

SUMMARY OF PRODUCT CHARACTERISTICS

Zosert 50

(Sertraline Hydrochloride Tablets BP 50 mg)

1. NAME OF THE MEDICINAL PRODUCT

Zosert 50

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Zosert 50

Each film coated tablet contains:

Sertraline hydrochloride Ph. Eur

Equivalent to sertraline..... 50 mg

For the full list of excipients, see **section 6.1**.

3. PHARMACEUTICAL FORM

Tablet

4. CLINICAL PARTICULARS

4.1 *Therapeutic indications*

Zosert 50 is indicated for the treatment of:

- Major depressive episodes. Prevention of recurrence of major depressive episodes.
- Panic disorder, with or without agoraphobia.
- Obsessive compulsive disorder (OCD) in adults and paediatric patients aged 6-17 years.
- Social anxiety disorder.
- Post traumatic stress disorder (PTSD).

4.2 *Posology and method of administration*

Zosert 50 is available in the strengths of 50 mg and may not be suitable for all dosage recommendations given below. Therefore, other suitable available strengths and/or dosage forms of sertraline should be used in such cases. Posology

Initial treatment

Depression and OCD

Sertraline treatment should be started at a dose of 50 mg/day.

Panic Disorder, PTSD, and Social Anxiety Disorder

Therapy should be initiated at 25 mg/day. After one week, the dose should be increase to 50 mg once daily. This dosage regimen has been shown to reduce the frequency of early treatment emergent side effects

characteristic of panic disorder.

Titration

Depression, OCD, Panic Disorder, Social Anxiety Disorder and PTSD
Patients not responding to a 50 mg dose may benefit from dose increases. Dose changes should be made in steps of 50mg at intervals of at least one week, up to a maximum of 200 mg/day. Changes in dose should not be made more frequently than once per week given the 24-hour elimination half life of sertraline.

The onset of therapeutic effect may be seen within 7 days. However, longer periods are usually necessary to demonstrate therapeutic response, especially in OCD.

Maintenance

Dosage during long-term therapy should be kept at the lowest effective level, with subsequent adjustment depending on therapeutic response.

Depression

Longer-term treatment may also be appropriate for prevention of recurrence of major depressive episodes (MDE). In most of the cases, the recommended dose in prevention of recurrence of MDE is the same as the one used during current episode. Patients with depression should be treated for a sufficient period of time of at least 6 months to ensure they are free from symptoms.

Panic disorder and OCD

Continued treatment in panic disorder and OCD should be evaluated regularly, as relapse prevention has not been shown for these disorders.

Elderly patients

Elderly should be dosed carefully, as elderly may be more at risk for hyponatraemia (see **section 4.4**).

Patients with hepatic impairment

The use of sertraline in patients with hepatic disease should be approached with caution. A lower or less frequent dose should be used in patients with hepatic impairment (see section 4.4). Sertraline should not be used in cases of severe hepatic impairment as no clinical data are available (see section 4.4).

Patients with renal impairment

No dosage adjustment is necessary in patients with renal impairment (see section 4.4).

Paediatric population

Children and adolescents with obsessive compulsive disorder

Age 13-17 years: Initially 50 mg once daily.

Age 6-12 years: Initially 25 mg once daily. The dosage may be increased to 50 mg once daily after one week.

Subsequent doses may be increased in case of less than desired response in 50 mg increments over a period of some weeks, as needed.

The maximum dosage is 200 mg daily. However, the generally lower body weights of children compared to those of adults should be taken into consideration when increasing the dose from 50 mg. Dose changes should not occur at intervals of less than one week. Efficacy is not reported in paediatric major depressive disorder.

No data have been reported for children under 6 years of age (see also **section 4.4**).

Method of administration

Sertraline should be administered once daily, either in the morning or evening. Sertraline tablet can be administered with or without food.

Withdrawal symptoms seen on discontinuation of sertraline

Abrupt discontinuation should be avoided. When stopping treatment with sertraline the dose should be gradually reduced over a period of at least one to two weeks in order to reduce the risk of withdrawal reactions (see **sections 4.4 and 4.8**). If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose, but at a more gradual rate.

Contraindications

- Hypersensitivity to the active substance or any of the excipients listed in **section 6.1**.
- Concomitant treatment with irreversible monoamine oxidase inhibitors (MAOIs) is contraindicated due to the risk of serotonin syndrome with symptoms such as agitation, tremor and hyperthermia. Sertraline must not be initiated for at least 14 days after discontinuation of treatment with an irreversible MAOI. Sertraline must be discontinued for at least 7 days before starting treatment with an irreversible MAOI (see **section 4.5**).
- Concomitant intake of pimozide is contraindicated (see **section 4.5**).

4.3 *Special warnings and special precautions for use*

Serotonin Syndrome (SS) or Neuroleptic Malignant Syndrome (NMS)

The development of potentially life-threatening syndromes like serotonin syndrome (SS) or Neuroleptic Malignant Syndrome (NMS) has been reported with SSRIs, including treatment with sertraline. The risk of SS or NMS with SSRIs is reported to increase with concomitant use of other serotonergic drugs (including other serotonergic antidepressants, amphetamines, triptans), with drugs which impair metabolism of serotonin (including MAOIs e.g. methylene blue), antipsychotics and other dopamine antagonists, and with opiate drugs. Patients should be monitored for the emergence of

signs and symptoms of SS or NMS syndrome (see **section 4.3**).P

Switching from Selective Serotonin Reuptake Inhibitors (SSRIs), antidepressants or anti-obsessional drugs

As per the reports, there is limited controlled experience regarding the optimal timing of switching from SSRIs, antidepressants or anti-obsessional drugs to sertraline. Care and prudent medical judgment should be exercised when switching, particularly from long-acting agents such as fluoxetine.

