Olagen® 5mg, 10mg

اولاجِن زبان پر حل ہونے والی ٹیبلٹ

(اولانزاپین) ٹیبلٹس یو۔ایس۔پی۔ ۵ ملی گرام ۱۰ ملی گرام

(Olanzapine)

Orally Disintegrating Tablets U.S.P.

QUALITATIVE AND QUANTITATIVE DESCRIPTION

Olagen® ODT Tablets U.S.P. 5mg
Each orally disintegrating tablet contains:
Olanzapine U.S.P. 5mg

Olagen® ODT Tablets U.S.P. 10mg
Each orally disintegrating tablet contains:
Olanzapine U.S.P. 10mg

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Olanzapine is not approved for the treatment of patients with dementia-related. When using olanzapine and fluoxetine in combination, also refer to the Boxed Warning section of the package insert for Symbyax.

DESCRIPTION

Olagen® ODT Tablets U.S.P. contains olanzapine is an atypical antipsychotic that belongs to the thienobenzodiazepine class.

CLINICAL PHARMACOLOGY

Mechanism of Action: The mechanism of action of olanzapine, as with other drugs having efficacy in schizophrenia, acute manic or mixed episodes associated with bipolar I disorder is unknown. However, it has beenproposed that this drug's efficacy in schizophrenia is mediated through a combination of dopamine and serotonin type 2 (5HT2) antagonism. **Pharmacodynamics:** Olanzapine binds with high affinity to the following receptors: serotonin 5HT2A/2C, 5HT6, dopamine D1-4, histamine H1, and adrenergic α1 receptors. Olanzapine is an antagonist with moderate affinity binding for serotonin 5HT3 and muscarinic M1-5, and 48 nM, respectively. Olanzapine binds weakly to GABAA, BZD, and β-adrenergic receptors. Antagonism at receptors other than dopamine and 5HT2 may explain some of the other therapeutic and side effects of olanzapine. Olanzapine's antagonism of muscarinic M1-5 receptors may explain its anticholinergic-like effects. Olanzapine's antagonism of histamine H1 receptors may explain the somnolence observed with this drug. Olanzapine's antagonism of adrenergic α1 receptors may explain the orthostatic hypotension observed with this drug. **Pharmacokinetics:** *Oral Administration* Monotherapy-Olanzapine is well absorbed and reaches peak concentrations in approximately 6 hours following an oral dose. It is eliminated extensively by first pass metabolism, with approximate-

