

Summary Product Characteristics (SPC)

1. NAME OF THE MEDICINAL PRODUCT

OPELAN ODT 10

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each Orodispersible tablet contains:

Olanzapine USP 10 mg

Excipients of known concern;

Lactose Monohydrate

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Orodispersible tablet

Pale yellow to yellow colored, circular shaped, flat faced beveled edge, orodispersible tablet, with

breakline on one face and plain on other face. Tablet may contain few yellow colored specks of active pharmaceutical ingredient.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Olanzapine is indicated for the treatment of schizophrenia.

Olanzapine is effective in maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response.

Olanzapine is indicated for the treatment of moderate to severe manic episode.

In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder

4.2 Posology and method of administration

Adults

Schizophrenia: The recommended starting dose for olanzapine is 10 mg/day.

Manic episode: The starting dose is 15 mg as a single daily dose in monotherapy or 10 mg daily in combination therapy.

Preventing recurrence in bipolar disorder: The recommended starting dose is 10 mg/day.

For patients who have been receiving olanzapine for treatment of manic episode, continue therapy for preventing recurrence at the same dose. If a new manic, mixed, or depressive episode occurs,

olanzapine treatment should be continued (with dose optimization as needed), with supplementary

therapy to treat mood symptoms, as clinically indicated.

During treatment for schizophrenia, manic episode and recurrence prevention in bipolar disorder, daily dosage may subsequently be adjusted on the basis of individual clinical status within the range 5- 20 mg/day. An increase to a dose greater than the recommended starting dose is advised only after appropriate clinical reassessment and should generally occur at intervals of not less than 24 hours.

Olanzapine can be given without regards for meals as absorption is not affected by food.

Gradual tapering of the dose should be considered when discontinuing olanzapine.

Olanzapine Orodispersible Tablet should be placed in the mouth, where it will rapidly disperse in saliva, so it can be easily swallowed. Removal of the intact Orodispersible tablet from the mouth is difficult. Since the Orodispersible tablet is fragile, it should be taken

immediately on opening the blister. Alternatively, it may be dispersed in a full glass of water or other suitable beverage (orange juice, apple juice, milk or coffee) immediately before administration.

Olanzapine Orodispersible tablet is bioequivalent to olanzapine coated tablets, with a similar rate and extent of absorption. It has the same dosage and frequency of administration as olanzapine coated tablets. Olanzapine Orodispersible tablets may be used as an alternative to olanzapine coated tablets.

Paediatric population

Olanzapine is not recommended for use in children and adolescents below 18 years of age due to a lack of data on safety and efficacy. A greater magnitude of weight gain, lipid and prolactin alterations has been reported in short term studies of adolescent patients than in studies of adult patients.

Elderly patients

A lower starting dose (5 mg/day) is not routinely indicated but should be considered for those 65 and over when clinical factors warrant.

Patients with renal and/or hepatic impairment

A lower starting dose (5 mg) should be considered for such patients. In cases of moderate hepatic insufficiency (cirrhosis, Child-Pugh Class A or B), the starting dose should be 5 mg and only increased with caution.

Gender

The starting dose and dose range need not be routinely altered for female patients relative to male patients.

Smokers

The starting dose and dose range need not be routinely altered for non-smokers relative to smokers.

When more than one factor is present which might result in slower metabolism (female gender, geriatric age, non-smoking status), consideration should be given to decreasing the starting dose. Dose escalation, when indicated, should be conservative in such patients.

Method of administration

Olanzapine can be given without regards for meals as absorption is not affected by food. Gradual tapering of the dose should be considered when discontinuing olanzapine.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients. Patients with known risk of narrow-angle glaucoma

4.4 Special warnings and precautions for use

During antipsychotic treatment, improvement in the patient's clinical condition may take several days to some weeks. Patients should be closely monitored during this period.

