OMEPRAZOLE - omeprazole capsule, delayed release pellets
REMEDYREPACK INC.

These highlights do not include all the information needed to use Omeprazole safely and effectively. See full prescribing information for Omeprazole.OMEPRAZOLE DELAYED-RELEASE CAPSULES, USP Initial U.S. Approval: 1989

INDICATIONS & USAGE

Omeprazole delayed-release capsules are indicated for short-term treatment of active duodenal ulcer in adults. Most patients heal within four weeks. Some patients may require an additional four weeks of therapy.

Omeprazole delayed-release capsules in combination with clarithromycin and amoxicillin, is indicated for treatment of patients with *H. pylori* infection and duodenal ulcer disease (active or up to 1-year history) to eradicate *H. pylori* in adults.

Omeprazole delayed-release capsules in combination with clarithromycin is indicated for treatment of patients with *H. pylori* infection and duodenal ulcer disease to eradicate *H. pylori* in adults.

Eradication of *H. pylori* has been shown to reduce the risk of duodenal ulcer recurrence [*see Clinical Studies (14.1) and Dosage and Administration (2)*].

Among patients who fail therapy, Omeprazole delayed-release capsules with clarithromycin are more likely to be associated with the development of clarithromycin resistance as compared with triple therapy. In patients who fail therapy, susceptibility testing should be done. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted. [*See Microbiology section (12.4)*], and the clarithromycin package insert, Microbiology section.)

Omeprazole delayed-release capsules are indicated for short-term treatment (4 to 8 weeks) of active benign gastric ulcer in adults. [*See Clinical Studies (14.2)*]

Symptomatic GERD

Omeprazole delayed-release capsules are indicated for the treatment of heartburn and other symptoms associated with GERD in pediatric patients and adults.

Erosive Esophagitis

Omeprazole delayed-release capsules are indicated for the short-term treatment (4 to 8 weeks) of erosive esophagitis that has been diagnosed by endoscopy in pediatric patients and adults. [*See Clinical Studies (14.4)*]

The efficacy of omeprazole delayed-release capsules used for longer than 8 weeks in these patients has not been established. If a patient does not respond to 8 weeks of treatment, an additional 4 weeks of treatment may be given. If there is recurrence of erosive esophagitis or GERD symptoms (eg, heartburn), additional 4 to 8 week courses of omeprazole may be considered.

Omeprazole delayed-release capsules are indicated to maintain healing of erosive esophagitis in pediatric patients and adults.

Controlled studies do not extend beyond 12 months. [*See Clinical Studies (14.4)*]

Omeprazole delayed-release capsules are indicated for the long-term treatment of pathological hypersecretory conditions (eg, Zollinger-Ellison syndrome, multiple endocrine adenomas and systemic mastocytosis) in adults.

DOSAGE & ADMINISTRATION

Omeprazole delayed-release capsules should be taken before eating. In the clinical trials, antacids were used concomitantly with omeprazole.

Patients should be informed that the omeprazole delayed-release capsule should be swallowed whole.

For patients unable to swallow an intact capsule, alternative administration options are available [*See Dosage and Administration (2.8*)].

The recommended adult oral dose of omeprazole delayed-release capsules are 20 mg once daily. Most patients heal within four weeks. Some patients may require an additional four weeks of therapy.

Triple Therapy (omeprazole/clarithromycin/amoxicillin) — The recommended adult oral regimen is omeprazole delayed-release capsules 20 mg plus clarithromycin 500 mg plus amoxicillin 1000 mg each given twice daily for 10 days. In patients with an ulcer present at the time of initiation of therapy, an additional 18 days of omeprazole delayed-release capsules 20 mg once daily is recommended for ulcer healing and symptom relief.

Dual Therapy (omeprazole/clarithromycin) — The recommended adult oral regimen is omeprazole delayed-release capsules 40 mg once daily plus clarithromycin 500 mg three times daily for 14 days. In patients with an ulcer present at the time of initiation of therapy, an additional 14 days of omeprazole delayed-release capsules 20 mg once daily is recommended for ulcer healing and symptom relief.

The recommended adult oral dose is 40 mg once daily for 4 to 8 weeks.

The recommended adult oral dose for the treatment of patients with symptomatic GERD and no esophageal lesions is 20 mg daily for up to 4 weeks. The recommended adult oral dose for the treatment of patients with erosive esophagitis and accompanying symptoms due to GERD is 20 mg daily for 4 to 8 weeks.

The recommended adult oral dose is 20 mg daily. [*See Clinical Studies (14.4)*]

The dosage of omeprazole delayed-release capsules in patients with pathological hypersecretory conditions varies with the individual patient. The recommended adult oral starting dose is 60 mg once daily. Doses should be adjusted to individual patient needs and should continue for as long as clinically indicated. Doses up to 120 mg three times daily have been administered. Daily dosages of greater than 80 mg should be administered in divided doses. Some patients with Zollinger-Ellison syndrome have been treated continuously with omeprazole delayed-release capsules for more than 5 years.

For the treatment of GERD and maintenance of healing of erosive esophagitis, the recommended daily dose for pediatric patients 2 to 16 years of age is as follows:

Patient Weight	Omeprazole Daily Dose
10 < 20 kg	10 mg
> 20 kg	20 mg

On a per kg basis, the doses of omeprazole required to heal erosive esophagitis in pediatric patients are greater than those for adults.

Alternative administrative options can be used for pediatric patients unable to swallow an intact capsule [*See Dosage and Administration (2.8)*].

Omeprazole is available as a delayed-release capsule.

For patients who have difficulty swallowing capsules, the contents of an omeprazole delayed-release capsule can be added to applesauce. One tablespoon of applesauce should be added to an empty bowl and the capsule should be opened. All of the pellets inside the capsule should be carefully emptied on the applesauce. The pellets should be mixed with the applesauce and then swallowed immediately with a glass of cool water to ensure complete swallowing of the pellets. The applesauce used should not be hot and should be soft enough to be swallowed without chewing. The pellets should not be chewed or crushed. The pellets/applesauce mixture should not be stored for future use.

Avoid concomitant use of clopidogrel and omeprazole. Co-administration of clopidogrel with 80 mg omeprazole, a proton pump inhibitor that is an inhibitor of CYP2C19, reduces the pharmacological acitivity of clopidogrel if given concomitantly or if given 12 hours apart [*see Warnings and Precautions (5.4) and Drug Interactions (7.3)*].

DOSAGE FORMS & STRENGTHS

Omeprazole delayed-release capsules, USP 10 mg, are opaque, hard gelatin, light green and white colored capsules, imprinted “Andrx 610” on the cap and “10 mg” on the body.

Omeprazole delayed-release capsules, USP 20 mg, are opaque, hard gelatin, dark green and white colored capsules, imprinted “Andrx 620” on the cap and “20 mg” on the body.

Omeprazole delayed-release capsules, USP 40 mg, are opaque, hard gelatin, dark green and light green colored capsules, imprinted “Andrx 640” on the cap and “40 mg” on the body.

CONTRAINDICATIONS

Omeprazole delayed-release capsules are contraindicated in patients with known hypersensitivity to substituted benzimidazoles or to any component of the formulation. Hypersensitivity reactions may include anaphylaxis, anaphylactic shock, angioedema, bronchospasm, interstitial nephritis, and urticaria [*See Adverse Reactions (6)*].

WARNINGS AND PRECAUTIONS

Symptomatic response to therapy with omeprazole does not preclude the presence of gastric malignancy.

Atrophic gastritis has been noted occasionally in gastric corpus biopsies from patients treated long-term with omeprazole.