ly 40% of the dose metabolized before reaching the systemic circulation. Food does not affect the rate or extent of olanzapine absorption. Pharmacokinetic studies showed that Olanzapine tablets and Olanzapine orally disintegrating tablets dosage forms of olanzapine are bioequivalent. Olanzapine displays linear kinetics over the clinical dosing range. Its half-life ranges from 21 to 54 hours, and apparent plasma clearance ranges from 12 to 47 L/hr (5th to 95th percentile; mean of 25 L/hr). Administration of olanzapine once daily leads to steady-state concentrations in about 1 week that are approximately twice the concentrations after single doses. Plasma concentrations, half-life, and clearance of olanzapine may vary between individuals on the basis of smoking status, gender, and age. Olanzapine is extensively distributed throughout the body, with a volume of distribution of approximately 1000 L. It is 93% bound to plasma proteins over the concentration range of 7 to 1100 ng/mL, binding primarily to albumin and α1-acid glycoprotein. *Metabolism and Elimination* Following a single oral dose of 14C labelled olanzapine, 7% of the dose of olanzapine was recovered in the urine as unchanged drug, indicating that olanzapine is highly metabolized. Approximately 57% and 30% of the dose was recovered in the urine and feces, respectively. In the plasma, olanzapine accounted for only 12% of the AUC for total radioactivity, indicating significant exposure to metabolites. After multiple dosing, the major circulating metabolites were the 10-N-glucuronide, present at steady state at 44% of the concentration of olanzapine, and 4´-N-desmethyl olanzapine, present at steady state at 31% of the concentration of olanzapine. Both metabolites lack pharmacological activity at the concentrations observed. Direct glucuronidation and cytochrome P450 (CYP) mediated oxidation are the primary metabolic pathways for olanzapine. In vitro studies suggest that CYPs 1A2 and 2D6, and the flavin-containing monooxygenase system are involved in olanzapine oxidation. CYP2D6 mediated oxidation appears to be a minor metabolic pathway in vivo, because the clearance of olanzapine is not reduced in subjects who are deficient in this enzyme. **Specific Populations:** *Renal Impairment:* Because olanzapine is highly metabolized before excretion and only 7% of the drug is excreted unchanged, renal dysfunction alone is unlikely to have a major impact on the pharmacokinetics of olanzapine. The pharmacokinetic characteristics of olanzapine were similar in patients with severe renal impairment and normal subjects, indicating that dosage adjustment based upon the degree of renal impairment is not required. In addition, olanzapine is not removed by dialysis. The effect of renal impairment on metabolite elimination has not been studied. *Hepatic Impairment:* Although the presence of hepatic impairment may be expected to reduce the clearance of olanzapine, a study of the effect of impaired liver function in subjects (n=6) with clinically significant (Childs Pugh Classification A and B) cirrhosis revealed little effect on the pharmacokinetics of olanzapine. *Geriatric:* In a study involving 24 healthy subjects, the mean elimination half-life of olanzapine was about 1.5 times greater in elderly (≥65 years) than in nonelderly subjects (<65 years). Caution should be used in dosing the elderly, especially if there are other factors that might additively influence drug metabolism and/or pharmacodynamic sensitivity. *Gender:* Clearance of olanzapine is approximately 30% lower in women than in men. There were, however, no apparent differences between men and women in effectiveness or adverse effects. Dosage modifications based on gender should not be needed. *Smoking Status:* Olanzapine clearance is about 40% higher in smokers than in non-smokers, although dosage modifications are not routinely recommended. *Race:* In vivo studies have shown that exposures are similar among Japanese, Chinese and Caucasians, especially after normalization for body weight differences. Dosage modifications for race are, therefore, not recommended. *Combined Effects:* The combined effects of age, smoking, and gender could lead to substantial pharmacokinetic differences in populations. The clearance in young smoking males, for example, may be 3 times higher than that in elderly non-smoking females. Dosing modification may be necessary in patients who exhibit a combination of factors that may result in slower metabolism of olanzapine Adolescents

(ages 13 to 17 years).

INDICATIONS AND USAGE

Schizophrenia: Oral olanzapine is indicated for the treatment of schizophrenia. **Bipolar I Disorder (Manic or Mixed Episodes):** *Monotherapy* Oral Olanzapine is indicated for the acute treatment of manic or mixed episodes associated with bipolar I disorder and maintenance treatment of bipolar I disorder. **Olanzapine and Fluoxetine in Combination:** Depressive Episodes Associated with Bipolar I Disorder Oral olanzapine and fluoxetine in combination is indicated for the treatment of depressive episodes associated with bipolar I disorder, based on clinical studies. **Olanzapine and Fluoxetine in Combination:** Treatment Resistant Depression Oral olanzapine and fluoxetine in combination is indicated for the treatment of treatment resistant depression (major depressive disorder in patients who do not respond to 2 separate trials of different antidepressants of adequate dose and duration in the current episode), based on clinical studies in adult patients.

DOSAGE AND ADMINISTRATION

As directed by the physician.

Schizophrenia: *Adults Dose Selection* Oral olanzapine should be administered on a once-a-day schedule without regard to meals, generally beginning with 5 to 10mg initially, with a target dose of 10mg/day within several days. Further dosage adjustments, if indicated, should generally occur at intervals of not less than 1 week, since steady state for olanzapine would not be achieved for approximately 1 week in the typical patient. When dosage adjustments are necessary, dose increments/decrements of 5mg QD are recommended. Efficacy in schizophrenia was demonstrated in a dose range of 10 to 15mg/day in clinical trials. However, doses above 10mg/day were not demonstrated to be more efficacious than the 10mg/day dose. An increase to a dose greater than the target dose of 10mg/day (i.e., to a dose of 15mg/day or greater) is recommended only after clinical assessment. Olanzapine is not indicated for use in doses above 20mg/day. *Dosing in Special Populations* The recommended starting dose is 5mg in patients who are debilitated, who have a predisposition to hypotensive reactions, who otherwise exhibit a combination of factors that may result in slower metabolism of olanzapine (e.g., nonsmoking female patients ≥65 years of age), or who may be more pharmacodynamically sensitive to olanzapine. When indicated, dose escalation should be performed with caution in these patients. *Maintenance Treatment* The effectiveness of oral olanzapine, 10mg/day to 20mg/day, in maintaining treatment response in schizophrenic patients who had been stable on olanzapine for approximately 8 weeks and were then followed for relapse has been demonstrated in a placebo-controlled trial. The physician who elects to use olanzapine for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

