharmacol Ther* 1996;60:543-553.
28. Hindmarch I. A pharmacological profile of fluoxetine and other antidepressants, on aspects of skilled performance and car handling ability. *Brit J Psychiatry* 1988;153:99-104.
29. Jalil P. Toxic reaction following the combined administration of fluoxetine and phenytoin: two case reports. *J Neurol Neurosurg Psychiatry* 1992;5:412-413.
30. Laakman G, Blaschke D, Engel R, Schwarz, A. Fluoxetine vs amitriptyline in the treatment of depressed out-patients. *Brit J Psychiatry* 1988;153:64-68.

31. Lader MH. Fluoxetine efficacy vs comparative drugs: an overview. *Brit J Psychiatry* 1988; 153:51-58.
32. Lemberger L, Bergstrom RF, Wolen RL, et al. Fluoxetine: clinical pharmacology and physiologic disposition. *J Clin Psychiatry* 1985;46:14-19.
33. Lester BM, Cucca J, Andreozzi L, et al. Possible association between fluoxetine hydrochloride and colic in an infant. *J Am Acad Child Adolesc Psychiatry* 1993;32:1253-1255.
34. Liu BA, Mittmann N, Knowles SR, Shear NH. Hyponatremia and the syndrome of inappropriate secretion of antidiuretic hormone associated with the use of selective serotonin reuptake inhibitors: a review of spontaneous reports. *Cdn Med Assn J* 1996;155:519-527.
35. Lucena MI, Blanco E, Corrales MA, Berthed ML. Interaction of fluoxetine and valproic acid. *Am J Psychiatry* 1998; 155:575.
36. Miranda MC, Armijo GV, Miranda PC. Severe hyponatremia in a female treated with fluoxetine. *Revista Medica De Chile* 1999;127:337-340.
37. Montgomery SA. The benefits and risks of 5-HT uptake inhibitors in depression. *Brit J Psychiatry* 1988; 153:7-10.
38. Nash JF, Bopp RJ, Carmichael RH, et al. Determination of fluoxetine and norfluoxetine in plasma by gas chromatography with electron-capture detection. *Clin Chem* 1982; 28:2100-2102.
39. Reimherr FW, Wood DR, Byerley B, et al. Characteristics of responders to fluoxetine. *Psychopharmacol Bull* 1984;20:70-72.
40. Rickels K, et al. Comparison of two dosage regimens of fluoxetine in major depression. *J Clin Psychiatry* 1985; 46:38-41.
41. Richelson E. Synaptic pharmacology of antidepressants: an update. *McLean Hosp J* 1988; XIII: 67-88.
42. Romerio SC, Radanowicz V, Schlienger RG. SIADH with convulsions and coma in a patient using fluoxetine. *Schweizerische Rundschau fur Medizin/Praxis* 2000; 89:404-410.
43. Schmidt MJ, Fuller RW, Wong DT. Fluoxetine, a highly selective serotonin reuptake inhibitor: a review of preclinical studies. *Brit J Psychiatry* 1988; 153(3):40-46.
44. Sommi RW, Crimson ML, and Bowden CL. Fluoxetine: a serotonin-specific second-generation antidepressant. *Pharmacotherapy* 1987;7:001-015.
45. Stark P, Fuller RW, Wong DT. The pharmacologic profile of fluoxetine. *J Clin Psychiatry*

1985; 46:7-13.

46. Stark P, Hardison CD. A review of multicenter controlled studies of fluoxetine vs imipramine and placebo in outpatients with major depressive disorder. *J Clin Psychiatry* 1985; 46:53-58.
47. Steiner W, Fontain R. Toxic reaction following the combined administration of fluoxetine and 1-tryptophan: five case reports. *Biol Psychiatry* 1986;21:1067-1071.
48. VonBahr C, et al. Plasma levels of thioridazine and metabolites are influenced by the debrisoquin hydroxylation phenotype. *Clin Pharmacol Ther* 1991;49(3):234-240.
49. Walsh BT. Fluoxetine treatment in bulimia nervosa. *J. Psychosomatic Res* 1991;35: 33-40.
50. Wilcox JA. Fluoxetine and bulimia. *J. Psychoactive Drugs* 1990;22:81-82.
51. Wernicke JF, Bremner JD. Fluoxetine effective in the long term treatment of depression. *Brit J Clin Practice* 1986; 40:17-23.
52. Wernicke JF, Dunlop SR, Dornseif BE, Bosomworth JC, and Humbert M. Low-dose fluoxetine therapy for depression. *Psychopharm Bull* 1988;24 (1):183-188.
53. Wheadon D, Rampey A, Thompson V, et al. Lack of association between fluoxetine and suicidality in bulimia nervosa. *J Clin Psychiatry* 1992; 53:235-241.
54. Product monograph for ^{Pt}PROZAC[®] (fluoxetine hydrochloride) Capsules manufactured by Eli Lilly Canada Inc. (24 September 2013).