Other serotonergic drugs e.g. tryptophan, fenfluramine and 5-HT agonists

Co-administration of sertraline with other drugs which enhance the effects of serotonergic neurotransmission such as amphetamines, tryptophan or fenfluramine or 5-HT agonists, or the herbal medicine, St John's Wort (*Hypericum perforatum*), should be undertaken with caution and avoided whenever possible due to the potential for a pharmacodynamic interaction.

QTc Prolongation/Torsade de Pointes (TdP)

Cases of QTc prolongation and TdP have been reported during post-marketing use of sertraline. The majority of reports occurred in patients with other risk factors for QTc prolongation/TdP. Effect on QTc prolongation was confirmed in a thoroughly reported QTc study in healthy volunteers, with a statistically significant positive exposure response relationship. Therefore sertraline should be used with caution in patients with additional risk factors for QTc prolongation such as cardiac disease, hypokalaemia or hypomagnesaemia, familial history of QTc prolongation, bradycardia and concomitant use of medications which prolong QTc interval (see **sections 4.5**).

Activation of hypomania or mania

Manic/hypomanic symptoms have been reported to emerge in a small proportion of patients treated with marketed antidepressant and anti-obsessional drugs, including sertraline. Therefore sertraline should be used with caution in patients with a history of mania/hypomania. Close surveillance by the physician is required. Sertraline should be discontinued in any patient entering a manic phase.

Schizophrenia

Psychotic symptoms might become aggravated in schizophrenic patients.

Seizures

Seizures may occur with sertraline therapy: sertraline should be avoided in patients with unstable epilepsy and patients with controlled

epilepsy should be carefully monitored. Sertraline should be discontinued in any patient who develops seizures.

Suicide/suicidal thoughts/suicide attempts or clinical worsening

Depression is associated with an increased risk of suicidal thoughts, self-harm and suicide (suicide-related events). This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery.

Other psychiatric conditions, for which sertraline is prescribed, can also be associated with an increased risk of suicide-related events. In addition, these conditions may be co-morbid with major depressive disorder. The same precautions observed when treating patients with major depressive disorder should therefore be observed when treating patients with other psychiatric disorders.

Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment. A meta-analysis of placebo-controlled clinical studies of antidepressant drugs in adult patients with psychiatric disorders reported an increased risk of suicidal behaviour with antidepressants compared to placebo in patients less than 25 years old.

Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical

worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present.

Sexual dysfunction

Selective serotonin reuptake inhibitors (SSRIs) may cause symptoms of sexual dysfunction (see **section 4.7**). There have been reports of long-lasting sexual dysfunction where the symptoms have continued despite discontinuation of SSRIs.

Paediatric population

Sertraline should not be used in the treatment of children and adolescents under the age of 18 years, except for patients with

obsessive compulsive disorder aged 6-17 years old. Suicide-related behaviours (suicide attempt and suicidal thoughts), and hostility (predominantly aggression, oppositional behaviour and anger) have been more frequently reported among children and adolescents treated with antidepressants. If, based on clinical need, a decision to treat is nevertheless taken; the patient should be carefully monitored for appearance of suicidal symptoms. In addition only limited clinical evidence is available concerning, long-term safety data in children and adolescents including effects on growth, sexual maturation and cognitive and behavioural developments. A few cases of retarded growth and delayed puberty have been reported post-marketing. The clinical relevance and causality are yet unclear (see **section 5.3** for corresponding preclinical safety data). Physicians must monitor paediatric patients on long term treatment for abnormalities in growth and development.

Abnormal bleeding/Haemorrhage

There have been reports of bleeding abnormalities with SSRIs including cutaneous bleeding (ecchymoses and purpura) and other haemorrhagic events such as gastrointestinal or gynaecological bleeding, including fatal haemorrhages. SSRIs/SNRIs may increase the risk of postpartum haemorrhage (see **sections 4.6, 4.7**). Caution is advised in patients taking SSRIs, particularly in concomitant use with drugs known to affect platelet function (e.g. anticoagulants, atypical antipsychotics and phenothiazines, most tricyclic antidepressants, acetylsalicylic acid and non-steroidal anti-inflammatory drugs (NSAIDs)) as well as in patients with a history of bleeding disorders (see **section 4.5**).

Hyponatraemia

Hyponatraemia may occur as a result of treatment with SSRIs or SNRIs including sertraline. In many cases, hyponatraemia appears to be the result of a syndrome of inappropriate antidiuretic hormone secretion (SIADH). Cases of serum sodium levels lower than 110 mmol/L have been reported.

Elderly patients may be at greater risk of developing hyponatraemia with SSRIs and SNRIs. Also patients taking diuretics or who are otherwise volume-depleted may be at greater risk (see ***Use in elderly***). Discontinuation of sertraline should be considered in

patients with symptomatic hyponatraemia and appropriate medical intervention should be instituted. Signs and symptoms of hyponatraemia include headache, difficulty concentrating, memory impairment, confusion, weakness and unsteadiness which may lead to falls. Signs and symptoms associated with more severe and/or acute

cases have included hallucination, syncope, seizure, coma, respiratory arrest, and death.