Adolescents, Dose Selection Oral olanzapine should be administered on a once-a-day schedule without regard to meals with a recommended starting dose of 2.5 or 5mg, with a target dose of 10mg/day. Efficacy in adolescents with schizophrenia was demonstrated based on a flexible dose range of 2.5 to 20mg/day in clinical trials, with a mean modal dose of 12.5mg/day (mean dose of 11.1mg/day). When dosage adjustments are necessary, dose increments/decrements of 2.5 or 5mg are recommended. The safety and effectiveness of doses above 20mg/day have not been evaluated in clinical trials. *Maintenance Treatment* The efficacy of olanzapine for the maintenance treatment of schizophrenia in the adolescent population has not been systematically evaluated; however, maintenance efficacy can be extrapolated from adult data along with comparisons of olanzapine pharmacokinetic parameters in adult and adolescent patients. Thus, it is generally recommended that responding patients be continued beyond the acute response, but at the lowest dose needed to maintain remission. Patients should be periodically reassessed to determine the need for maintenance treatment.

Bipolar I Disorder (Manic or Mixed Episodes): *Adults Dose Selection for Monotherapy* Oral olanzapine should be administered on a once-a-day schedule without regard to meals, generally beginning with 10 or 15mg. Dosage adjustments, if indicated, should generally occur at intervals of not less than 24 hours, reflecting the procedures in the placebo-controlled trials. When dosage adjustments are necessary, dose increments/decrements of 5mg QD are recommended. Short-term (3-4 weeks) antimanic efficacy was demonstrated in a dose range of 5mg to 20mg/day in clinical trials. The safety of doses above 20mg/day has not been evaluated in clinical trials.
Maintenance Monotherapy The benefit of maintaining bipolar I patients on monotherapy with oral olanzapine at a dose of 5 to 20mg/day, after achieving a responder status for an average duration of 2 weeks, was demonstrated in a controlled trial. The physician who elects to use olanzapine for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient. *Dose Selection for Adjunctive Treatment* When administered as adjunctive treatment to lithium or valproate, oral olanzapine dosing should generally begin with 10mg once-a-day without regard to meals. Antimanic efficacy was demonstrated in a dose range of 5mg to 20mg/day in clinical trials. The safety of doses above 20mg/day has not been evaluated in clinical trials. *Adolescents Dose Selection* - Oral olanzapine should be administered on a once-a-day schedule without regard to meals with a recommended starting dose of 2.5 or 5mg, with a target dose of 10mg/day. Efficacy in adolescents with bipolar I disorder (manic or mixed episodes) was demonstrated based on a flexible dose range of 2.5 to 20mg/-day in clinical trials, with a mean modal dose of 10.7mg/day (mean dose of 8.9mg/day). When dosage adjustments are necessary, dose increments/-decrements of 2.5 or 5mg are recommended. The safety and effectiveness of doses above 20mg/day have not been evaluated. *Maintenance Treatment* - The efficacy of olanzapine for the maintenance treatment of bipolar I disorder in the adolescent population has not been evaluated; however, maintenance efficacy can be extrapolated from adult data along with comparisons of olanzapine pharmacokinetic parameters in adult and adolescent patients. Thus, it is generally recommended that responding patients be continued beyond the acute response, but at the lowest dose needed to maintain remission. Patients should be periodically reassessed to determine the need for maintenance treatment.