Several published observational studies suggest that proton pump inhibitor (PPI) therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine. The risk of fracture was increased in patients who received high-dose, defined as multiple daily doses, and long-term PPI therapy (a year or longer). Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated. Patients at risk for osteoporosis-related fractures should be managed according to established treatment guidelines. [*see Dosage and Administration (2) and Adverse Reactions (6.3)]*.

Clopidogrel is a prodrug. Inhibition of platelet aggregation by clopidogrel is entirely due to an active metabolite. The metabolism of clopidogrel to its active metabolite can be impaired by use with concomitant medications, such as omeprazole, that interfere with CYP2C19 activity. Avoid concomitant use of clopidogrel and omeprazole. Co-administration of clopidogrel with 80 mg omeprazole, a proton pump inhibitor that is an inhibitor of CYP2C19, reduces the pharmacological activity of clopidogrel if given concomitantly or if given 12 hours apart [*see Drug Interactions (7)*].

Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens. Before initiating therapy with amoxicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins or other allergens. If an allergic reaction occurs, amoxicillin should be discontinued and appropriate therapy instituted. Serious anaphylactic reactions require immediate emergency treatment with epinephrine. Oxygen, intravenous steroids and airway management, including intubation, should also be administered as indicated.

Pseudomembranous colitis has been reported with nearly all antibacterial agents and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of “antibiotic-associated colitis.”

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *Clostridium difficile* colitis.

Clarithromycin should not be used in pregnant women except in clinical circumstances where no alternative therapy is appropriate. If pregnancy occurs while taking clarithromycin, the patient should be apprised of the potential hazard to the fetus. (See Warnings in prescribing information for clarithromycin.)

Co-administration of omeprazole and clarithromycin has resulted in increases in plasma levels of omeprazole, clarithromycin, and 14-hydroxy-clarithromycin. [*See Clinical Pharmacology (12)*]

Concomitant administration of clarithromycin with cisapride or pimozide, is contraindicated.

Hypomagnesemia, symptomatic and asymptomatic, has been reported rarely in patients treated with PPIs for at least three months, in most cases after a year of therapy. Serious adverse events include tetany, arrhythmias, and seizures. In most patients, treatment of hypomagnesemia required magnesium replacement and discontinuation of the PPI.

For patients expected to be on prolonged treatment or who take PPIs with medications such as digoxin or drugs that may cause hypomagnesemia (e.g., diuretics), health care professionals may consider monitoring magnesium levels prior to initiation of PPI treatment and periodically. [*See Adverse Reactions (6.3)*]

Drugs which induce CYP2C19 or CYP3A4 (such as St John's Wort or rifampin) can substantially decrease omeprazole concentrations. [*See Drug Interactions (7.3)*] Avoid concomitant use of PRILOSEC with St John's Wort or rifampin.

Serum chromogranin A (CgA) levels increase secondary to drug-induced decreases in gastric acidity. The increased CgA level may cause false positive results in diagnostic investigations for neuroendocrine tumors. Providers should temporarily stop omeprazole treatment before assessing CgA levels and consider repeating the test if initial CgA levels are high. If serial tests are performed (e.g. for monitoring), the same commercial laboratory should be used for testing, as reference ranges between tests may vary.

Literature suggests that concomitant use of PPIs with methotrexate (primarily at high dose; see methotrexate prescribing information) may elevate and prolong serum levels of methotrexate and/or its metabolite, possibly leading to methotrexate toxicities. In high-dose methotrexate administration a temporary withdrawal of the PPI may be considered in some patients. *[see Drug Interactions (7.6)]*

ADVERSE REACTIONS

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The safety data described below reflects exposure to omeprazole delayed-release capsules in 3096 patients from worldwide clinical trials (465 patients from US studies and 2,631 patients from international studies). Indications clinically studied in US trials included duodenal ulcer, resistant ulcer, and Zollinger-Ellison syndrome. The international clinical trials were double blind and open-label in design. The most common adverse reactions reported (i.e., with an incidence rate ≥ 2%) from omeprazole -treated patients enrolled in these studies included headache (6.9%), abdominal pain (5.2%), nausea (4.0%), diarrhea (3.7%), vomiting (3.2%), and flatulence (2.7%).

Additional adverse reactions that were reported with an incidence ≥1% included acid regurgitation (1.9%), upper respiratory infection (1.9%), constipation (1.5%), dizziness (1.5%), rash (1.5%), asthenia (1.3%), back pain (1.1%), and cough (1.1%).

The clinical trial safety profile in patients greater than 65 years of age was similar to that in patients 65 years of age or less.

The clinical trial safety profile in pediatric patients who received omeprazole delayed-release capsules was similar to that in adult patients. Unique to the pediatric population, however, adverse reactions of the respiratory system were most frequently reported in the 2 to 16 year age groups (18.5%). Similarly, accidental injuries were reported frequently in the 2 to 16 year age group (3.8%).[*See Use in Specific Populations (8.4)*]

In clinical trials using either dual therapy with omeprazole and clarithromycin, or triple therapy with omeprazole, clarithromycin, and amoxicillin, no adverse reactions unique to these drug combinations were observed. Adverse reactions observed were limited to those previously reported with omeprazole, clarithromycin, or amoxicillin alone.

Dual Therapy (omeprazole/clarithromycin)

Adverse reactions observed in controlled clinical trials using combination therapy with omeprazole and clarithromycin (n = 346) that differed from those previously described for omeprazole alone were taste perversion (15%), tongue discoloration (2%), rhinitis (2%), pharyngitis (1%) and flu-syndrome (1%). (For more information on clarithromycin, refer to the clarithromycin prescribing information, Adverse Reactions section).

Triple Therapy (omeprazole/clarithromycin/amoxicillin)

The most frequent adverse reactions observed in clinical trials using combination therapy with omeprazole, clarithromycin, and amoxicillin (n = 274) were diarrhea (14%), taste perversion (10%), and headache (7%). None of these occurred at a higher frequency than that reported by patients taking antimicrobial agents alone. (For more information on clarithromycin or amoxicillin, refer to the respective prescribing information, Adverse Reactions sections).

The following adverse reactions have been identified during post-approval use of omeprazole delayed-release capsules. Because these reactions are voluntarily reported from a population of uncertain size, it is not always possible to reliably estimate their actual frequency or establish a causal relationship to drug exposure.

Body As a Whole: Hypersensitivity reactions including anaphylaxis, anaphylactic shock, angioedema, bronchospasm, interstitial nephritis, urticaria, (see also *Skin* below); fever; pain; fatigue; malaise;

Cardiovascular: Chest pain or angina, tachycardia, bradycardia, palpitations, elevated blood pressure, peripheral edema

Endocrine: Gynecomastia

Gastrointestinal: Pancreatitis (some fatal), anorexia, irritable colon, fecal discoloration, esophageal candidiasis, mucosal atrophy of the tongue, stomatitis, abdominal swelling, dry mouth. During treatment with omeprazole, gastric fundic gland polyps have been noted rarely. These polyps are benign and appear to be reversible when treatment is discontinued.

Gastroduodenal carcinoids have been reported in patients with ZE syndrome on long-term treatment with omeprazole. This finding is believed to be a manifestation of the underlying condition, which is known to be associated with such tumors.