PART III: CONSUMER INFORMATION

VAN-Fluoxetine

This leaflet is part III of a three-part "Product Monograph" published when VAN-Fluoxetine were approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about VAN-Fluoxetine.

Contact your doctor or pharmacist if you have any questions about the drug.

Please read this information before you start to take your medicine, even if you have taken this drug before. Keep this information with your medicine in case you need to read it again.

ABOUT THIS MEDICATION

What the medication is used for:

VAN-Fluoxetine has been prescribed by your doctor to relieve your symptoms of:

- depression (feeling sad, a change in appetite or weight, difficulty concentrating or sleeping, feeling tired, headaches, unexplained aches and pain)
- bulimia (eating disorder, characterized by self-induced vomiting after eating)
- or obsessive-compulsive disorder (recurrent and intrusive thought, feeling, idea, or sensation; recurrent pattern of behavior, or unwanted thoughts or actions)

What it does:

Fluoxetine belongs to a group of medicines called selective serotonin reuptake inhibitors (SSRIs). Fluoxetine is thought to work by increasing the levels of a chemical in the brain called serotonin (5-hydroxytryptamine).

When it should not be used:

Do not use VAN-Fluoxetine if you:

- are allergic to it or any of the components of its formulation (see What the nonmedicinal ingredients are:).
- are currently or have recently taken the drug thioridazine.
- are currently or have recently taken monamine oxidase anti-depressants (e.g. phenelzine sulphate, moclobemide).

What the medicinal ingredient is:

VAN-Fluoxetine contains the active ingredient fluoxetine hydrochloride.

What the nonmedicinal ingredients are:

VAN-Fluoxetine 10 mg and 20 mg contains colloidal anhydrous silica, magnesium stearate, pregelatinised starch and purified talc.

The capsule shells contain:

10 mg: black ink (black iron oxide, butyl alcohol,

20 mg: black ink (black iron oxide, butyl alcohol, dehydrated alcohol, isopropyl alcohol, potassium hydroxide, propylene glycol, shellac, strong ammonia solution), erythrosine, gelatin, indigo carmine, quinoline yellow and titanium dioxide.

What dosage forms it comes in:

VAN-Fluoxetine are available in 10 mg (green) and 20 mg (green and yellow) strength.

WARNINGS AND PRECAUTIONS

During treatment with these types of medications, it is important that you and your doctor have good ongoing communication about how you are feeling.

VAN-Fluoxetine are not for use in children under 18 years of age.

New or Worsened Emotional or Behavioral Problems

Particularly in the first few weeks or when doses are adjusted, a small number of patients taking drugs of this type may feel worse instead of better. They may experience new or worsened feelings of agitation, hostility, anxiety, impulsivity, or thoughts about suicide, self-harm or harm to others. Suicidal thoughts and actions can occur in any age group but may be more likely in patients 18 to 24 years old.

Should this happen to you or those in your care, **consult your doctor immediately**. Close observation by a doctor is necessary in this situation. **Do not discontinue your medication on your own.**

You may be more likely to think like this if you have previously had thoughts about harming yourself. You may find it helpful to tell a relative or close friend that you are depressed or have an anxiety disorder, and ask them to read this leaflet. You might ask them to tell you if they think your depression or anxiety is getting worse, or if they are worried about changes in your behavior.