Dementia-related psychosis and/or behavioral disturbances

Olanzapine is not approved for the treatment of dementia-related psychosis and/or behavioral disturbances and is not recommended for use in this particular group of patients because of an increase in mortality and the risk of cerebrovascular accident. In placebo-controlled clinical trials (6-12 weeks duration) of elderly patients (mean age 78 years) with dementia-related psychosis and/or disturbed behaviors, there was a 2-fold increase in the incidence of death in olanzapine-treated patients compared to patients treated with placebo (3.5% vs. 1.5%, respectively). The higher incidence of death was not associated with olanzapine dose (mean daily dose 4.4 mg) or duration of treatment. Risk factors that may predispose this patient population to increased mortality include age > 65 years, dysphagia,

sedation, malnutrition and dehydration, pulmonary conditions (e.g., pneumonia, with or without aspiration), or concomitant use of benzodiazepines. However, the incidence of death was higher in olanzapine-treated than in placebo-treated patients independent of these risk factors.

In the same clinical trials, cerebrovascular adverse events (CVAE e.g., stroke, transient ischemic attack), including fatalities, were reported. There was a 3-fold increase in CVAE in patients treated with olanzapine compared to patients treated with placebo (1.3% vs. 0.4%, respectively).

All olanzapine- and placebo-treated patients who experienced a cerebrovascular event had pre-

existing risk factors. Age > 75 years and vascular/mixed type dementia were identified as risk factors for CVAE in association with olanzapine treatment. The efficacy of olanzapine was not established in these trials.

Parkinson's disease

The use of olanzapine in the treatment of dopamine agonist associated psychosis in patients with Parkinson's disease is not recommended. In clinical trials, worsening of Parkinsonian symptomatology and hallucinations were reported very commonly and more frequently than with placebo, and olanzapine was not more effective than placebo in the treatment of psychotic symptoms. In these trials, patients were initially required to be stable on the lowest effective dose of anti-Parkinsonian medicinal products (dopamine agonist) and to remain on the same anti-Parkinsonian medicinal products and dosages throughout the study. Olanzapine was started at 2.5 mg/day and titrated to a maximum of 15 mg/day based on investigator judgment.

Neuroleptic Malignant Syndrome (NMS)

NMS is a potentially life-threatening condition associated with antipsychotic medicinal product. Rare cases reported as NMS have also been received in association with olanzapine. Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. If a patient develops signs and symptoms indicative of NMS, or presents with unexplained high fever without additional clinical manifestations of NMS, all antipsychotic medicines, including olanzapine must be discontinued.

Hyperglycemia and diabetes

Hyperglycemia and/or development or exacerbation of diabetes occasionally associated with ketoacidosis or coma has been reported rarely, including some fatal cases. In some cases, a prior increase in body weight has been reported which may be a predisposing factor. Appropriate clinical monitoring is advisable in accordance with utilized antipsychotic guidelines, e.g. measuring of blood glucose at baseline, 12 weeks after starting olanzapine treatment and annually thereafter. Patients treated with any antipsychotic agents, including Olanzapine, should be observed for signs and symptoms of hyperglycemia (such as polydipsia, polyuria, polyphagia, and weakness) and patients with diabetes mellitus or with risk factors for diabetes mellitus should be monitored regularly for worsening of glucose control. Weight should be monitored regularly, e.g. at baseline, 4, 8 and 12 weeks after starting olanzapine treatment and quarterly thereafter.

Lipid alterations

Undesirable alterations in lipids have been observed in olanzapine-treated patients in placebo-controlled clinical trials. Lipid alterations should be managed as clinically appropriate, particularly in dyslipidemia patients and in patients with risk factors for the development of lipids disorders. Patients treated with any antipsychotic agents, including Olanzapine, should be monitored regularly for lipids in accordance with utilized

antipsychotic guidelines, e.g. at baseline, 12 weeks after starting olanzapine treatment and every 5 years thereafter.

Anticholinergic activity

While olanzapine demonstrated anticholinergic activity *in vitro*, experience during the clinical trials revealed a low incidence of related events. However, as clinical experience with olanzapine in patients with concomitant illness is limited, caution is advised when prescribing for patients with prostatic hypertrophy, or paralytic ileus and related conditions.