CONTRAINDICATIONS

- None with olanzapine monotherapy.
- When using olanzapine and fluoxetine in combination, also refer to the Contraindications section of the package insert for olanzapine/fluoxetine.
- For specific information about the contraindications of lithium or valproate, refer to the Contraindications section of the package inserts for these other products. **Other Adverse Reactions:** Following is a list of treatment-emergent adverse reactions reported by patients treated with oral olanzapine (at multiple doses ≥1mg/day) in clinical trials. This listing is not intended to include reactions (1) already listed in previous tables or elsewhere in labelling, (2) for which a drug cause was remote, (3) which were so general as to be uninformative, (4) which were not considered to have significant clinical implications, or (5) which occurred at a rate equal to or less than placebo. Reactions are classified by body system using the following definitions: frequent adverse reactions are those occurring in at least 1/100 patients; infrequent adverse reactions are those occurring in 1/100 to 1/1000 patients; rare reactions are those occurring in fewer than 1/1000 patients.
- Body as a Whole - Infrequent: chills, face edema, photosensitivity reaction, suicide attempt; Rare: chills and fever, hangover effect, sudden death1 .
- Cardiovascular System - Infrequent: cerebrovascular accident, vasodilatation.
- Digestive System - Infrequent: nausea and vomiting, tongue edema; Rare: ileus, intestinal obstruction, liver fatty deposit.
- Hemic and Lymphatic System - Infrequent: leukopenia, thrombocytopenia.

Metabolic and Nutritional
• Disorders - Infrequent: alkaline phosphatase increased, bilirubinemia, hypoproteinemia.
• Musculoskeletal System - Rare: osteoporosis.
• Nervous System - Infrequent: ataxia, dysarthria, libido decreased, stupor; Rare: coma.
• Respiratory System - Infrequent: epistaxis; Rare: lung edema. Skin and Appendages - Infrequent: alopecia.
• Special Senses - Infrequent: abnormality of accommodation, dry eyes; Rare: mydriasis.
• Urogenital System - Infrequent: amenorrhea, breast pain, decreased menstruation, impotency, increased menstruation, menorrhagia, metrorrhagia, polyuria, urinary frequency, urinary retention, urinary urgency, urination impaired.
These terms represent serious adverse events but do not meet the definition for adverse drug reactions. They are included here because of their seriousness.
Adjusted for gender.

DRUG INTERACTIONS

The risks of using olanzapine in combination with other drugs have not been extensively evaluated in systematic studies.
Potential for Other Drugs to Affect Olanzapine
Diazepam - The co-administration of diazepam with olanzapine potentiated the orthostatic hypotension observed with olanzapine.
Cimetidine and Antacids - Single doses of cimetidine (800mg) or aluminum- and magnesium-containing antacids did not affect the oral bioavailability of olanzapine.
Inducers of CYP1A2 - Carbamazepine therapy (200mg bid) causes an approximately 50% increase in the clearance of olanzapine. This increase is likely due to the fact that carbamazepine is a potent inducer of CYP1A2 activity. Higher daily doses of carbamazepine may cause an even greater increase in olanzapine clearance.
Alcohol - Ethanol (45mg/70kg single dose) did not have an effect on olanzapine pharmacokinetics. The coadministration of alcohol (i.e., ethanol) with olanzapine potentiated the orthostatic hypotension observed with olanzapine.
Inhibitors of CYP1A2
Fluvoxamine - Fluvoxamine, a CYP1A2 inhibitor, decreases the clearance of olanzapine. This results in a mean increase in olanzapine Cmax following fluvoxamine of 54% in female nonsmokers and 77% in male smokers. The mean increase in olanzapine AUC is 52% and 108%, respectively. Lower doses of olanzapine should be considered in patients receiving concomitant treatment with fluvoxamine.
Inhibitors of CYP2D6
Fluoxetine - Fluoxetine (60mg single dose or 60mg daily dose for 8 days) causes a small (mean 16%) increase in the maximum concentration of olanzapine and a small (mean 16%) decrease in olanzapine clearance. The magnitude of the impact of this factor is small in comparison to the overall variability between individuals, and therefore dose modification is not routinely recommended.
Warfarin - Warfarin (20mg single dose) did not affect olanzapine.
Inducers of CYP1A2 or Glucuronyl Transferase - Omeprazole and rifampin may cause an increase in olanzapine clearance.
Charcoal - The administration of activated charcoal (1g) reduced the Cmax and AUC of oral olanzapine by about 60%. As peak olanzapine levels are not typically obtained until about 6 hours after dosing, charcoal may be a useful treatment for olanzapine overdose.
Potential for Olanzapine to Affect Other Drugs:
CNS Acting Drugs - Given the primary CNS effects of olanzapine, caution should be used when olanzapine is taken in combination with other centrally