Withdrawal symptoms seen on discontinuation of sertraline treatment

Withdrawal symptoms when treatment is discontinued are common, particularly if discontinuation is abrupt (see **section 4.7**). In clinical studies, among patients treated with sertraline, the incidence of reported withdrawal reactions was 23% in those discontinuing sertraline compared to 12% in those who continued to receive sertraline treatment.

The risk of withdrawal symptoms may be dependent on several factors including the duration and dose of therapy and the rate of dose reduction. Dizziness, sensory disturbances (including paraesthesia), sleep disturbances (including insomnia and intense dreams), agitation or anxiety, nausea and/or vomiting, tremor and headache are the most commonly reported reactions. Generally these symptoms are mild to moderate; however, in some patients they may be severe in intensity. They usually occur within the first few days of discontinuing treatment, but there have been very rare reports of such symptoms in patients who have inadvertently missed a dose. Generally these symptoms are self-limiting and usually resolve within 2 weeks, though in some individuals they may be prolonged (2-3 months or more). It is therefore advised that sertraline should be gradually tapered when discontinuing treatment over a period of several weeks or months, according to the patient's needs.

Akathisia/psychomotor restlessness

The use of sertraline has been reported to be associated with the development of akathisia, characterised by a subjectively unpleasant or distressing restlessness and need to move often accompanied by an inability to sit or stand still. This is most likely to occur within the first few weeks of treatment. In patients who develop these symptoms, increasing the dose may be detrimental.

Hepatic impairment

Sertraline is extensively metabolised by the liver. A multiple dose pharmacokinetic study in subjects with mild, stable cirrhosis reported a prolonged elimination half-life and approximately three-fold greater AUC and C_{max} in comparison to normal subjects. No significant differences in plasma protein binding have been reported between the two groups. The use of sertraline in patients with hepatic disease must be approached with caution. If sertraline is administered to patients with hepatic impairment, a lower or less frequent dose should

be considered. Sertraline should not be used in patients with severe hepatic impairment. Renal impairment

Sertraline is extensively metabolised, and excretion of unchanged drug in urine is a minor route of elimination. In reported studies of patients with mild to moderate renal impairment (creatinine clearance 30-60 ml/min) or moderate to severe renal impairment (creatinine clearance 10-29 ml/min), multiple-dose pharmacokinetic parameters (AUC₀₋₂₄ or C_{max}) were not significantly different compared with controls. Sertraline dosing does not have to be adjusted based on the degree of renal impairment.

Use in elderly

The pattern and incidence of adverse reactions in the elderly was reported to be similar to that in younger patients.

SSRIs or SNRIs including sertraline have however been associated with cases of clinically significant hyponatraemia in elderly patients, who may be at greater risk for this adverse event (see ***Hyponatraemia*** in **section 4.4**).

Diabetes

In patients with diabetes, treatment with an SSRI may alter glycaemic control. Insulin and/or oral hypoglycaemic dosage may need to be adjusted.

Electroconvulsive therapy

There are no reported clinical studies establishing the risks or benefits of the combined use of ECT and sertraline.

Grapefruit juice

The administration of sertraline with grapefruit juice is not recommended (see **section 4.5**).

Interference with urine screening tests

False-positive urine immunoassay screening tests for benzodiazepines have been reported in patients taking sertraline. This is due to lack of specificity of the screening tests. False-positive test results may be expected for several days following discontinuation of sertraline therapy. Confirmatory tests, such as gas chromatography/mass spectrometry, will distinguish sertraline from benzodiazepines.

Angle-Closure glaucoma

SSRIs including sertraline may have an effect on pupil size resulting in mydriasis. This mydriatic effect has the potential to narrow the eye angle resulting in increased intraocular pressure and angle-closure glaucoma, especially in patients pre-disposed. Sertraline should therefore be used with caution in patients with angle-closure glaucoma or history of glaucoma.

Excipients

Zosert 50 contains less than 1 mmol sodium per tablet, that is to

say essentially 'sodium-free'.

4.4 **Interaction with other medicinal products and other**

forms of interaction Contraindicated

Monoamine Oxidase Inhibitors

- *Irreversible MAOIs (e.g. selegiline)*

Sertraline must not be used in combination with irreversible MAOIs such as selegiline. Sertraline must not be initiated for at least 14 days after discontinuation of treatment with an irreversible MAOI. Sertraline must be discontinued for at least 7 days before starting treatment with an irreversible MAOI (see **section 4.3**).

- *Reversible, selective MAO-A inhibitor (moclobemide)*

Due to the risk of serotonin syndrome, the combination of sertraline with a reversible and selective MAOI, such as moclobemide, should not be given. Following treatment with a reversible MAO-inhibitor, a shorter withdrawal period than 14 days may be used before initiation of sertraline treatment. It is recommended that sertraline should be discontinued for at least 7 days before starting treatment with a reversible MAOI (see **section 4.3**).

- *Reversible, non-selective MAOI (linezolid)*

The antibiotic linezolid is a weak reversible and non-selective MAOI and should not be given to patients treated with sertraline (see **section 4.3**).