Hepatic function

Transient, asymptomatic elevations of hepatic aminotransferases, ALT, AST have been seen commonly, especially in early treatment. Caution should be exercised and follow-up organized in patients with elevated ALT and/or AST, in patients with signs and symptoms of hepatic impairment, in patients with pre-existing conditions associated with limited hepatic functional reserve, and in patients who are being treated with potentially hepatotoxic medicines. In cases where hepatitis (including hepatocellular, cholestatic or mixed liver injury) has been diagnosed, olanzapine treatment should be discontinued.

Neutropenia

Caution should be exercised in patients with low leukocyte and/or neutrophil counts for any reason, in patients receiving medicines known to cause neutropenia, in patients with a history of drug-induced bone marrow depression/toxicity, in patients with bone marrow depression caused by concomitant illness, radiation therapy or chemotherapy and in patients with hypereosinophilic conditions or with myeloproliferative disease. Neutropenia has been reported commonly when olanzapine and valproate are used concomitantly.

Discontinuation of treatment

Acute symptoms such as sweating, insomnia, tremor, anxiety, nausea, or vomiting have been reported very rarely (< 0.01%) when olanzapine is stopped abruptly.

QT interval

In clinical trials, clinically meaningful QTc prolongations (Fridericia QT correction [QTcF] $\geq$ 500 milliseconds [msec] at any time post baseline in patients with baseline QTcF < 500 msec) were uncommon (0.1% to 1%) in patients treated with olanzapine, with no significant differences in associated cardiac events compared to placebo. However, as with other antipsychotics, caution should be exercised when olanzapine is prescribed with medicines known to increase QTc interval, especially in the elderly, in patients with congenital long QT syndrome, congestive heart failure, heart hypertrophy, hypokalemia or hypomagnesaemia.

Thromboembolism

Temporal association of olanzapine treatment and venous thromboembolism has been reported uncommonly ($\geq$ 0.1% and < 1%). A causal relationship between the occurrence of venous thromboembolism and treatment with olanzapine has not been established. However, since patients with schizophrenia often present with acquired risk factors for venous thromboembolism all possible risk factors of VTE e.g. immobilization of patients should be identified and preventive measures undertaken.

General CNS activity

Given the primary CNS effects of olanzapine, caution should be used when it is taken in combination with other centrally acting medicines and alcohol. As it exhibits *in vitro* dopamine antagonism, olanzapine may antagonize the effects of direct and indirect dopamine agonists.

Seizures

Olanzapine should be used cautiously in patients who have a history of seizures or are

subject to factors which may lower the seizure threshold. Seizures have been reported to occur rarely in patients when treated with olanzapine. In most of these cases, a history of seizures or risk factors for seizures was reported.

Tardive Dyskinesia

In comparator studies of one year or less duration, olanzapine was associated with a statistically significant lower incidence of treatment emergent dyskinesia. However the risk of tardive dyskinesia increases with long term exposure, and therefore if signs or symptoms of tardive dyskinesia appear in a patient on olanzapine, a dose reduction or discontinuation should be considered. These symptoms can temporally deteriorate or even arise after discontinuation of treatment.

Postural hypotension

Postural hypotension was infrequently observed in the elderly in olanzapine clinical trials. As with other antipsychotics, it is recommended that blood pressure is measured periodically in patients over 65 years.

Sudden cardiac death

In post marketing reports with olanzapine, the event of sudden cardiac death has been reported in patients with olanzapine. In a retrospective observational cohort study, the risk of presumed sudden cardiac death in patients treated with olanzapine was approximately twice the risk in patients not using antipsychotics. In the study, the risk of olanzapine was comparable to the risk of atypical antipsychotics included in a pooled analysis.

Paediatric population

Olanzapine is not indicated for use in the treatment of children and adolescents. Studies in patients aged 13-17 years showed various adverse reactions, including weight gain, changes in metabolic parameters and increases in prolactin levels. Long-term outcomes associated with these events have not been studied and remain unknown.

Lactose

Olanzapine Film-coated Tablets contain lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

4.5 Interaction with other medicinal products and other forms of interaction

Paediatric population

Interaction studies have only been performed in adults.

Potential interactions affecting olanzapine

Since olanzapine is metabolised by CYP1A2, substances that can specifically induce or inhibit this isoenzyme may affect the pharmacokinetics of olanzapine.