Fluoxetine has an effect on the electrical activity of the heart

In very rare cases, this effect can lead to disturbances in heart rhythm. These heart rhythm disturbances are more likely in patients with risk factors, such as heart disease, or in the presence of certain drugs. In general, females and people more than 65 years in age are at higher risk. It is important to follow the instructions of your doctor with regard to dosing.

If you experience any symptoms of a possible heart rhythm disturbance, such as dizziness, palpitations (sensation of rapid, pounding, or irregular heart beat), fainting, or

seizures, you should seek immediate medical attention.

Before starting VAN-Fluoxetine, tell your doctor or pharmacists:

- if you have ever had an allergic reaction to any medication
- if you have QT/QTc prolongation or a family history of QT/QTc prolongation;
- if you have a heart disease;
- if you have a personal history of fainting spells;
- if you have a family history of sudden cardiac death at <50 years;
- if you have electrolyte disturbances (e.g., low blood potassium or magnesium levels) or conditions that could lead to electrolyte disturbances (e.g., vomiting, diarrhea, dehydration);
- if you use diuretics, enemas and/or laxatives
- all your medical conditions, including a history of liver or kidney problems, seizures or blackouts, diabetes, bleeding disorder or have been told that you have low platelets, glaucoma or increased pressure in the eyes, eye pain, or blurred vision.
- if you had a recent bone fracture or were told you have osteoporosis or risk factors for osteoporosis.
- any medications (prescription or nonprescription) you are taking or have recently taken, especially monoamine oxidase (MAO) inhibitors (e.g., phenelzine sulfate, tranylcypromine sulfate, moclobemide or selegiline) or thioridazine, or anticoagulants, acetylsalicylic acid (e.g., Aspirin) and other non-steroidal anti-inflammatory drugs (e.g., ibuprofen).
- if you are taking tamoxifen (used to treat breast cancer)
- any natural or herbal products you are taking (e.g. St. John's Wort)
- if you are pregnant or thinking about becoming pregnant, or if you are breast feeding
- your habits of alcohol and /or street drug consumption
- if you drive a vehicle or perform hazardous tasks during your work

Effects on Pregnancy and Newborns

If you are already taking Fluoxetine Capsules BP and have just found out that you are pregnant, you should talk to your doctor as soon as possible.

Taking VAN-Fluoxetine in early stages of pregnancy:

Some studies have suggested a small increased risk of birth defects affecting the heart in babies whose mothers took fluoxetine capsules during the first few months of pregnancy. In the general population, about 1 in 100 babies are born with a heart defect. The studies found that this increased to about 2 in 100 babies whose mothers took fluoxetine capsules during early pregnancy.

Taking VAN-Fluoxetine in later stages of pregnancy:

Possible complications at birth (from taking any newer antidepressant, including VAN-Fluoxetine):

Post-marketing reports indicate that some newborns whose mothers took an SSRI (selective serotonin reuptake inhibitor) or other newer anti-depressant during pregnancy have developed complications at birth requiring prolonged hospitalization, breathing support and tube feeding. Reported symptoms included feeding and/or breathing difficulties, seizures, tense or overly relaxed muscles, jitteriness and constant crying.

In most cases, the newer anti-depressant was taken during the third trimester of pregnancy. These symptoms are consistent with either a direct adverse effect of the anti-depressant on the baby, or possibly a discontinuation syndrome caused by sudden withdrawal from the drug. These symptoms normally resolve over time. However, if your baby experiences any of these symptoms, contact your doctor as soon as you can.

Persistent Pulmonary Hypertension (PPHN) and newer antidepressants:

The use of SSRIs, including Fluoxetine Capsules BP, during late pregnancy, may increase the risk of a serious lung condition called persistent pulmonary hypertension of the newborn (PPHN) that causes breathing difficulties in newborns soon after birth. In the general population, PPHN is known to occur in about 1 or 2 per 1000 newborns but this may be increased 2 to 6 times in babies whose mothers used SSRIs during late pregnancy.

If you are pregnant and taking an SSRI, or other newer anti-depressant, you should discuss the risks and benefits of the various treatment options with your doctor. It is very important that you do NOT stop taking these medications without first consulting your doctor. See SIDE EFFECTS AND WHAT TO DO ABOUT THEM section for more information.