Severe adverse reactions have been reported in patients who have recently been discontinued from an MAOI (e.g. methylene blue) and started on sertraline, or have recently had sertraline therapy discontinued prior to initiation of an MAOI. These reactions have included tremor, myoclonus, diaphoresis, nausea, vomiting, flushing, dizziness, and hyperthermia with features resembling neuroleptic malignant syndrome, seizures, and death.

Pimozide

Increased pimozide levels of approximately 35% have been reported in a study of a single low dose pimozide (2 mg). These increased levels were not reported to be associated with any changes in EKG. While the mechanism of this interaction is unknown, due to the narrow therapeutic index of pimozide, concomitant administration of sertraline and pimozide is contraindicated (see **section 4.3**).

Co-administration with sertraline is not recommended

CNS depressants and alcohol

It has been reported that the co-administration of sertraline 200 mg daily did not potentiate the effects of alcohol, carbamazepine, haloperidol, or phenytoin on cognitive and psychomotor performance in healthy subjects; however, the concomitant use of sertraline and

alcohol is not recommended.

Other serotonergic drugs See **section 4.4**.

Caution is also advised with fentanyl (used in general anaesthesia or in the treatment of chronic pain), other serotonergic drugs (including other serotonergic antidepressants, amphetamines, triptans), and with other opiate drugs.

Special Precautions

Drugs that Prolong the QT Interval

The risk of QTc prolongation and/or ventricular arrhythmias (e.g. TdP) may be increased with concomitant use of other drugs which prolong the QTc interval (e.g. some antipsychotics and antibiotics) (see **sections 4.4**).

Lithium

In a reported placebo-controlled trial in normal volunteers, the co-administration of sertraline with lithium did not significantly alter lithium pharmacokinetics, but did result in an increase in tremor relative to placebo, indicating a possible pharmacodynamic interaction. When co-administering sertraline with lithium, patients should be appropriately monitored.

Phenytoin

It has been reported that chronic administration of sertraline 200 mg/day does not produce clinically important inhibition of phenytoin metabolism. Nonetheless, as some case reports have emerged of high phenytoin exposure in patients using sertraline, it is recommended that plasma phenytoin concentrations be monitored following initiation of sertraline therapy, with appropriate adjustments to the phenytoin dose. In addition, co-administration of phenytoin may cause a reduction of sertraline plasma levels. It cannot be excluded that other CYP3A4 inducers, e.g. phenobarbital, carbamazepine, St John's Wort, rifampicin may cause a reduction of sertraline plasma levels.

Metamizole

Co-administration of sertraline with metamizole, which is an inducer of metabolising enzymes including CYP2B6 and CYP3A4, may cause a reduction in plasma concentrations of sertraline with potential decrease in clinical efficacy. Therefore, caution is advised when metamizole and sertraline are administered concurrently; clinical response and/or drug levels should be monitored as appropriate.

Triptans

There have been rare post-marketing reports describing patients with weakness, hyperreflexia, incoordination, confusion, anxiety and agitation following the use of sertraline and sumatriptan. Symptoms of serotonergic syndrome may also occur with other products of the same class (triptans). If concomitant treatment with sertraline and triptans is clinically warranted, appropriate observation of the patient is

advised (see **section 4.4**).

Warfarin

It has been reported that co-administration of sertraline 200 mg daily with warfarin resulted in a small but statistically significant increase in prothrombin time, which may in some rare cases unbalance the INR value.

Accordingly, prothrombin time should be carefully monitored when sertraline therapy is initiated or stopped.

Other drug interactions, digoxin, atenolol, cimetidine

It has been reported that co-administration with cimetidine caused a substantial decrease in sertraline clearance. The clinical significance of these changes is unknown. Sertraline had no effect on the beta-adrenergic blocking ability of atenolol. No interaction of sertraline 200 mg daily was reported with digoxin.

Drugs affecting platelet function

The risk of bleeding may be increased when medicines acting on platelet function (e.g. NSAIDs, acetylsalicylic acid and ticlopidine) or other medicines that might increase bleeding risk are concomitantly administered with SSRIs, including sertraline (see **section 4.4**).

Neuromuscular Blockers

SSRIs may reduce plasma cholinesterase activity resulting in a prolongation of the neuromuscular blocking action of mivacurium or other neuromuscular blockers.

Drugs Metabolized by Cytochrome P450

Sertraline may act as a mild-moderate inhibitor of CYP 2D6. It has been reported that chronic dosing with sertraline 50 mg daily showed moderate elevation (mean 23%-37%) of steady-state desipramine plasma levels (a marker of CYP 2D6 isozyme activity). Clinical relevant interactions may occur with other CYP 2D6 substrates with a narrow therapeutic index like class 1C antiarrhythmics such as propafenone and flecainide, TCAs and typical antipsychotics, especially at higher sertraline dose levels.

Sertraline does not act as an inhibitor of CYP 3A4, CYP 2C9, CYP 2C19, and CYP 1A2 to a clinically significant degree. This has been confirmed by reported *in-vivo* interaction studies with CYP3A4 substrates (endogenous cortisol, carbamazepine, terfenadine, alprazolam), CYP2C19 substrate diazepam, and CYP2C9 substrates tolbutamide, glibenclamide and phenytoin. The reported *in vitro* studies indicate that sertraline has little or no potential to inhibit CYP 1A2.