Hepatic: Liver disease including hepatic failure (some fatal), liver necrosis (some fatal), hepatic encephalopathy hepatocellular disease, cholestatic disease, mixed hepatitis, jaundice, and elevations of liver function tests [ALT, AST, GGT, alkaline phosphatase, and bilirubin]

Metabolic and Nutritional disorders: Hypoglycemia, hypomagnesemia, hyponatremia, weight gain

Musculoskeletal: Muscle weakness, myalgia, muscle cramps, joint pain, leg pain, bone fracture

Nervous System/Psychiatric: Psychiatric and sleep disturbances including depression, agitation, aggression, hallucinations, confusion, insomnia, nervousness, apathy, somnolence, anxiety, and dream abnormalities; tremors, paresthesia; vertigo

Respiratory: Epistaxis, pharyngeal pain

Skin: Severe generalized skin reactions including toxic epidermal necrolysis (some fatal), Stevens-Johnson syndrome, and erythema multiforme; photosensitivity; urticaria; rash; skin inflammation; pruritus; petechiae; purpura; alopecia; dry skin; hyperhidrosis

Special Senses: Tinnitus, taste perversion

Ocular: Optic atrophy, anterior ischemic optic neuropathy, optic neuritis, dry eye syndrome, ocular irritation, blurred vision, double vision

Urogenital: Interstitial nephritis, hematuria, proteinuria, elevated serum creatinine, microscopic pyuria, urinary tract infection, glycosuria, urinary frequency, testicular pain

Hematologic: Agranulocytosis (some fatal), hemolytic anemia, pancytopenia, neutropenia, anemia, thrombocytopenia, leukopenia, leucocytosis

DRUG INTERACTIONS

Concomitant use of atazanavir and nelfinavir with proton pump inhibitors is not recommended. Co-administration of atazanavir with proton pump inhibitors is expected to substantially decrease atazanavir plasma concentrations and may result in a loss of therapeutic effect and the development of drug resistance. Co-administration of saquinavir with proton pump inhibitors is expected to increase saquinavir concentrations, which may increase toxicity and require dose reduction.

Omeprazole has been reported to interact with some antiretroviral drugs. The clinical importance and the mechanisms behind these interactions are not always known. Increased gastric pH during omeprazole treatment may change the absorption of the antiretroviral drug. Other possible interaction mechanisms are via CYP 2C19.

Reduced concentrations of atazanavir and nelfinavir

For some antiretroviral drugs, such as atazanavir and nelfinavir, decreased serum levels have been reported when given together with omeprazole. Following multiple doses of nelfinavir (1250 mg, twice daily) and omeprazole (40 mg daily), AUC was decreased by 36% and 92%, C_{max} by 37% and 89% and C_{min} by 39% and 75% respectively for nelfinavir and M8. Following multiple doses of atazanavir (400 mg, daily) and omeprazole (40 mg, daily, 2 hr before atazanavir), AUC was decreased by 94%, C_{max} by 96%, and C_{min} by 95%. Concomitant administration with omeprazole and drugs such as atazanavir and nelfinavir is therefore not recommended.

Increased concentrations of saquinavir

For other antiretroviral drugs, such as saquinavir, elevated serum levels have been reported, with an increase in AUC by 82%, in C_{max} by 75%, and in C_{min} by 106%, following multiple dosing of saquinavir/ritonavir (1000/100 mg) twice daily for 15 days with omeprazole 40 mg daily co-administered days 11 to 15. Therefore, clinical and laboratory monitoring for saquinavir toxicity is recommended during concurrent use with omeprazole. Dose reduction of saquinavir should be considered from the safety perspective for individual patients.

There are also some antiretroviral drugs of which unchanged serum levels have been reported when given with omeprazole.

Because of its profound and long lasting inhibition of gastric acid secretion, it is theoretically possible that omeprazole may interfere with absorption of drugs where gastric pH is an important determinant of their bioavailability. Like with other drugs that decrease the intragastric acidity, the absorption of drugs such as ketoconazole, ampicillin esters, iron salts and erlotinib can decrease, while the absorption of drugs such as digoxin can increase during treatment with omeprazole. Concomitant treatment with omeprazole (20 mg daily) and digoxin in healthy subjects increased the bioavailability of digoxin by 10% (30% in two subjects). Therefore, patients may need to be monitored when digoxin is taken concomitantly with omeprazole. In the clinical trials, antacids were used concomitantly with the administration of omeprazole.

Omeprazole can prolong the elimination of diazepam, warfarin and phenytoin, drugs that are metabolized by oxidation in the liver. There have been reports of increased INR and prothrombin time in patients receiving proton pump inhibitors, including omeprazole, and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with proton pump inhibitors and warfarin may need to be monitored for increases in INR and prothrombin time.

Although in normal subjects no interaction with theophylline or propranolol was found, there have been clinical reports of interaction with other drugs metabolized via the cytochrome P450 system (e.g., cyclosporine, disulfiram, benzodiazepines). Patients should be monitored to determine if it is necessary to adjust the dosage of these drugs when taken concomitantly with omeprazole.

Concomitant administration of omeprazole and voriconazole (a combined inhibitor of CYP2C19 and CYP3A4) resulted in more than doubling of the omeprazole exposure. Dose adjustment of omeprazole is not normally required. However, in patients with Zollinger-Ellison syndrome, who may require higher doses up to 240 mg/day, dose adjustment may be considered. When voriconazole (400 mg Q12h x 1 day, then 200 mg x 6 days) was given with omeprazole (40 mg once daily x 7 days) to healthy subjects, it significantly increased the steady-state C_{max} and AUC_{0-24} of omeprazole, an average of 2 times (90% CI: 1.8, 2.6) and 4 times (90% CI: 3.3, 4.4) respectively as compared to when omeprazole was given without voriconazole.

Omeprazole acts as an inhibitor of CYP 2C19. Omeprazole, given in doses of 40 mg daily for one week to 20 healthy subjects in cross-over study, increased C_{max} and AUC of cilostazol by 18% and 26% respectively. C_{max} and AUC of one of its active metabolites, 3,4-dihydro-cilostazol, which has 4 to 7 times the activity of cilostazol, were increased by 29% and 69% respectively. Co-administration of cilostazol with omeprazole is expected to increase concentrations of cilostazol and its above mentioned active metabolite. Therefore a dose reduction of cilostazol from 100 mg twice daily to 50 mg twice daily should be considered.

Drugs known to induce CYP2C19 or CYP3A4 (such as rifampin) may lead to decreased omeprazole serum levels. In a cross-over study in 12 healthy male subjects, St John’s wort (300 mg three times daily for 14 days), an inducer of CYP3A4, decreased the systemic exposure of omeprazole in CYP2C19 poor metabolisers (C_{max} and AUC decreased by 37.5% and 37.9%, respectively) and extensive metabolisers (C_{max} and AUC decreased by 49.6% and 43.9%, respectively). Avoid concomitant use of St. John’s Wort or rifampin with omeprazole.

clopidogrel

Omeprazole is an inhibitor of CYP2C19 enzyme. Clopidogrel is metabolized to its active metabolite in part by CYP2C19. Concomitant use of omeprazole 80 mg results in reduced plasma concentrations of the active metabolite of clopidogrel and a reduction in platelet inhibition [*see Warnings and Precautions (5.4)*].

In a crossover clinical study, 72 healthy subjects were administered clopidogrel (300 mg loading dose followed by 75 mg per day) alone and with omeprazole (80 mg at the same time as clopidogrel) for 5 days. The exposure to the active metabolite of clopidogrel was decreased by 46% (Day 1) and 42% (Day 5) when clopidogrel and omeprazole were administered together. The active metabolite of

clopidogrel selectively and irreversibly inhibits the binding of adenosine diphosphate (ADP) to its platelet $P2Y_{12}$ receptor, thereby inhibiting platelet aggregation. The mean inhibition of platelet aggregation at 5 mcM ADP was diminished by 39% (Day 1) and 21% (Day 5) when clopidogrel and omeprazole were administered together.