Taking VAN-Fluoxetine may increase your risk of breaking a bone if you are elderly or have osteoporosis or have other major risk factors for breaking a bone. You should take extra care to avoid falls especially if you get dizzy or have low blood pressure.

INTERACTIONS WITH THIS MEDICATION

Serious Drug Interactions

Do not use VAN-Fluoxetine if you are taking or have recently taken:

- Monoamine oxidase inhibitor (e.g., phenelzine, tranylcypromine, moclobemide or selegiline, linezolid, methylene blue)
- Thioridazine

You should tell your doctor if you are taking or have

recently taken any medications (prescription, nonprescription or natural/herbal), especially:

- other anti-depressants, such as SSRIs, certain tricyclics, drugs used to treat schizophrenia, or bipolar depression (e.g. lithium)
- anti-infectives
- cancer drugs
- asthma drugs
- drugs to treat nausea and vomiting
- painkillers
- diuretics
- certain medicines which may affect blood clotting and increase bleeding, such as oral anticoagulants (e.g., warfarin, dabigatran), acetylsalicylic acid (e.g. Aspirin) and other non-steroidal anti-inflammatory drugs (e.g. ibuprofen)
- tamoxifen which is used to treat breast cancer
- certain medicines used to treat patients with irregular heart beats (antiarrhythmics)
- certain drugs used to treat diabetes
- other drugs that affect serotonin, such as lithium, linezolid, drugs containing tryptophan, St. Johns Wort, triptans used to treat migraines
- certain medicines used to treat pain, such as fentanyl (used in anaesthesia or to treat chronic pain), tramadol, tapentadol, meperidine, methadone, pentazocine
- certain medicines used to treat cough, such as dextromethorphan
- sedatives such as benzodiazepines

As with many drugs that work directly on the brain, use of alcohol while taking VAN-Fluoxetine should be limited/moderate.

PROPER USE OF THIS MEDICATION

- It is very important that you take Fluoxetine Capsules BP exactly as your doctor has instructed.
- Fluoxetine Capsule BP is usually taken once a day. It may be taken with or without food. If you are taking capsules, you should swallow the capsules whole; do not chew them.
- You should continue to take your medicine even if you do not feel better, as it may take a number of weeks for your medicine to work.
- Keep taking your VAN-Fluoxetine until the doctor tells you to stop.
- Talk to your doctor before you stop taking your medication on your own.

Usual adult dose:

Depression

Usual initial dose: 20 mg a day in the morning.

Maximum dose: 60 mg a day.

Bulimia

Recommended dose: 60 mg a day.

Obsessive-Compulsive Disorder

Dose range: 20 to 60 mg a day.

Missed Dose

If you forget to take a dose of VAN-Fluoxetine, take it as soon as you remember. Take your next dose at the next scheduled time; do not try to make up for a missed dose by taking a double dose the next time.

Overdose:

In case of drug overdose, contact a health care practitioner, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Like other medications, VAN-Fluoxetine can cause some side effects. You may not experience any of them. For most patients, side effects are likely to be minor and temporary. However, some may be serious. Some of these side effects may be dose related. Consult your doctor if you experience these or other side effects, as the dose may have to be adjusted.

The most common side effects of fluoxetine capsules are:

- nausea
- dizziness
- headache
- anxiety
- nervousness
- drowsiness
- insomnia (difficulty falling or staying asleep)
- fatigue
- weakness
- diarrhea
- upset stomach
- dry mouth
- loss of appetite
- excessive sweating

Fluoxetine capsules do not usually affect people's normal activities. However, some people feel sleepy while taking it, in which case they should not drive or operate machinery.

Although psychiatric disorders may be associated with decreases in sexual desire, performance and satisfaction, treatment with this medication may also affect sexual functioning. Occasionally, these symptoms may continue after stopping VAN-Fluoxetine.

VAN-Fluoxetine can raise your levels of a hormone called "prolactin" (measured with a blood test). Symptoms of high prolactin may include.

In men: breast swelling, difficulty in getting or maintaining erections, or other sexual dysfunction.

In women: breast discomfort, leakage of milk from the breasts, missed menstrual periods, or other problems with your cycle.

If you experience any symptoms of a possible heart rhythm disturbance, such as dizziness, palpitations, fainting or seizures, you should seek immediate medical attention.