It has been reported that intake of three glasses of grapefruit juice daily increased the sertraline plasma levels by approximately 100% in a cross-over study in eight Japanese healthy subjects. Therefore, the intake of grapefruit juice should be avoided during treatment with

sertraline (see **section 4.4**).

Based on the reported interaction study with grapefruit juice, it cannot be excluded that the concomitant administration of sertraline and potent CYP3A4 inhibitors, e.g. protease inhibitors, ketoconazole, itraconazole, posaconazole, voriconazole, clarithromycin, telithromycin and nefazodone, would result in even larger increases in exposure of sertraline. This also concerns moderate CYP3A4 inhibitors, e.g. aprepitant, erythromycin, fluconazole, verapamil and diltiazem. The intake of potent CYP3A4 inhibitors should be avoided during treatment with sertraline.

It cannot be excluded that CYP3A4 inducers, e.g. phenobarbital, carbamazepine, St. John's Wort and rifampicin, may cause a reduction of sertraline plasma levels.

Sertraline plasma levels are reported to be enhanced by about 50% in poor metabolizers of CYP2C19 compared to rapid metabolizers (see **section 5.2**). Interaction with strong inhibitors of CYP2C19, e.g. omeprazole, lansoprazole, pantoprazole, rabeprazole, fluoxetine, fluvoxamine cannot be excluded.

4.5 Fertility, pregnancy and

lactation Pregnancy

There are no well controlled studies in pregnant women. However, a substantial amount

of reported data did not reveal evidence of induction of congenital malformations by sertraline. The reported animal studies showed evidence for effects on reproduction probably due to maternal toxicity caused by the pharmacodynamic action of the compound and/or direct pharmacodynamic action of the compound on the foetus (see **section 5.3**).

Use of sertraline during pregnancy has been reported to cause symptoms, compatible with withdrawal reactions, in some neonates, whose mothers had been on sertraline. This phenomenon has also been reported with other SSRI antidepressants. Sertraline is not recommended in pregnancy, unless the clinical condition of the woman is such that the benefit of the treatment is expected to outweigh the potential risk. Reported data indicated an increased risk (less than 2-fold) of postpartum haemorrhage following SSRI/SNRI exposure within the month prior to birth (see **sections 4.4, 4.7**).

Neonates should be observed if maternal use of sertraline continues into the later stages of pregnancy, particularly the third trimester. The following symptoms may occur in the neonate after maternal sertraline use in later stages of pregnancy: respiratory distress, cyanosis, apnoea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycaemia, hypertonia, hypotonia, hyperreflexia,

tremor, jitteriness, irritability, lethargy, constant crying, somnolence and difficulty in sleeping. These symptoms could be due to either serotonergic effects or withdrawal symptoms. In a majority of instances the complications begin immediately or soon (<24 hours) after delivery.

Epidemiological data have reported that the use of SSRIs in pregnancy, particular in late pregnancy, may increase the risk of persistent pulmonary hypertension in the newborn (PPHN). The reported risk was approximately 5 cases per 1000 pregnancies. In the general population 1 to 2 cases of PPHN per 1000 pregnancies have been reported.

Breast-feeding

Published data concerning sertraline levels in breast milk has reported that small quantities of sertraline and its metabolite N-desmethylsertraline are excreted in milk. Generally negligible to undetectable levels were found in infant serum, with one exception of an infant with serum levels about 50% of the maternal level (but without a noticeable health effect in this infant). To date, no adverse effects on the health of infants nursed by mothers using sertraline have been reported, but a risk cannot be excluded. Use in nursing mothers is not recommended unless, in the judgment of the physician, the benefit outweighs the risk.

Fertility

The reported animal data did not show an effect of sertraline on fertility parameters (see **section 5.3**).

Human case reports with some SSRI's have reported that an effect on sperm quality is reversible.

Impact on human fertility has not been reported so far.

4.6 *Effects on ability to drive and use machines*

Clinical pharmacology studies have reported that sertraline has no effect on psychomotor performance. However, as psychotropic drugs may impair the mental or

physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, the patient should be cautioned accordingly.

4.7 **Undesirable effects**

Nausea is the most common undesirable effect. In the treatment of social anxiety disorder, sexual dysfunction (ejaculation failure) in men has been reported in 14% for sertraline vs 0% in placebo. These undesirable effects are dose dependent and are often transient in nature with continued treatment.

The undesirable effects profile commonly reported in patients with OCD, panic disorder, PTSD and social anxiety disorder was similar to that of patients with depression.

Table 1 displays adverse reactions reported from post-marketing experience (frequency not known) and placebo-controlled clinical studies in depression, OCD, panic disorder, PTSD and social anxiety disorder.

Some adverse drug reactions listed in Table 1 may decrease in intensity and frequency with continued treatment and do not generally lead to cessation of therapy.