Induction of CYP1A2

The metabolism of olanzapine may be induced by smoking and carbamazepine, which may lead to reduced olanzapine concentrations. Only slight to moderate increase in olanzapine clearance has been observed. The clinical consequences are likely to be limited, but clinical monitoring is recommended and an increase of olanzapine dose may be considered if necessary.

Inhibition of CYP1A2

Fluvoxamine, a specific CYP1A2 inhibitor, has been shown to significantly inhibit the metabolism of olanzapine. The mean increase in olanzapine C_{max} following fluvoxamine was 54

% in female non- smokers and 77 % in male smokers. The mean increase in olanzapine AUC was 52 % and 108 % respectively. A lower starting dose of olanzapine should be considered in patients who are using fluvoxamine or any other CYP1A2 inhibitors, such as ciprofloxacin. A decrease in the dose of olanzapine should be considered if treatment with an inhibitor of CYP1A2 is initiated.

Decreased bioavailability

Activated charcoal reduces the bioavailability of oral olanzapine by 50 to 60% and should be taken at least 2 hours before or after olanzapine.

Fluoxetine (a CYP2D6 inhibitor), single doses of antacid (aluminum, magnesium) or cimetidine have not been found to significantly affect the pharmacokinetics of olanzapine.

Potential for olanzapine to affect other medicinal products

Olanzapine may antagonize the effects of direct and indirect dopamine agonists.

Olanzapine does not inhibit the main CYP450 isoenzyme *in vitro* (e.g. 1A2, 2D6, 2C9, 2C19, 3A4). Thus no particular interaction is expected as verified through *in vivo* studies where no inhibition of metabolism of the following active substances was found: tricyclic antidepressant (representing mostly CYP2D6 pathway), warfarin (CYP2C9), theophylline (CYP1A2) or diazepam (CYP3A4 and 2C19).

Olanzapine showed no interaction when co-administered with lithium or biperiden.

Therapeutic monitoring of valproate plasma levels did not indicate that valproate dosage adjustment is required after the introduction of concomitant olanzapine.

General CNS activity

Caution should be exercised in patients who consume alcohol or receive medicinal products that can cause central nervous system depression.

The concomitant use of olanzapine with anti-Parkinsonian medicinal products in patients with Parkinson's disease and dementia is not recommended.

QTc interval

Caution should be used if olanzapine is being administered concomitantly with medicinal products known to increase QTc interval.

4.6 Pregnancy and lactation

Pregnancy

There are no adequate and well-controlled studies in pregnant women. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with olanzapine. Nevertheless, because human experience is limited, olanzapine should be used in pregnancy only if the potential benefit justifies the potential risk to the foetus.

Neonates exposed to antipsychotics (including olanzapine) during the third trimester of pregnancy are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, or feeding disorder. Consequently, newborns should be monitored carefully.

Lactation

In a study in breast feeding, healthy women, olanzapine was excreted in breast milk. Mean infant exposure (mg/kg) at steady state was estimated to be 1.8% of the maternal olanzapine dose (mg/kg). Patients should be advised not to breast feed an infant if they are taking olanzapine.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed.

Because olanzapine may cause somnolence and dizziness, patients should be cautioned about operating machinery, including motor vehicles.

4.8 Undesirable effects

Adults

The most frequently (seen in $\geq 1\%$ of patients) reported adverse reactions associated with the use of olanzapine in clinical trials were somnolence, weight gain, eosinophilia, elevated prolactin, cholesterol, glucose and triglyceride levels, Glucosuria, increased appetite, dizziness, akathisia, parkinsonism, dyskinesia, orthostatic hypotension, anticholinergic effects, transient asymptomatic elevations of hepatic aminotransferases, rash, asthenia, fatigue and oedema.

Tabulated list of adverse reactions

The following table lists the adverse reactions and laboratory investigations observed from spontaneous reporting and in clinical trials. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The frequency terms listed are defined as follows: Very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$), not known (cannot be estimated from the data available).