In another study, 72 healthy subjects were given the same doses of clopidogrel and 80 mg omeprazole but the drugs were administered 12 hours apart; the results were similar, indicating that administering clopidogrel and omeprazole at different times does not prevent their interaction [*see Warnings and Precautions (5.4)*].

There are no adequate combination studies of a lower dose of omeprazole or a higher dose of clopidogrel in comparison with the approved dose of clopidogrel.

Concomitant administration of omeprazole and tacrolimus may increase the serum levels of tacrolimus.

Drug-induced decrease in gastric acidity results in enterochromaffin-like cell hyperplasia and increased Chromogranin A levels which may interfere with investigations for neuroendocrine tumors. *[see Warnings and Precautions (5.7) and Clinical Pharmacology(12)].*

Case reports, published population pharmacokinetic studies, and retrospective analyses suggest that concomitant administration of PPIs and methotrexate (primarily at high dose; see methotrexate prescribing information) may elevate and prolong serum levels of methotrexate and/or its metabolite hydroxymethotrexate. However, no formal drug interaction studies of methotrexate with PPIs have been conducted [*see Warnings and Precautions (5.10)*].

USE IN SPECIFIC POPULATIONS

Pregnancy Category C

Reproductive studies in rats and rabbits with omeprazole and multiple cohort studies in pregnant women with omeprazole use during the first trimester do not show an increased risk of congenital anomalies or adverse pregnancy outcomes. There are no adequate and well-controlled studies on the use of omeprazole in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed. The vast majority of reported experience with omeprazole during human pregnancy is first trimester exposure and the duration of use is rarely specified, e.g., intermittent vs. chronic. An expert review of published data on experiences with omeprazole use during pregnancy by TERIS – the Teratogen Information System – concluded that therapeutic doses during pregnancy are unlikely to pose a substantial teratogenic risk (the quantity and quality of data were assessed as fair).

Three epidemiological studies compared the frequency of congenital abnormalities among infants born to women who used omeprazole during pregnancy with the frequency of abnormalities among infants of women exposed to H_2-receptor antagonists or other controls. A population-based prospective cohort epidemiological study from the Swedish Medical Birth Registry, covering approximately 99% of pregnancies, reported on 955 infants (824 exposed during the first trimester with 39 of these exposed beyond first trimester, and 131 exposed after the first trimester) whose mothers used omeprazole during pregnancy. *In utero* exposure to omeprazole was not associated with increased risk of any malformation (odds ratio 0.82, 95% CI 0.50 to 1.34), low birth weight or low Apgar score. The number of infants born with ventricular septal defects and the number of stillborn infants was slightly higher in the omeprazole-exposed infants than the expected number in the normal population. The author concluded that both effects may be random.

A retrospective cohort study reported on 689 pregnant women exposed to either H_2-blockers or omeprazole in the first trimester (134 exposed to omeprazole). The overall malformation rate was 4.4% (95% CI 3.6 to 5.3) and the malformation rate for first trimester exposure to omeprazole was 3.6% (95% CI 1.5 to 8.1). The relative risk of malformations associated with first trimester exposure to omeprazole compared with non-exposed women was 0.9 (95% CI 0.3 to 2.2). The study could effectively rule out a relative risk greater than 2.5 for all malformations. Rates of preterm delivery or growth retardation did not differ between the groups.

A controlled prospective observational study followed 113 women exposed to omeprazole during pregnancy (89% first trimester exposures). The reported rates of major congenital malformations was 4% for the omeprazole group, 2% for controls exposed to non-teratogens, and 2.8% in disease-paired controls (background incidence of major malformations 1 to 5%). Rates of spontaneous and elective abortions, preterm deliveries, gestational age at delivery, and mean birth weight did not differ between the groups. The sample size in this study has 80% power to detect a 5-fold increase in the rate of major malformation.

Several studies have reported no apparent adverse short-term effects on the infant when single dose oral or intravenous omeprazole was administered to over 200 pregnant women as premedication for cesarean section under general anesthesia.

Reproductive studies conducted with omeprazole on rats at oral doses up to 56 times the human dose and in rabbits at doses up to 56 times the human dose did not show any evidence of teratogenicity. In pregnant rabbits, omeprazole at doses about 5.5 to 56 times the human dose produced dose-related increases in embryo-lethality, fetal resorptions, and pregnancy loss. In rats treated with omeprazole at doses about 5.6 to 56 times the human dose, dose-related embryo/fetal toxicity and postnatal developmental toxicity occurred in offspring. [*See Animal Toxicology and/or Pharmacology (13.2)*].

Omeprazole concentrations have been measured in breast milk of a woman following oral administration of 20 mg. The peak concentration of omeprazole in breast milk was less than 7% of the peak serum concentration. This concentration would correspond to 0.004 mg of omeprazole in 200 mL of milk. Because omeprazole is excreted in human milk, because of the potential for serious adverse reactions in nursing infants from omeprazole, and because of the potential for tumorigenicity shown for omeprazole in rat carcinogenicity studies, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Use of omeprazole in pediatric and adolescent patients 2 to 16 years of age for the treatment of GERD is supported by a) extrapolation of results, already included in the currently approved labeling, from adequate and well-controlled studies that supported the approval of omeprazole for adults, and b) safety and pharmacokinetic studies performed in pediatric and adolescent patients. [*See Clinical Pharmacology, Pharmacokinetics, Pediatric* for pharmacokinetic information *(12.3)* and *Dosage and Administration (2), Adverse Reactions (6.1*) *and Clinical Studies (14.6)].* The safety and effectiveness of omeprazole for the treatment of GERD in patients <1 year of age have not been established. The safety and effectiveness of omeprazole for other pediatric uses have not been established.

Omeprazole was administered to over 2000 elderly individuals (≥ 65 years of age) in clinical trials in the U.S. and Europe. There were no differences in safety and effectiveness between the elderly and younger subjects. Other reported clinical experience has not identified differences in response between the elderly and younger subjects, but greater sensitivity of some older individuals cannot be ruled out.

Pharmacokinetic studies have shown the elimination rate was somewhat decreased in the elderly and bioavailability was increased. The plasma clearance of omeprazole was 250 mL/min (about half that of young volunteers) and its plasma half-life averaged one hour, about twice that of young healthy

volunteers. However, no dosage adjustment is necessary in the elderly. [*See Clinical Pharmacology (12.3)*]

Consider dose reduction, particularly for maintenance of healing of erosive esophagitis. [*See Clinical Pharmacology (12.3)*]

No dosage reduction is necessary. [*See Clinical Pharmacology (12.3)*]

Consider dose reduction, particularly for maintenance of healing of erosive esophagitis. [*See Clinical Pharmacology (12.3)*]

OVERDOSAGE

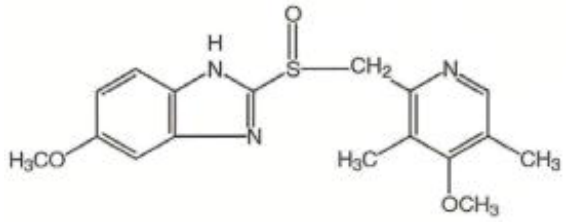
Reports have been received of overdosage with omeprazole in humans. Doses ranged up to 2400 mg (120 times the usual recommended clinical dose). Manifestations were variable, but included confusion, drowsiness, blurred vision, tachycardia, nausea, vomiting, diaphoresis, flushing, headache, dry mouth, and other adverse reactions similar to those seen in normal clinical experience. [*See Adverse Reactions (6)*] Symptoms were transient, and no serious clinical outcome has been reported when omeprazole was taken alone. No specific antidote for omeprazole overdosage is known. Omeprazole is extensively protein bound and is, therefore, not readily dialyzable. In the event of overdosage, treatment should be symptomatic and supportive.