Table 1: Adverse Reactions Frequency of adverse reactions reported from placebo-controlled clinical studies in depression, OCD, panic disorder, PTSD and social anxiety disorder. Reported pooled analysis and reported post-marketing experience.					
System Organ Class	Very Common (≥1/10)	Common (≥1/100 to <1/10)	Uncommon (≥1/1,000 to <1/100)	Rare (≥1/10,000 to <1/1,000)	Frequency Not Known (Cannot be Estimated From the Available Data)
Infections and infestations		upper respiratory tract infection, pharyngitis, rhinitis	gastroenteritis, otitis media	diverticulitis ^s	

Neoplasms benign, malignant and unspecified (including cysts and polyps)			neoplasm		
Blood and lymphatic system disorders				lymphadenopathy, thrombocytopenia* §, leukopenia*§	
Immune system disorders			hypersensitivity*, seasonal allergy*	anaphylactoid reaction*	
Endocrine disorders			hypothyroidism*	hyperprolactinaemia*§, inappropriate antidiuretic hormone secretion*§	
Metabolism and nutrition disorders		decreased appetite, increased appetite*		hypercholesterolaemia, diabetes mellitus*, hypoglycaemia* , hyperglycaemia*§, hyponatraemia*§	
Psychiatric disorders	insomnia	anxiety*, depression*, agitation*, libido decreased*, nervousness, depersonalisation,	suicidal ideation/behaviour , psychotic disorder*, thinking abnormal, apathy, hallucination*	conversion disorder*§, paroniria*§, drug dependence, sleep walking, premature	

		nightmare, bruxism*	, aggression*, euphoric mood*, paranoia	ejaculation	
Nervous system disorders	dizziness, headache*, somnolence	tremor, movement disorders (including extrapyramidal symptoms such as hyperkinesia, hypertonia, dystonia, teeth grinding or gait abnormalities), paraesthesia*, hypertonia*, disturbance in attention, dysgeusia	amnesia, hypoaesthesia*, muscle contractions involuntary*, syncope*, hyperkinesia*, migraine*, convulsion*, dizziness postural, coordination abnormal, speech disorder	coma*, akathisia (see section 4.4), dyskinesia, hyperaesthesia, cerebrovascular spasm (including reversible cerebral vasoconstriction syndrome and Call-Fleming syndrome)*§, psychomotor restlessness* § (see section 4.4), sensory disturbance, choreoathetosis§, also reported were signs and symptoms associated with serotonin syndrome* or neuroleptic malignant syndrome: In some cases associated with concomitant use of serotonergic drugs that included	

				agitation, confusion, diaphoresis, diarrhoea, fever, hypertension, rigidity and tachycardia [§]	
Eye disorders		visual disturbance*	mydriasis*	scotoma, glaucoma, diplopia, photophobia, hyphaema* [§] , pupils unequal* [§] , vision abnormal [§] , lacrimal disorder	maculopathy
Ear and labyrinth disorders		tinnitus*	ear pain		
Cardiac disorders		palpitations*	tachycardia*, cardiac disorder	myocardial infarction* [§] , Torsade de Pointes* [§] (see sections 4.4, 4.5), bradycardia, QTc prolongation* (see sections 4.4, 4.5)	
Vascular disorders		hot flush*	abnormal bleeding (such as gastrointestinal bleeding)*, hypertension* , flushing, haematuria*	peripheral ischaemia	

Respiratory, thoracic and mediastinal disorders		yawning*	dyspnoea, epistaxis*, bronchospasm*	hyperventilation, interstitial lung disease*§, laryngospasm, dysphonia, stridor*§, hypoventilation, hiccups	
Gastrointestinal disorders	nausea, diarrhoea, dry mouth	dyspepsia, constipation*, abdominal pain*, vomiting*, flatulence	melaena, tooth disorder, oesophagitis, glossitis, haemorrhoids, salivary hypersecretion, dysphagia, eructation, tongue disorder	mouth ulceration, pancreatitis*§, haematochezia, tongue ulceration, stomatitis	colitis microscopic*

Hepatobiliary disorders				hepatic function abnormal, serious liver events (including hepatitis, jaundice and hepatic failure)	
Skin and subcutaneous tissue disorders		hyperhidrosis, rash*	periorbital oedema*, urticaria*, alopecia*, pruritus*, purpura*, dermatitis, dry skin, face oedema, cold sweat	rare reports of severe cutaneous adverse reactions (SCAR): e.g. Stevens-Johnson syndrome* and epidermal necrolysis*§, skin reaction*§, photosensitivity§, angioedema, hair texture abnormal, skin odour abnormal, dermatitis bullous, rash follicular	
Musculoskeletal and connective tissue disorders		back pain, arthralgia*, myalgia	osteoarthritis, muscle twitching, muscle cramps*, muscular weakness	rhabdomyolysis*§, bone disorder	trismus*
Renal and urinary disorders			pollakiuria, micturition disorder, urinary retention, urinary incontinence*, polyuria, nocturia	urinary hesitation*, oliguria	

Reproductive system and breast disorders	ejaculation failure	menstruation irregular*, erectile dysfunction	sexual dysfunction (see section 4.4), menorrhagia, vaginal haemorrhage, female sexual dysfunction (see section 4.4)	galactorrhoea*, atrophic vulvovaginitis, genital discharge, balanoposthitis*§, gynaecomastia*, priapism*	postpartum haemorrhage*†
General disorders and administration site conditions	fatigue*	malaise*, chest pain*, asthenia*, pyrexia*	oedema peripheral*, chills, gait disturbance*, thirst	hernia, drug tolerance decreased	
Investigations		weight increased*	alanine aminotransferase increased*, aspartate aminotransferase increased*, weight decreased*	blood cholesterol increased*, abnormal clinical laboratory results, semen abnormal, altered platelet function*§	
Injury, poisoning and procedural complications		injury			
Surgical and medical procedures				vasodilation procedure	

* ADR identified post-marketing

§ ADR frequency represented by the estimated upper limit of the 95% confidence interval using "The Rule of 3".