Very common	Common	Uncommon	Not known
Blood and the lymphatic system disorders			
	Eosinophilia	Leukopenia Neutropenia	Thrombocytopenia
Immune system disorders			
			Allergic reaction
Metabolism and nutrition disorders			
Weight gain ¹	Elevated cholesterol levels ^{2,3} Elevated glucose levels ⁴ Elevated triglyceride levels ^{2,5} Glucosuria Increased appetite		Development or exacerbation of diabetes occasionally associated with ketoacidosis or coma, including some fatal cases Hypothermia
Nervous system disorders			
Somnolence	Dizziness Akathisia Parkinsonism		Seizures where in most cases a history of seizures or risk

		Dyskinesia	factors for seizures were reported Neuroleptic malignant syndrome Dystonia (including oculogyration) Tardive dyskinesia Discontinuation symptoms ⁷
Cardiac disorders			
		Bradycardia QTc prolongation	Ventricular tachycardia/fibrillation, sudden death

Vascular disorders			
	Orthostatic hypotension	Thromboembolism (including pulmonary embolism and deep vein thrombosis)	
Gastrointestinal disorders			
	Mild, transient anticholinergic effects including constipation and dry mouth		Pancreatitis
Hepato-biliary disorders			
	Transient, asymptomatic elevations of hepatic aminotransferases (ALT, AST), especially in early treatment		Hepatitis (including hepatocellular, cholestatic or mixed liver injury)
Skin and subcutaneous tissue disorders			

	Rash	Photosensitivity reaction Alopecia	
Musculoskeletal and connective tissue disorders			
			Rhabdomyolysis
Renal and urinary disorders			
		Urinary incontinence, urinary retention	Urinary hesitation
Pregnancy, puerperium and perinatal conditions			
			Drug withdrawal syndrome neonatal
Reproductive system and breast disorders			
	Erectile dysfunction in	Amenorrhea	Priapism

General disorders and administration site conditions

Clinically significant weight gain was observed across all baseline Body Mass Index (BMI) categories. Following short term treatment (median duration 47 days), weight gain $\geq 7\%$ of baseline body weight was very common (22.2 %), $\geq 15\%$ was common (4.2 %) and $\geq 25\%$ was uncommon (0.8 %). Patients gaining $\geq 7\%$, $\geq 15\%$ and $\geq 25\%$ of their baseline body weight with long-term exposure (at least 48 weeks) were very common (64.4 %, 31.7 % and 12.3 % respectively).

Mean increases in fasting lipid values (total cholesterol, LDL cholesterol, and triglycerides) were greater in patients without evidence of lipid deregulation at baseline.

Observed for fasting normal levels at baseline (< 5.17 mmol/l) which increased to high (≥ 6.2 mmol/l). Changes in total fasting cholesterol levels from borderline at baseline ($\geq 5.17 - < 6.2$ mmol/l) to high (≥ 6.2 mmol/l) were very common.

Observed for fasting normal levels at baseline (< 5.56 mmol/l) this increased to high (≥ 7 mmol/l). Changes in fasting glucose from borderline at baseline ($\geq 5.56 - < 7$ mmol/l) to high (≥ 7 mmol/l) were very common.

Observed for fasting normal levels at baseline (< 1.69 mmol/l) this increased to high (≥ 2.26 mmol/l). Changes in fasting triglycerides from borderline at baseline (≥ 1.69 mmol/l - < 2.26 mmol/l) to high (≥ 2.26 mmol/l) were very common.

In clinical trials, the incidence of Parkinsonism and dystonia in olanzapine-treated patients was numerically higher, but not statistically significantly different from placebo. Olanzapine-treated patients had a lower incidence of Parkinsonism, akathisia and dystonia compared with titrated

doses of haloperidol. In the absence of detailed information on the pre-existing history of

individual acute and tardive extrapyramidal movement disorders, it can not be concluded at present that olanzapine produces less tardive dyskinesia and/or other tardive extrapyramidal syndromes.

Acute symptoms such as sweating, insomnia, tremor, anxiety, nausea and vomiting have been reported when olanzapine is stopped abruptly.

In clinical trials of up to 12 weeks, plasma prolactin concentrations exceeded the upper limit of normal range in approximately 30% of olanzapine treated patients with normal baseline prolactin value. In the majority of these patients the elevations were generally mild, and remained below two times the upper limit of normal range.