Discontinuation Symptoms

Contact your doctor before stopping or reducing your dosage of VAN-Fluoxetine. Symptoms such as headache, insomnia, paresthesias (numbness, tingling, burning, or prickling sensation) nervousness, anxiety, nausea, sweating, dizziness, jitteriness and weakness and other symptoms have been reported after stopping fluoxetine capsules. These symptoms usually disappear without needing treatment. Tell your doctor immediately if you have these or any other symptoms. Your doctor may adjust the dosage of VAN-Fluoxetine to alleviate the symptoms. See WARNINGS AND PRECAUTIONS section for more information.

Effects on Newborns

Some newborns whose mothers took an SSRI (Selective Serotonin Uptake Inhibitor) or other newer antidepressants during pregnancy have shown such symptoms as breathing and feeding difficulties, jitteriness and constant crying. If your baby experiences any of these symptoms, contact your doctor as soon as you can. See WARNING AND PRECAUTIONS section for more information.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM				
Symptom / effect		Talk with your doctor or pharmacist		Seek immediate emergency medical assistance
		Only if severe	In all cases	
Common	Allergic reactions [red skin, hives, itching, swelling of the lips, face, tongue, throat, trouble breathing, wheezing, shortness of breath, skin rashes, blisters of the skin, sores or pain in the mouth or eyes]			√
	Allergic reactions (skin rash, hives alone)		√	
Unknown	Low Platelets: Bruising or unusual bleeding from the skin or other areas		√	
Uncommon	Hallucinations [strange visions or sounds]		√	
	Inability to urinate		√	
	Akathisia [feeling restless and unable to sit or stand still]		√	
	Seizures [i.e. loss of consciousness with uncontrollable shaking (“fit”)]			√
	Mania [overactive behaviour and thoughts]		√	

See Warnings & Precautions	New or worsened emotional or behavioural problems		√	
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This is not a complete list of side effects. For any unexpected effects while taking VAN-Fluoxetine, contact your doctor or pharmacist

REPORTING SUSPECTED SIDE EFFECTS

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- Report online at <http://www.healthcanada.gc.ca/medeffect>**
- Call toll-free at 1-866-234-2345**
- Complete a Canada Vigilance Reporting Form and:**

- Fax toll-free to 1-866-678-6789**
- Mail to: Canada Vigilance Program
Health Canada
Postal Locator 0701E
Ottawa, ON K1A 0K9**

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on the MedEffect™ Canada Web site at <http://www.healthcanada.gc.ca/medeffect>.

NOTE: Should you require information related to the management of side effects, contact your health professional. The Canada Vigilance Program does not provide medical advice.

HOW TO STORE IT

Keep all medicines out of the reach and sight of children. VAN-Fluoxetine should be stored in its original package at 15-30°C, in a dry place and out of direct sunlight. The expiry date of this medicine is printed on the package label. Do not use the medicine after the expiry date. If your doctor tells you to stop taking VAN-Fluoxetine or you find that they have passed their expiry date, please return any left over medicine to your pharmacist.

Symptom / effect	Talk with your doctor or pharmacist		Seek immediate emergency medical assistance
	Only if severe	In all cases	
Rare	Gastrointestinal bleeding [vomiting blood or passing blood in stools]		√
	Glaucoma: Increased pressure in the eyes, eye pain and blurred vision	√	
	Liver disorder [symptoms include nausea, vomiting, loss of appetite combined with itching, yellowing of the skin or eyes, dark urine]		√
	Uncontrollable movements of the body or face	√	
	Low sodium level in blood [symptoms of tiredness, weakness, confusion combined with achy, stiff or uncoordinated muscles]	√	
Very Rare	Serotonin syndrome [a combination of most or all of the following; confusion, restlessness, sweating, shaking, shivering, high fever, hallucinations, sudden jerking of the muscles, fast heartbeat]		√

MORE INFORMATION

This document plus the full product monograph, prepared for health professionals can be found by contacting

Manufacturer and Distributor:

Vanc Pharmaceuticals Inc.
Building 152, 11782 River Road
Richmond, BC V6X 1Z7

www.vancpharm.com

Help line: 1-877-929-0699

Email: safety@vancpharm.com

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