As with the management of any overdose, the possibility of multiple drug ingestion should be considered. For current information on treatment of any drug overdose, contact a Poison Control Center at 1-800-222-1222.

Single oral doses of omeprazole at 1350, 1339, and 1200 mg/kg were lethal to mice, rats, and dogs, respectively. Animals given these doses showed sedation, ptosis, tremors, convulsions, and decreased activity, body temperature, and respiratory rate and increased depth of respiration.

DESCRIPTION

The active ingredient in omeprazole delayed-release capsules is a substituted benzimidazole, 5-methoxy-2-[[(4-methoxy-3, 5-dimethyl-2-pyridinyl)methyl] sulfinyl]-1*H*-benzimidazole, a compound that inhibits gastric acid secretion. Its empirical formula is $C_{17}H_{19}N_3O_3S$, with a molecular weight of 345.42. The structural formula is:



Omeprazole Structural Formula

Omeprazole is a white to off-white crystalline powder that melts with decomposition at about 155°C. It is a weak base, freely soluble in ethanol and methanol, and slightly soluble in acetone and isopropanol

and very slightly soluble in water. The stability of omeprazole is a function of pH; it is rapidly degraded in acid media, but has acceptable stability under alkaline conditions.

Omeprazole is supplied as delayed-release capsules for oral administration. Each delayed-release capsule contains either 10 mg, 20 mg or 40 mg of omeprazole in the form of enteric-coated granules with the following inactive ingredients: cetyl alcohol, disodium phosphate, hydroxy propyl methylcellulose phthalate, lactose anhydrous, povidone, sodium lauryl sulfate, sucrose and talc. The capsule shells and imprinting inks have the following inactive ingredients: ammonium hydroxide, D&C Yellow #10, FD&C Blue #2 Aluminum Lake, FD&C Green #3, gelatin, propylene glycol, shellac and titanium dioxide.

CLINICAL PHARMACOLOGY

Omeprazole belongs to a class of antisecretory compounds, the substituted benzimidazoles, that suppress gastric acid secretion by specific inhibition of the H^+/K^+ ATPase enzyme system at the secretory surface of the gastric parietal cell. Because this enzyme system is regarded as the acid (proton) pump within the gastric mucosa, omeprazole has been characterized as a gastric acid-pump inhibitor, in that it blocks the final step of acid production. This effect is dose-related and leads to inhibition of both basal and stimulated acid secretion irrespective of the stimulus. Animal studies indicate that after rapid disappearance from plasma, omeprazole can be found within the gastric mucosa for a day or more.

Antisecretory Activity

After oral administration, the onset of the antisecretory effect of omeprazole occurs within one hour, with the maximum effect occurring within two hours. Inhibition of secretion is about 50% of maximum at 24 hours and the duration of inhibition lasts up to 72 hours. The antisecretory effect thus lasts far longer than would be expected from the very short (less than one hour) plasma half-life, apparently due to prolonged binding to the parietal H^+/K^+ ATPase enzyme. When the drug is discontinued, secretory activity returns gradually, over 3 to 5 days. The inhibitory effect of omeprazole on acid secretion increases with repeated once-daily dosing, reaching a plateau after four days.

Results from numerous studies of the antisecretory effect of multiple doses of 20 mg and 40 mg of omeprazole in normal volunteers and patients are shown below. The “max” value represents determinations at a time of maximum effect (2 to 6 hours after dosing), while “min” values are those 24 hours after the last dose of omeprazole.

Table 1 Range of Mean Values from Multiple Studies of the Mean Antisecretory Effects of Omeprazole After Multiple Daily Dosing

	Omeprazole 20 mg	Omeprazole 40 mg		
Parameter	Max	Min	Max	Min
% Decrease in Basal Acid Output	78*	58-80	94*	80-93
% Decrease in Peak Acid Output	79*	50-59	88*	62-68
% Decrease in 24-hr. Intragastric Acidity		80-97		92-94

* Single Studies

Single daily oral doses of omeprazole ranging from a dose of 10 mg to 40 mg have produced 100% inhibition of 24-hour intragastric acidity in some patients.

Serum Gastrin Effects

In studies involving more than 200 patients, serum gastrin levels increased during the first 1 to 2 weeks of once-daily administration of therapeutic doses of omeprazole in parallel with inhibition of acid secretion. No further increase in serum gastrin occurred with continued treatment. In comparison with histamine H_2-receptor antagonists, the median increases produced by 20 mg doses of omeprazole were higher (1.3 to 3.6 fold vs. 1.1 to 1.8 fold increase). Gastrin values returned to pretreatment levels, usually within 1 to 2 weeks after discontinuation of therapy.

Increased gastrin causes enterochromaffin-like cell hyperplasia and increased serum Chromogranin A (CgA) levels. The increased CgA levels may cause false positive results in diagnostic investigations for neuroendocrine tumors.

Enterochromaffin-like (ECL) Cell Effects

Human gastric biopsy specimens have been obtained from more than 3000 patients treated with omeprazole in long-term clinical trials. The incidence of ECL cell hyperplasia in these studies increased with time; however, no case of ECL cell carcinoids, dysplasia, or neoplasia has been found in these patients. [*See Clinical Pharmacology (12)*] However, these studies are of insufficient duration and size to rule out the possible influence of long-term administration of omeprazole on the development of any premalignant or malignant conditions.

Other Effects

Systemic effects of omeprazole in the CNS, cardiovascular and respiratory systems have not been found to date. Omeprazole, given in oral doses of 30 or 40 mg for 2 to 4 weeks, had no effect on thyroid function, carbohydrate metabolism, or circulating levels of parathyroid hormone, cortisol, estradiol, testosterone, prolactin, cholecystokinin or secretin.

No effect on gastric emptying of the solid and liquid components of a test meal was demonstrated after a single dose of omeprazole 90 mg. In healthy subjects, a single I.V. dose of omeprazole (0.35 mg/kg) had no effect on intrinsic factor secretion. No systematic dose-dependent effect has been observed on basal or stimulated pepsin output in humans.

However, when intragastric pH is maintained at 4.0 or above, basal pepsin output is low, and pepsin activity is decreased.

As do other agents that elevate intragastric pH, omeprazole administered for 14 days in healthy subjects produced a significant increase in the intragastric concentrations of viable bacteria. The pattern of the bacterial species was unchanged from that commonly found in saliva. All changes resolved within three days of stopping treatment.

The course of Barrett's esophagus in 106 patients was evaluated in a U.S. double-blind controlled study of omeprazole 40 mg twice daily for 12 months followed by 20 mg twice daily for 12 months or ranitidine 300 mg twice daily for 24 months. No clinically significant impact on Barrett's mucosa by antisecretory therapy was observed. Although neosquamous epithelium developed during antisecretory therapy, complete elimination of Barrett's mucosa was not achieved. No significant difference was observed between treatment groups in development of dysplasia in Barrett's mucosa and no patient developed esophageal carcinoma during treatment. No significant differences between treatment groups were observed in development of ECL cell hyperplasia, corpus atrophic gastritis, corpus intestinal metaplasia, or colon polyps exceeding 3 mm in diameter [*See Clinical Pharmacology (12)*].