Long-term exposure (at least 48 weeks)

The proportion of patients who had adverse, clinically significant changes in weight gain, glucose, total/LDL/HDL cholesterol or triglycerides increased over time. In adult patients who completed 9-12 months of therapy, the rate of increase in mean blood glucose slowed after approximately 6 months.

Additional information on special populations

In clinical trials in elderly patients with dementia, olanzapine treatment was associated with a higher incidence of death and cerebrovascular adverse reactions compared to placebo. Very common adverse reactions associated with the use of olanzapine in this patient group were abnormal gait and falls. Pneumonia, increased body temperature, lethargy, erythema, visual hallucinations and urinary incontinence were observed commonly.

In clinical trials in patients with drug-induced (dopamine agonist) psychosis associated with Parkinson's disease, worsening of Parkinsonian symptomatology and hallucinations were reported very commonly and more frequently than with placebo.

In one clinical trial in patients with bipolar mania, valproate combination therapy with olanzapine resulted in an incidence of neutropenia of 4.1%; a potential contributing factor could be high plasma valproate levels. Olanzapine administered with lithium or valproate resulted in increased levels ($\geq 10\%$) of tremor, dry mouth, increased appetite, and weight gain. Speech disorder was also reported commonly. During treatment with olanzapine in combination with lithium or divalproex, an increase of $\geq 7\%$ from baseline body weight occurred in 17.4% of patients during acute treatment (up to 6 weeks). Long-term olanzapine treatment (up to 12 months) for recurrence prevention in patients with bipolar disorder was associated with an increase of $\geq 7\%$ from baseline body weight in 39.9% of patients.

Paediatric population

Olanzapine is not indicated for the treatment of children and adolescent patients below 18 years. Although no clinical studies designed to compare adolescents to adults have been conducted, data from the adolescent trials were compared to those of the adult trials.

The following table summarises the adverse reactions reported with a greater frequency in adolescent patients (aged 13-17 years) than in adult patients or adverse reactions only identified during short-term clinical trials in adolescent patients. Clinically significant weight gain ($\geq 7\%$) appears to occur more frequently in the adolescent population compared to adults with comparable exposures. The magnitude of weight gain and the proportion of adolescent patients who had clinically significant weight gain were greater with long-term exposure (at least 24 weeks) than with short-term exposure.

Reporting of suspected adverse reactions:

Reporting suspected adverse reactions after authorisation of the medicinal product is important as it allows continued monitoring of the benefit-risk balance of the medicinal product. Healthcare professionals are requested to report any suspected adverse reactions to the marketing authorisation holder or, where applicable, via the national reporting system

4.9 Overdose

Signs and symptoms: Very common symptoms in overdose ($> 10\%$ incidence) include tachycardia, agitation/aggressiveness, dysarthria, various extrapyramidal symptoms, and reduced level of consciousness ranging from sedation to coma.

Other medically significant sequelae of overdose include delirium, convulsion, coma,

possible neuroleptic malignant syndrome, respiratory depression, aspiration, hypertension or hypotension, cardiac arrhythmias (< 2% of overdose cases) and cardiopulmonary arrest. Fatal outcomes have been reported for acute overdoses as low as 450 mg but survival has also been reported following acute overdose of approximately 2 g of oral olanzapine.

Management

There is no specific antidote for olanzapine. Induction of emesis is not recommended. Standard procedures for management of overdose may be indicated (i.e. gastric lavage, administration of activated charcoal). The concomitant administration of activated charcoal was shown to reduce the oral bioavailability of olanzapine by 50 to 60%.

Symptomatic treatment and monitoring of vital organ function should be instituted according to clinical presentation, including treatment of hypotension and circulatory collapse and support of respiratory function. Do not use epinephrine, dopamine, or other sympathomimetic agents with beta- agonist activity since beta stimulation may worsen hypotension. Cardiovascular monitoring is necessary to detect possible arrhythmias. Close medical supervision and monitoring should continue until the patient recovers.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Olanzapine is an antipsychotic, antimanic and mood stabilizing agent that demonstrates a broad pharmacologic profile across a number of receptor systems.