† This event has been reported for the therapeutic class of SSRIs/SNRIs (see **sections 4.4, 4.6**).

Withdrawal symptoms seen on discontinuation of sertraline

treatment Discontinuation of sertraline (particularly when abrupt) commonly leads to withdrawal symptoms. Dizziness, sensory disturbances (including paraesthesia), sleep disturbances (including insomnia and intense dreams), agitation or anxiety, nausea and/or vomiting, tremor and headache are the most commonly reported. Generally these events are mild to moderate and are self-limiting; however, in some patients they may be severe and/or prolonged. It is therefore advised that when sertraline treatment is no longer required, gradual discontinuation by dose tapering should be carried out (see **section 4.4**).

Elderly population

SSRIs or SNRIs including sertraline have been reported to be associated with cases of clinically significant hyponatraemia in elderly patients, who may be at greater risk for this adverse event (see **section 4.4**).

Paediatric population

The overall profile of adverse reactions in pediatric patients treated with sertraline was generally similar to that reported in adults. The following adverse reactions have been reported:

Very common ($\geq 1/10$): Headache (22%), insomnia (21%), diarrhoea (11%) and nausea (15%).

Common ($\geq 1/100$ to $< 1/10$): Chest pain, mania, pyrexia, vomiting, anorexia, affect lability, aggression, agitation, nervousness, disturbance in attention, dizziness, hyperkinesia, migraine, somnolence, tremor, visual disturbance, dry mouth, dyspepsia, nightmare, fatigue, urinary incontinence, rash, acne, epistaxis, flatulence. *Uncommon ($\geq 1/1000$ to $< 1/100$):* ECG QT prolonged (see **sections 4.4** and **4.5**), suicide attempt, convulsion, extrapyramidal disorder, paraesthesia, depression, hallucination, purpura, hyperventilation, anaemia, hepatic function abnormal, alanine aminotransferase increased, cystitis, herpes simplex, otitis externa, ear pain, eye pain, mydriasis, malaise, haematuria, rash pustular, rhinitis, injury, weight decreased, muscle twitching, abnormal dreams, apathy, albuminuria, pollakiuria, polyuria, breast pain, menstrual disorder, alopecia, dermatitis, skin disorder, skin odour abnormal, urticaria, bruxism, flushing.

Frequency not known: enuresis

Class effects

Epidemiological studies, mainly conducted in patients 50 years of age and older, reported an increased risk of bone fractures in patients

receiving SSRIs and TCAs. The mechanism leading to this risk is unknown.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions to National Regulatory Authority.

4.9 Overdose

Toxicity

Sertraline has a margin of safety dependent on patient population and/or concomitant

medication. Deaths have been reported involving overdoses of sertraline, alone or in combination with other drugs and/or alcohol. Therefore, any overdosage should be medically treated aggressively.

Symptoms

Symptoms of overdose include serotonin-mediated side effects such as somnolence, gastrointestinal disturbances (e.g nausea and vomiting), tachycardia, tremor, agitation and dizziness. Coma has been reported although less frequently.

QTc prolongation/Torsade de Pointes has been reported following sertraline overdose; therefore, ECG-monitoring is recommended in all ingestions of sertraline overdoses (see **sections 4.4** and **4.5**).

Management

There are no specific antidotes to sertraline. It is recommended to establish and maintain an airway and, if necessary, ensure adequate oxygenation and ventilation. Activated charcoal, which may be used with a cathartic, may be as, or more effective than lavage, and should be considered in treating overdose. Induction of emesis is not recommended. Cardiac (e.g. ECG) and vital sign monitoring is also recommended, along with general symptomatic and supportive measures. Due to the large volume of distribution of sertraline, forced diuresis, dialysis, haemoperfusion and exchange transfusion are unlikely to be of benefit.

PHARMACOLOGICAL PROPERTIES

4.10 Pharmacodynamic properties

Pharmacotherapeutic group: Selective serotonin reuptake inhibitors (SSRI), ATC code: N06 AB06

Mechanism of action

Sertraline is a potent and specific inhibitor of neuronal serotonin (5-HT) uptake in vitro, which results in the potentiation of the effects of 5-HT in animals. It has only very weak effects on norepinephrine and dopamine neuronal reuptake. At clinical doses, sertraline blocks the uptake of serotonin into human platelets. It is devoid of stimulant, sedative or anticholinergic activity or cardiotoxicity in animals. In reported controlled studies in normal volunteers, sertraline did not cause sedation and did not interfere with psychomotor performance. In accord with its selective inhibition of 5-HT uptake, sertraline does not enhance catecholaminergic activity. Sertraline has no affinity for muscarinic (cholinergic), serotonergic, dopaminergic, adrenergic, histaminergic, GABA or benzodiazepine receptors. The chronic administration of sertraline in animals was reported to be associated with down-regulation of brain norepinephrine receptors as observed with other clinically effective antidepressants and antiobsessional drugs.