Absorption

Omeprazole delayed-release capsules contain an enteric-coated granule formulation of omeprazole

(because omeprazole is acid-labile), so that absorption of omeprazole begins only after the granules leave the stomach. Absorption is rapid, with peak plasma levels of omeprazole occurring within 0.5 to 3.5 hours. Peak plasma concentrations of omeprazole and AUC are approximately proportional to doses up to 40 mg, but because of a saturable first-pass effect, a greater than linear response in peak plasma concentration and AUC occurs with doses greater than 40 mg. Absolute bioavailability (compared with intravenous administration) is about 30 to 40% at doses of 20 to 40 mg, due in large part to presystemic metabolism. In healthy subjects the plasma half-life is 0.5 to 1 hour, and the total body clearance is 500 to 600 mL/min.

The bioavailability of omeprazole increases slightly upon repeated administration of omeprazole delayed-release capsules.

Omeprazole delayed-release capsule 40 mg was bioequivalent when administered with and without applesauce. However, omeprazole delayed-release capsule 20 mg was not bioequivalent when administered with and without applesauce. When administered with applesauce, a mean 25% reduction in C_{max} was observed without a significant change in AUC for omeprazole delayed-release capsule 20 mg. The clinical relevance of this finding is unknown.

Distribution

Protein binding is approximately 95%.

Metabolism

Omeprazole is extensively metabolized by the cytochrome P450 (CYP) enzyme system.

Excretion

Following single dose oral administration of a buffered solution of omeprazole, little if any unchanged drug was excreted in urine. The majority of the dose (about 77%) was eliminated in urine as at least six metabolites. Two were identified as hydroxyomeprazole and the corresponding carboxylic acid. The remainder of the dose was recoverable in feces. This implies a significant biliary excretion of the metabolites of omeprazole. Three metabolites have been identified in plasma — the sulfide and sulfone derivatives of omeprazole, and hydroxyomeprazole. These metabolites have very little or no antisecretory activity.

Combination Therapy with Antimicrobials

Omeprazole 40 mg daily was given in combination with clarithromycin 500 mg every 8 hours to healthy adult male subjects. The steady state plasma concentrations of omeprazole were increased (C_{max}, AUC_{0-24}, and $T_{1/2}$ increases of 30%, 89% and 34% respectively) by the concomitant administration of clarithromycin. The observed increases in omeprazole plasma concentration were associated with the following pharmacological effects. The mean 24-hour gastric pH value was 5.2 when omeprazole was administered alone and 5.7 when co-administered with clarithromycin.

The plasma levels of clarithromycin and 14-hydroxy-clarithromycin were increased by the concomitant administration of omeprazole. For clarithromycin, the mean C_{max} was 10% greater, the mean C_{min} was 27% greater, and the mean AUC_{0-8} was 15% greater when clarithromycin was administered with omeprazole than when clarithromycin was administered alone. Similar results were seen for 14-hydroxy-clarithromycin, the mean C_{max} was 45% greater, the mean C_{min} was 57% greater, and the mean AUC_{0-8} was 45% greater. Clarithromycin concentrations in the gastric tissue and mucus were also increased by concomitant administration of omeprazole.

Table 2

Clarithromycin Tissue Concentrations 2 hours after Dose[1]		
Tissue	Clarithromycin	Clarithromycin + Omeprazole
Antrum	10.48 ± 2.01 (n = 5)	19.96 ± 4.71 (n = 5)
Fundus	20.81 ± 7.64 (n = 5)	24.25 ± 6.37 (n = 5)
Mucus	4.15 ± 7.74 (n = 4)	39.29 ± 32.79 (n = 4)

[1]Mean ± SD (µg/g)

Special Populations

Geriatric Population

The elimination rate of omeprazole was somewhat decreased in the elderly, and bioavailability was increased. Omeprazole was 76% bioavailable when a single 40 mg oral dose of omeprazole (buffered solution) was administered to healthy elderly volunteers, versus 58% in young volunteers given the same dose. Nearly 70% of the dose was recovered in urine as metabolites of omeprazole and no unchanged drug was detected. The plasma clearance of omeprazole was 250 mL/min (about half that of young volunteers) and its plasma half-life averaged one hour, about twice that of young healthy volunteers.

Pediatric Use

The pharmacokinetics of omeprazole have been investigated in pediatric patients 2 to 16 years of age:

Table 3 Pharmacokinetic Parameters of Omeprazole Following Single and Repeated Oral Administration in Pediatric Populations Compared with Adults

Single or Repeated Oral Dosing /Parameter	Children† ≤ 20 kg 2 to 5 years 10 mg	Children† > 20 kg 6 to 16 years 20 mg	Adults‡ (mean 76 kg) 23 to 29 years (n=12)
Single Dosing			
C_{max} * (ng/mL)	288 (n=10)	495 (n=49)	668
AUC* (ng h/mL)	511 (n=7)	1140 (n=32)	1220
Repeated Dosing			
C_{max} * (ng/mL)	539 (n=4)	851 (n=32)	1458
AUC*	1179	2276	3352

(ng h/mL)	(n=2)	(n=23)

Note: * = plasma concentration adjusted to an oral dose of 1 mg/kg.

†Data from single and repeated dose studies

‡Data from a single and repeated dose study

Doses of 10, 20 and 40 mg omeprazole as enteric-coated granules

Following comparable mg/kg doses of omeprazole, younger children (2 to 5 years of age) have lower AUCs than children 6 to 16 years of age or adults; AUCs of the latter two groups did not differ. [*See Dosage and Administration (2)*]

Hepatic Impairment

In patients with chronic hepatic disease, the bioavailability increased to approximately 100% compared with an I.V. dose, reflecting decreased first-pass effect, and the plasma half-life of the drug increased to nearly 3 hours compared with the half-life in normals of 0.5 to 1 hour. Plasma clearance averaged 70 mL/min, compared with a value of 500 to 600 mL/min in normal subjects. Dose reduction, particularly where maintenance of healing of erosive esophagitis is indicated, for the hepatically impaired should be considered.

Renal Impairment

In patients with chronic renal impairment, whose creatinine clearance ranged between 10 and 62 mL/min/1.73 m^2, the disposition of omeprazole was very similar to that in healthy volunteers, although there was a slight increase in bioavailability. Because urinary excretion is a primary route of excretion of omeprazole metabolites, their elimination slowed in proportion to the decreased creatinine clearance. No dose reduction is necessary in patients with renal impairment.

Asian Population

In pharmacokinetic studies of single 20 mg omeprazole doses, an increase in AUC of approximately four-fold was noted in Asian subjects compared with Caucasians. Dose reduction, particularly where maintenance of healing of erosive esophagitis is indicated, for Asian subjects should be considered.

Omeprazole and clarithromycin dual therapy and omeprazole, clarithromycin and amoxicillin triple therapy have been shown to be active against most strains of *Helicobacter pylori in vitro* and in clinical infections as described in the *Indications and Usage section (1.1).*

Helicobacter

Helicobacter pylori-Pretreatment Resistance Clarithromycin pretreatment resistance rates were 3.5% (4/113) in the omeprazole/clarithromycin dual therapy studies (4 and 5) and 9.3% (41/439) in omeprazole/clarithromycin/amoxicillin triple therapy studies (1, 2, and 3).