In preclinical studies, olanzapine exhibited a range of receptor affinities ($K_i < 100$ nM) for serotonin 5 HT_{2A/2C}, 5 HT₃, 5 HT₆; dopamine D₁, D₂, D₃, D₄, D₅; cholinergic muscarinic receptors M₁-M₅; α_1 adrenergic; and histamine H₁ receptors. Animal behavioral studies with olanzapine indicated 5HT, dopamine, and cholinergic antagonism, consistent with the receptor-binding profile. Olanzapine demonstrated a greater *in vitro* affinity for serotonin 5HT₂ than dopamine D₂ receptors and greater 5 HT₂ than D₂ activity *in vivo* models. Electrophysiological studies demonstrated that olanzapine selectively reduced the firing of mesolimbic (A10) dopaminergic neurons, while having little effect on the striatal (A9) pathways involved in motor function. Olanzapine reduced a conditioned avoidance response, a test indicative of antipsychotic activity, at doses below those producing catalepsy, an effect indicative of motor side-effects. Unlike some other antipsychotic agents, olanzapine increases responding in an "anxiolytic" test.

In a single oral dose (10 mg) Positron Emission Tomography (PET) study in healthy volunteers, olanzapine produced a higher 5 HT_{2A} than dopamine D₂ receptor occupancy. In addition, a Single Photon Emission Computed Tomography (SPECT) imaging study in schizophrenic patients revealed that olanzapine-responsive patients had lower striatal D₂ occupancy than some other antipsychotic- and Risperidone-responsive patients, while being comparable to clozapine-responsive patients.

5.2 Pharmacokinetic properties

Absorption

Olanzapine is well absorbed after oral administration, reaching peak plasma concentrations within 5 to 8 hours. The absorption is not affected by food. Absolute oral bioavailability relative to intravenous administration has not been determined.

Distribution

The plasma protein binding of olanzapine was about 93 % over the concentration range of about 7 to about 1000 ng/ml. Olanzapine is bound predominantly to albumin and α_1 -acid-glycoprotein.

Biotransformation

Olanzapine is metabolized in the liver by conjugative and oxidative pathways. The major circulating metabolite is the 10-N-glucuronide, which does not pass the blood brain

barrier. Cytochromes P450- CYP1A2 and P450-CYP2D6 contribute to the formation of the N-desmethyl

and 2-hydroxymethyl metabolites, both exhibited significantly less *in vivo* pharmacological activity than olanzapine in animal studies. The predominant pharmacologic activity is from the parent olanzapine.

Elimination

After oral administration, the mean terminal elimination half-life of olanzapine in healthy subjects varied on the basis of age and gender.

In healthy elderly (65 and over) versus non-elderly subjects, the mean elimination half-life was prolonged (51.8 versus 33.8 hr) and the clearance was reduced (17.5 versus 18.2 l/hr). The pharmacokinetic variability observed in the elderly is within the range for the non-elderly. In 44 patients with schizophrenia > 65 years of age, dosing from 5 to 20 mg/day was not associated with any distinguishing profile of adverse events.

In female versus male subjects the mean elimination half life was somewhat prolonged (36.7 versus 32.3 hrs) and the clearance was reduced (18.9 versus 27.3 l/hr). However, olanzapine (5-20 mg) demonstrated a comparable safety profile in female (n=467) as in male patients (n=869).

Renal impairment

In renally impaired patients (creatinine clearance < 10 ml/min) versus healthy subjects, there was no significant difference in mean elimination half-life (37.7 versus 32.4 hr) or clearance (21.2 versus 25.0 l/hr). A mass balance study showed that approximately 57 % of radiolabelled olanzapine appeared in urine, principally as metabolites.

Smokers

In smoking subjects with mild hepatic dysfunction, mean elimination half-life (39.3 hr) was prolonged and clearance (18.0 l/hr) was reduced analogous to non-smoking healthy subjects (48.8 hr and 14.1 l/hr, respectively).

In non-smoking versus smoking subjects (males and females) the mean elimination half-life was prolonged (38.6 versus 30.4 hr) and the clearance was reduced (18.6 versus 27.7 l/hr). The plasma clearance of olanzapine is lower in elderly versus young subjects, in females versus males, and in non-smokers versus smokers. However, the magnitude of the impact of age, gender, or smoking on olanzapine clearance and half-life is small in comparison to the overall variability between individuals.