acting drugs and alcohol.
Antihypertensive Agents - Olanzapine, because of its potential for inducing hypotension, may enhance the effects of certain antihypertensive agents.
Levodopa and Dopamine Agonists - Olanzapine may antagonize the effects of levodopa and dopamine agonists.
Lorazepam (IM) - Administration of intramuscular lorazepam and intramuscular olanzapine for injection added to the somnolence observed with either drug alone.
Lithium - Multiple doses of olanzapine (10mg for 8 days) did not influence the kinetics of lithium. Therefore, concomitant olanzapine administration does not require dosage adjustment of.
Valproate - Olanzapine (10mg daily for 2 weeks) did not affect the steady state plasma concentrations of valproate. Therefore, concomitant olanzapine administration does not require dosage adjustment of valproate.
Effect of Olanzapine on Drug Metabolizing Enzymes - Olanzapine is unlikely to cause clinically important drug interactions mediated by these enzymes.
Imipramine - Single doses of olanzapine did not affect the pharmacokinetics of imipramine or its active metabolite desipramine.
Warfarin - Single doses of olanzapine did not affect the pharmacokinetics of warfarin.
Diazepam - Olanzapine did not influence the pharmacokinetics of diazepam or its active metabolite N-desmethyl diazepam. However, diazepam co-administered with olanzapine increased the orthostatic hypotension observed with either drug given alone.
Alcohol - Multiple doses of olanzapine did not influence the kinetics of ethanol.
Biperiden - Multiple doses of olanzapine did not influence the kinetics of biperiden.
Theophylline - Multiple doses of olanzapine did not affect the pharmacokinetics of theophylline or its metabolites.

USE IN SPECIFIC POPULATIONS

When using olanzapine and fluoxetine in combination, also refer to the Use in Specific Populations section of the package insert for olanzapine/fluoxetine. **Pregnancy Teratogenic Effects, Pregnancy Category C:** In oral reproduction studies in rats at doses up to 18mg/kg/day and in rabbits at doses up to 30mg/kg/day (9 and 30 times the maximum recommended human daily oral dose on amg/m2 basis, respectively) no evidence of teratogenicity was observed. In an oral rat teratology study, early resorptions and increased numbers of nonviable fetuses were observed at a dose of 18mg/kg/day (9 times the maximum recommended human daily oral dose on amg/m basis). Gestation was prolonged at 10mg/kg/day (5 times the maximum recommended human daily oral dose on amg/m basis). In an oral rabbit teratology study, fetal toxicity (manifested as increased resorptions and decreased fetal weight) occurred at a maternally toxic dose of 30mg/kg/day (30 times the maximum recommended human daily oral dose on amg/m2 basis). Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Placental transfer of olanzapine occurs in rat pups:** There are no adequate and well-controlled trials with olanzapine in pregnant females. Seven pregnancies were observed during clinical trials with olanzapine, including 2 resulting in normal births, 1 resulting in neonatal death due to a cardiovascular defect, 3 therapeutic abortions, and 1 spontaneous abortion. **Nonteratogenic Effects:** Neonates exposed to antipsychotic drugs (including olanzapine), during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress and feeding disorder in these neonates. These complications have varied in severity; while in some cases symptoms have been self-limited, in other cases neonates have required intensive care unit support and prolonged hospitalization.