Amoxicillin pretreatment susceptible isolates (≤ 0.25 µg/mL) were found in 99.3% (436/439) of the patients in the omeprazole/clarithromycin/amoxicillin triple therapy studies (1, 2, and 3). Amoxicillin pretreatment minimum inhibitory concentrations (MICs) > 0.25 µg/mL occurred in 0.7% (3/439) of the

patients, all of whom were in the clarithromycin and amoxicillin study arm. One patient had an unconfirmed pretreatment amoxicillin minimum inhibitory concentration (MIC) of > 256 µg/mL by Etest®.

Table 4 Clarithromycin Susceptibility Test Results and Clinical/Bacteriological Outcomes

Clarithromycin Susceptibility Test Results and Clinical/Bacteriological Outcomes [a]					
Clarithromycin Pretreatment Results	Clarithromycin Post-treatment Results				
		H. pylori negative – eradicated	*H. pylori* positive – not eradicated		
Post-treatment susceptibility results					
S [b]	I [b]	R [b]	No MIC		
Dual Therapy – (omeprazole 40 mg once daily/clarithromycin 500 three times daily for 14 days followed by omeprazole 20 mg once daily for another 14 days) (Studies 4, 5)					
Susceptible [b]	108	72	1	26	9
Intermediate [b]	1			1	
Resistant [b]	4			4	
Triple Therapy – (omeprazole 20 mg twice daily/clarithromycin 500 mg twice daily/amoxicillin 1 g twice daily for 10 days – Studies 1, 2, 3; followed by omeprazole 20 mg once daily for another 18 days – Studies 1, 2)					
Susceptible [b]	171	153	7	3	8
Intermediate[b]					
Resistant [b]	14	4	1	6	3

[a]Includes only patients with pretreatment clarithromycin

susceptibility test results	[b]Susceptible (S) MIC ≤ 0.25 µg/mL, Intermediate (I) MIC 0.5 – 1.0 µg/mL, Resistant (R) MIC ≥ 2 µg/mL

Patients not eradicated of *H. pylori* following omeprazole/clarithromycin/amoxicillin triple therapy or omeprazole/clarithromycin dual therapy will likely have clarithromycin resistant *H. pylori* isolates. Therefore, clarithromycin susceptibility testing should be done, if possible. Patients with clarithromycin resistant *H. pylori* should not be treated with any of the following: omeprazole/clarithromycin dual therapy, omeprazole/clarithromycin/amoxicillin triple therapy, or other regimens which include clarithromycin as the sole antimicrobial agent.

Amoxicillin Susceptibility Test Results and Clinical/Bacteriological Outcomes

In the triple therapy clinical trials, 84.9% (157/185) of the patients in the omeprazole/clarithromycin/amoxicillin treatment group who had pretreatment amoxicillin susceptible MICs (≤ 0.25 µg/mL) were eradicated of *H. pylori* and 15.1% (28/185) failed therapy. Of the 28 patients who failed triple therapy, 11 had no post-treatment susceptibility test results and 17 had post-treatment *H. pylori* isolates with amoxicillin susceptible MICs. Eleven of the patients who failed triple therapy also had post-treatment *H. pylori* isolates with clarithromycin resistant MICs.

Susceptibility Test for Helicobacter pylori

The reference methodology for susceptibility testing of *H. pylori* is agar dilution MICs[1]. One to three microliters of an inoculum equivalent to a No. 2 McFarland standard (1×10^7 to 1×10^8 CFU/mL for *H. pylori*) are inoculated directly onto freshly prepared antimicrobial containing Mueller-Hinton agar plates with 5% aged defibrinated sheep blood (≥ 2 weeks old). The agar dilution plates are incubated at 35°C in a microaerobic environment produced by a gas generating system suitable for campylobacters. After 3 days of incubation, the MICs are recorded as the lowest concentration of antimicrobial agent required to inhibit growth of the organism. The clarithromycin and amoxicillin MIC values should be interpreted according to the following criteria:

Table 5

Clarithromycin MIC (µg/mL) [a]	Interpretation
≤ 0.25	Susceptible (S)
0.5	Intermediate (I)
> 1.0	Resistant (R)
Amoxicillin MIC (µg/mL) [a,b]	Interpretation
≤0.25	Susceptible (S)

[a] These are tentative breakpoints for the agar dilution methodology and they should not be used to interpret results obtained using alternative methods.

[b] There were not enough organisms with MICs >

0.25 µg/mL to determine a resistance breakpoint.

Standardized susceptibility test procedures require the use of laboratory control microorganisms to control the technical aspects of the laboratory procedures. Standard clarithromycin and amoxicillin powders should provide the following MIC values:

Microorganism	Antimicrobial Agent	MIC (µg/mL) [a]
H. pylori ATCC 43504	Clarithromycin	0.016- 0.12 (µg/mL)
H. pylori ATCC 43504	Amoxicillin	0.016- 0.12 (µg/mL)

[a]These are quality control ranges for the agar dilution methodology and they should not be used to control test results obtained using alternative methods.

Effects on Gastrointestinal Microbial Ecology

Decreased gastric acidity due to any means including proton pump inhibitors, increases gastric counts of bacteria normally present in the gastrointestinal tract. Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter* and, in hospitalized patients, possibly also *Clostridium difficile*.

NONCLINICAL TOXICOLOGY

In two 24-month carcinogenicity studies in rats, omeprazole at daily doses of 1.7, 3.4, 13.8, 44.0 and 140.8 mg/kg/day (about 0.7 to 57 times a human dose of 20 mg/day, as expressed on a body surface area basis) produced gastric ECL cell carcinoids in a dose-related manner in both male and female rats; the incidence of this effect was markedly higher in female rats, which had higher blood levels of omeprazole. Gastric carcinoids seldom occur in the untreated rat. In addition, ECL cell hyperplasia was present in all treated groups of both sexes. In one of these studies, female rats were treated with 13.8 mg omeprazole/kg/day (about 6 times a human dose of 20 mg/day, based on body surface area) for one year, and then followed for an additional year without the drug. No carcinoids were seen in these rats. An increased incidence of treatment-related ECL cell hyperplasia was observed at the end of one year (94% treated vs 10% controls). By the second year the difference between treated and control rats was much smaller (46% vs 26%) but still showed more hyperplasia in the treated group. Gastric adenocarcinoma was seen in one rat (2%). No similar tumor was seen in male or female rats treated for two years. For this strain of rat no similar tumor has been noted historically, but a finding involving only one tumor is difficult to interpret. In a 52-week toxicity study in Sprague-Dawley rats, brain astrocytomas were found in a small number of males that received omeprazole at dose levels of 0.4, 2, and 16 mg/kg/day (about 0.2 to 6.5 times the human dose on a body surface area basis). No astrocytomas were observed in female rats in this study. In a 2-year carcinogenicity study in Sprague-Dawley rats, no astrocytomas were found in males or females at the high dose of 140.8 mg/kg/day (about 57 times the human dose on a body surface area basis). A 78-week mouse carcinogenicity study of omeprazole did not show increased tumor occurrence, but the study was not conclusive. A 26-week p53 (+/-) transgenic mouse carcinogenicity study was not positive.

Omeprazole was positive for clastogenic effects in an *in vitro* human lymphocyte chromosomal aberration assay, in one of two *in vivo* mouse micronucleus tests, and in an *in vivo* bone marrow cell

chromosomal aberration assay. Omeprazole was negative in the *in vitro* Ames test, an *in vitro* mouse lymphoma cell forward mutation assay, and an *in vivo* rat liver DNA damage assay.

Omeprazole at oral doses up to 138 mg/kg/day in rats (about 56 times the human dose on a body surface area basis) was found to have no effect on fertility and reproductive performance.