In a study of Caucasians, Japanese, and Chinese subjects, there were no differences in the pharmacokinetic parameters among the three populations.

Paediatric population

Adolescents (ages 13 to 17 years): The pharmacokinetics of olanzapine are similar between adolescents and adults. In clinical studies, the average olanzapine exposure was approximately 27% higher in adolescents. Demographic differences between the adolescents and adults include a lower average body weight and fewer adolescents were smokers. Such factors possibly contribute to the higher average exposure observed in adolescents.

5.3 Preclinical safety data

Acute (single-dose) toxicity

Signs of oral toxicity in rodents were characteristic of potent neuroleptic compounds: hypoactivity, coma, tremors, clonic convulsions, salivation, and depressed weight gain. The median lethal doses were approximately 210 mg/kg (mice) and 175 mg/kg (rats). Dogs tolerated single oral doses up to 100 mg/kg without mortality. Clinical signs included sedation, ataxia, tremors, increased heart rate, labored respiration, miosis, and anorexia. In monkeys, single oral doses up to 100 mg/kg resulted in prostration and, at higher doses, semi-consciousness.

Repeated-dose toxicity

In studies up to 3 months duration in mice and up to 1 year in rats and dogs, the predominant effects were CNS depression, anticholinergic effects, and peripheral hematological disorders. Tolerance developed to the CNS depression. Growth parameters were decreased at high doses. Reversible effects consistent with elevated prolactin in rats included decreased weights of ovaries and uterus and morphologic changes in vaginal epithelium and in mammary gland.

Hematologic toxicity: Effects on hematology parameters were found in each species, including dose-related reductions in circulating leukocytes in mice and non-specific reductions of circulating leukocytes in rats; however, no evidence of bone marrow cytotoxicity was found. Reversible neutropenia, thrombocytopenia, or anemia developed in a few dogs treated with 8 or 10 mg/kg/day (total olanzapine exposure [area under the curve] is 12- to 15-fold greater than that of a man given a 12-mg dose). In cytogenic dogs, there were no adverse effects on progenitor and proliferating cells in the bone marrow.

Reproductive toxicity

Olanzapine had no teratogenic effects. Sedation affected mating performance of male rats. Estrous cycles were affected at doses of 1.1 mg/kg (3 times the maximum human dose) and reproduction parameters were influenced in rats given 3 mg/kg (9 times the maximum human dose). In the offspring of rats given olanzapine, delays in fetal development and transient decreases in offspring activity levels were seen.

Mutagenicity

Olanzapine was not mutagenic or clastogenic in a full range of standard tests, which included bacterial mutation tests and *in vitro* and *in vivo* mammalian tests.

Carcinogenicity

Based on the results of studies in mice and rats, it was concluded that olanzapine is not carcinogenic.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Lactose Monohydrate	USP
Microcrystalline Cellulose (Avicel PH 101)	USP
Pregelatinised starch	USP
Purified Water	USP
Microcrystalline Cellulose (Avicel PH 102)	USP
Sucralose	USPNF
Peppermint DC 117 PH flavor	IH
Magnesium stearate	USPNF

6.2 Incompatibilities

None

6.3 Shelf life

36 months from the date of manufacturing.

6.4 Special precautions for storage

Store below 30°C. Keep out from the reach of children.

6.5 Nature and contents of container

Primary pack: ALU/ALU blister pack of 10 Tablets.

Secondary pack: Such 3 blisters are packed in a printed outer carton along with a pack Insert.

6.6 Special precautions for disposal and other handling

No special requirements

7. Marketing authorisation holder

Micro Labs Limited, India # 27, Race Course Road Bangalore- 560 001
Tel: +91 80 2237 0451-54

MANUFACTURER

Micro Labs
Limited #92,
SIPCOT,
Hosur-635 126. INDIA.

8. Marketing authorisation number(s)

H2025/CTD7251/14298

9. Date of first authorisation/renewal of the authorization

2025 July 08

10. DATE OF REVISION OF THE TEXT

2025 July 08