Olanzapine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Labor and Delivery:** The effect of olanzapine on labor and delivery in humans is unknown. Parturition in rats was not affected by olanzapine. **Nursing Mothers:** In a study in lactating, healthy women, olanzapine was excreted in breast milk. Mean infant dose at steady state was estimated to be 1.8% of the maternal olanzapine dose. It is recommended that women receiving olanzapine should not breast-feed. **Paediatric Use:** The safety and effectiveness of oral olanzapine in the treatment of schizophrenia and manic or mixed episodes associated with bipolar I disorder were established in short-term studies in adolescents (ages 13 to 17 years). Use of olanzapine in adolescents is supported by evidence from adequate and well-controlled studies of olanzapine in which 268 adolescents received olanzapine in a range of 2.5 to 20mg/day. Recommended starting dose for adolescents is lower than that for adults. Compared to patients from adult clinical trials, adolescents were likely to gain more weight, experience increased sedation, and have greater increases in total cholesterol, triglycerides, LDL cholesterol, prolactin and hepatic aminotransferase levels. When deciding among the alternative treatments available for adolescents, clinicians should consider the increased potential (in adolescents as compared with adults) for weight gain and dyslipidemia. Clinicians should consider the potential long-term risks when prescribing to adolescents, and in many cases this may lead them to consider prescribing other drugs first in adolescents. **Geriatric Use:** Of the 2500 patients in premarketing clinical studies with oral olanzapine, 11% (263) were 65 years of age or over. In patients with schizophrenia, there was no indication of any different tolerability of olanzapine in the elderly compared to younger patients. Studies in elderly patients with dementia-related psychosis have suggested that there may be a different tolerability profile in this population compared to younger patients with schizophrenia. Elderly patients with dementiarelated psychosis treated with olanzapine are at an increased risk of death compared to placebo. In placebo-controlled studies of olanzapine in elderly patients with dementia-related psychosis, there was a higher incidence of cerebrovascular adverse events (e.g., stroke, transient ischemic attack) in patients treated with olanzapine compared to patients treated with placebo. Olanzapine is not approved for the treatment of patients with dementia-related psychosis. Also, the presence of factors that might decrease pharmacokinetic clearance or increase the pharmacodynamic response to olanzapine should lead to consideration of a lower starting dose for any geriatric patient. Clinical studies of olanzapine and fluoxetine in combination did not include sufficient numbers of patients ≥65 years of age to determine whether they respond differently from younger patients.

DRUG ABUSE AND DEPENDENCE

Dependence: In studies prospectively designed to assess abuse and dependence potential, olanzapine was shown to have acute depressive CNS effects but little or no potential of abuse or physical dependence in rats administered oral doses up to 15 times the maximum recommended human daily oral dose (20mg) and rhesus monkeys administered oral doses up to 8 times the maximum recommended human daily oral dose on amg/m2 basis. Olanzapine has not been systematically studied in humans for its potential for abuse, tolerance, or physical dependence. While the clinical trials did not reveal any tendency for any drug-seeking behaviour, these observations were not systematic, and it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, patients should be evaluated carefully for a history of drug abuse, and such patients should be observed closely for signs of misuse or abuse of olanzapine (e.g., development of tolerance, increases in dose, drug-seeking behaviour).

OVERDOSAGE

In the patient taking the largest identified amount, 300mg, the only symp-

toms reported were drowsiness and slurred speech. In the limited number of patients who were evaluated in hospitals, including the patient taking 300mg, there were no observations indicating an adverse change in laboratory analytes or ECG. Vital signs were usually within normal limits following overdoses. In reports of overdose with olanzapine alone, symptoms have been reported in the majority of cases. In symptomatic patients, symptoms with ≥10% incidence included agitation/aggressiveness, dysarthria, tachycardia, various extrapyramidal symptoms, and reduced level of consciousness ranging from sedation to coma. Among less commonly reported symptoms were the following potentially medically serious reactions: aspiration, cardiopulmonary arrest, cardiac arrhythmias (such as supraventricular tachycardia and 1 patient experiencing sinus pause with spontaneous resumption of normal rhythm), delirium, possible neuroleptic malignant syndrome, respiratory depression/arrest, convulsion, hypertension, and hypotension.

INSTRUCTIONS

Store at 20°C to 25°C, excursions permitted between 15°C to 30°C.

PRESENTATION

Olagen® ODT Tablets U.S.P. 5mg are packaged Alu-Alu blister pack of 10's tablets in a carton.
Olagen® ODT Tablets U.S.P. 10mg are packaged Alu-Alu blister pack of 10's tablets in a carton.

خوراک: ڈاکٹر کی ہدایت کے مطابق استعمال کریں۔
ہدایات: ۲۰ سے ۲۵ ڈگری سینٹی گریڈ پر رکھیں، محفوظ رکھنے کی حد ۱۵ سے ۳۰ ڈگری سینٹی گریڈ ہے۔ سورج کی روشنی اور نمی سے محفوظ رکھیں۔
تمام دوائیں بچوں کی پہنچ سے دور رکھیں۔

For detailed information:

GENIX **Genix Pharma (Pvt.) Ltd.**

44,45-B, Korangi Creek Road, Karachi-75190, Pakistan.
UAN: +92-21-111-10-10-11, **Email:** info@genixpharma.com

ISO 9001:2015 ISO 14001:2015 ISO 45001:2018

www.genixpharma.com