Sertraline has not demonstrated potential for abuse. In a reported placebo-controlled, double-blind randomized study of the comparative abuse liability of sertraline, alprazolam and d-amphetamine in humans, sertraline did not produce positive subjective effects indicative of abuse potential. In contrast, subjects rated both alprazolam and d-amphetamine significantly greater than placebo on measures of drug liking, euphoria and abuse potential. Sertraline did not produce either the stimulation and anxiety associated with d-amphetamine or the sedation and psychomotor impairment associated with alprazolam. Sertraline does not function as a positive reinforcer in rhesus monkeys trained to self-administer cocaine, nor does it substitute as a discriminative stimulus for either d-amphetamine or pentobarbital in rhesus monkeys.

5 Pharmacokinetic

properties Absorption

In man, following an oral once-daily dosage of 50 to 200 mg for 14 days, peak plasma

concentrations of sertraline have been reported to occur at 4.5 to 8.4 hours after the daily administration of the drug. Food does not significantly change the bioavailability of sertraline tablets.

Distribution

Approximately 98% of the circulating drug is reported to be bound to plasma

proteins.

Biotransformation

Sertraline undergoes extensive first-pass hepatic metabolism.

Based on reported clinical and *in vitro* data, it can be concluded that sertraline is metabolized by multiple pathways including CYP3A4, CYP2C19 (see **section 4.5**) and CYP2B6. Sertraline and its major metabolite desmethylsertraline are also substrate of P-glycoprotein *in-vitro*.

Elimination

The mean half-life of sertraline is reported to be approximately 26 hours (range 22-36 hours). Consistent with the terminal elimination half-life, there is an approximately two-fold accumulation up to steady state concentrations, which are achieved after one week of once-daily dosing. The half-life of N-desmethylsertraline is in the range of 62 to 104 hours. Sertraline and N-desmethylsertraline are both extensively metabolized in man and the resultant metabolites excreted in faeces and urine in equal amounts. Only a small amount (<0.2%) of unchanged sertraline is reported to be excreted in the urine.

Linearity/non-linearity

Sertraline has been reported to exhibit dose proportional pharmacokinetics in the range of 50 to 200 mg.

Pharmacokinetics in specific patient groups

Paediatric population with OCD

Pharmacokinetics of sertraline have been reported in paediatric patients aged 6-12 years old, and adolescent patients aged 13-17 years old. In steady state for the 200 mg dose, the sertraline plasma levels in the 6-12 year old group were reported to be approximately 35% higher compared to the 13-17 year old group, and 21% higher compared to adult reference group. No significant differences have been reported between boys and girls regarding clearance. A low starting dose and titration steps of 25 mg are therefore recommended for children, especially with low bodyweight. Adolescents could be dosed like adults.

Adolescents and elderly

The pharmacokinetic profile in adolescents or elderly is not significantly different from that in adults between 18 and 65 years.

Hepatic impairment

In patients with liver damage, the half-life of sertraline is prolonged and AUC is reported to be increased three fold (see **sections 4.4**).*Renal impairment*

In patients with moderate-severe renal impairment, no significant accumulation of sertraline has been reported.

Pharmacogenomics

Plasma levels of sertraline have been reported to be about 50% higher in poor metabolizers of CYP2C19 versus extensive metabolizers. The clinical meaning is not clear, and patients need to be titrated based on clinical response.

5.9 Preclinical safety data

The reported preclinical data does not indicate any special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity and carcinogenesis. Reproduction toxicity studies in animals reported no evidence of teratogenicity or adverse effects on male fertility. The reported foetotoxicity was probably related to maternal toxicity. Postnatal pup survival and body weight were decreased only during the first days after birth. The early postnatal mortality was due to *in utero* exposure after day 15 of pregnancy. It has been reported that postnatal developmental delays found in pups from treated dams were probably due to effects on the dams and therefore not relevant for human risk.

The reported animal data from rodents and non-rodents does not reveal effects on fertility.

Juvenile animal studies

A reported juvenile toxicology study in rats has been conducted in which sertraline was administered orally to male and female rats on Postnatal Days 21 through 56 (at doses of 10, 40, or 80 mg/kg/day) with a nondosing recovery phase up to Postnatal Day 196. Delays in sexual maturation occurred in males and females at different dose levels (males at 80 mg/kg and females at ≥ 10 mg/kg), but despite this finding there were no sertraline-related effects on any of the male or female reproductive endpoints that were assessed. In addition, on Postnatal Days 21 to 56, dehydration, chromorhinorrhea, and reduced average body weight gain was also reported. All of the aforementioned effects attributed to the administration of sertraline were reversed at some point during the nondosing recovery phase of the study. The clinical relevance of these effects observed in rats administered sertraline has not been established.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Microcrystalline cellulose, calcium hydrogen phosphate, sodium starch glycolate, hydroxypropyl cellulose-L, magnesium stearate,

opadry white. Incompatibilities

Not Applicable

6.2 *Shelf life*

36 Months

6.3 *Special precautions for storage*

Store below 30°C. Protected from light

6.4 *Nature and contents of container*

Zosert tablets are available in PVC blister packs of 10 tablets

6.5 *Special precautions for disposal and other handling*

No special requirement

**7 MARKETING AUTHORISATION HOLDER AND MANUFACTURING
SITE ADDRESS**

Sun Pharmaceutical Industries Limited

8 MARKETING AUTHORISATION NUMBER

H2002/008

9 DATE OF FIRST REGISTRATION /RENEWAL OF THE REGISTRATION

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10 DATE OF REVISION OF THE TEXT

March 2024