In 24-month carcinogenicity studies in rats, a dose-related significant increase in gastric carcinoid tumors and ECL cell hyperplasia was observed in both male and female animals [*See Warnings and Precautions (5)*] Carcinoid tumors have also been observed in rats subjected to fundectomy or long-term treatment with other proton pump inhibitors or high doses of H_2-receptor antagonists.

Reproductive Toxicology Studies

Reproductive studies conducted with omeprazole in rats at oral doses up to 138 mg/kg/day (about 56 times the human dose on a body surface area basis) and in rabbits at doses up to 69 mg/kg/day (about 56 times the human dose on a body surface area basis) did not disclose any evidence for a teratogenic potential of omeprazole. In rabbits, omeprazole in a dose range of 6.9 to 69.1 mg/kg/day (about 5.5 to 56 times the human dose on a body surface area basis) produced dose-related increases in embryo-lethality, fetal resorptions, and pregnancy disruptions. In rats, dose-related embryo/fetal toxicity and postnatal developmental toxicity were observed in offspring resulting from parents treated with omeprazole at 13.8 to 138.0 mg/kg/day (about 5.6 to 56 times the human doses on a body surface area basis).

CLINICAL STUDIES

Active Duodenal Ulcer— In a multicenter, double-blind, placebo-controlled study of 147 patients with endoscopically documented duodenal ulcer, the percentage of patients healed (per protocol) at 2 and 4 weeks was significantly higher with omeprazole 20 mg once daily than with placebo ($p \leq 0.01$).

Treatment of Active Duodenal Ulcer % of Patients Healed

	Omeprazole 20 mg a.m (n = 99)	Placebo a.m (n = 48)
Week 2	*41	13
Week 4	*75	27

*($p \leq 0.01$)

Complete daytime and nighttime pain relief occurred significantly faster ($p \leq 0.01$) in patients treated with omeprazole 20 mg than in patients treated with placebo. At the end of the study, significantly more patients who had received omeprazole had complete relief of daytime pain ($p \leq 0.05$) and nighttime pain ($p \leq 0.01$).

In a multicenter, double-blind study of 293 patients with endoscopically documented duodenal ulcer, the percentage of patients healed (per protocol) at 4 weeks was significantly higher with omeprazole 20 mg once daily than with ranitidine 150 mg b.i.d. ($p < 0.01$).

Treatment of Active Duodenal Ulcer % of Patients Healed

	Omeprazole 20 mg a.m (n = 145)	Ranitidine 150 mg twice daily (n = 148)
Week 2	42	34
Week 4	*82	63

*($p < 0.01$)

Healing occurred significantly faster in patients treated with omeprazole than in those treated with ranitidine 150 mg b.i.d. ($p < 0.01$).

In a foreign multinational randomized, double-blind study of 105 patients with endoscopically documented duodenal ulcer, 20 mg and 40 mg of omeprazole were compared with 150 mg b.i.d. of ranitidine at 2, 4 and 8 weeks. At 2 and 4 weeks both doses of omeprazole were statistically superior (per protocol) to ranitidine, but 40 mg was not superior to 20 mg of omeprazole, and at 8 weeks there was no significant difference between any of the active drugs.

Treatment of Active Duodenal Ulcer % of Patients Healed

	Omeprazole 20 mg (n = 34)	Ranitidine 40 mg (n = 36)	150 mg twice daily (n = 35)
Week 2	*83	*83	53
Week 4	*97	*100	82
Week 8	100	100	94

*($p \leq 0.01$)

H. pylori Eradication in Patients with Duodenal Ulcer Disease

Triple Therapy(omeprazole/clarithromycin/amoxicillin) — Three U.S., randomized, double-blind clinical studies in patients with *H. pylori* infection and duodenal ulcer disease (n = 558) compared omeprazole plus clarithromycin plus amoxicillin with clarithromycin plus amoxicillin. Two studies (1 and 2) were conducted in patients with an active duodenal ulcer, and the other study (3) was conducted in patients with a history of a duodenal ulcer in the past 5 years but without an ulcer present at the time of enrollment. The dose regimen in the studies was omeprazole 20 mg twice daily plus clarithromycin 500 mg twice daily plus amoxicillin 1 g twice daily for 10 days; or clarithromycin 500 mg. twice daily plus amoxicillin 1 g twice daily for 10 days. In studies 1 and 2, patients who took the omeprazole regimen also received an additional 18 days of omeprazole 20 mg once daily. Endpoints studied were eradication of *H. pylori* and duodenal ulcer healing (studies 1 and 2 only). *H. pylori* status was determined by CLOtest®, histology and culture in all three studies. For a given patient, *H. pylori* was considered eradicated if at least two of these tests were negative, and none was positive.

The combination of omeprazole plus clarithromycin plus amoxicillin was effective in eradicating *H. pylori.*

Table 6

Per-Protocol and Intent-to-Treat *H. pylori* Eradication Rates % of Patients Cured [95% Confidence Interval]

	Omeprazole +clarithromycin +amoxicillin		Clarithromycin +amoxicillin	
	Per-Protocol †	Intent-to-Treat ‡	Per-Protocol †	Intent-to-Treat ‡
Study 1	*77 [64, 86] (n = 64)	*69 [57, 79] (n = 80)	43 [31, 56] (n = 67)	37 [27, 48] (n = 84)
Study 2	*78 [67, 88] (n = 65)	*73 [61, 82] (n = 77)	41 [29, 54] (n = 68)	36 [26, 47] (n = 83)
Study 3	*90 [80, 96] (n = 69)	*83 [74, 91] (n = 84)	33 [24, 44] (n = 93)	32 [23, 42] (n = 99)

† Patients were included in the analysis if they had confirmed duodenal ulcer disease (active ulcer, studies 1 and 2; history of ulcer within 5 years, study 3) and *H. pylori* infection at baseline defined as at least two of three positive endoscopic tests from CLOtest®, histology, and/or culture. Patients were included in the analysis if they completed the study. Additionally, if patients dropped out of the study

due to an adverse event related to the study drug, they were included in the analysis as failures of therapy. The impact of eradication on ulcer recurrence has not been assessed in patients with a past history of ulcer.

‡ Patients were included in the analysis if they had documented *H. pylori* infection at baseline and had confirmed duodenal ulcer disease. All dropouts were included as failures of therapy.

* ($p < 0.05$) versus clarithromycin plus amoxicillin.

Dual Therapy (omeprazole/clarithromycin)

Four randomized, double-blind, multi-center studies (4, 5, 6, and 7) evaluated omeprazole 40 mg once daily plus clarithromycin 500 mg three times daily for 14 days, followed by omeprazole 20 mg once daily, (Studies 4, 5, and 7) or by omeprazole 40 mg once daily (Study 6) for an additional 14 days in patients with active duodenal ulcer associated with *H. pylori*. Studies 4 and 5 were conducted in the U.S. and Canada and enrolled 242 and 256 patients, respectively. *H. pylori* infection and duodenal ulcer were confirmed in 219 patients in Study 4 and 228 patients in Study 5. These studies compared the combination regimen to omeprazole and clarithromycin monotherapies. Studies 6 and 7 were conducted in Europe and enrolled 154 and 215 patients, respectively. *H. pylori* infection and duodenal ulcer were confirmed in 148 patients in study 6 and 208 patients in Study 7. These studies compared the combination regimen with omeprazole monotherapy. The results for the efficacy analyses for these

studies are described below. *H. pylori* eradication was defined as no positive test (culture or histology) at 4 weeks following the end of treatment, and two negative tests were required to be considered eradicated of *H. pylori*. In the per-protocol analysis, the following patients were excluded: dropouts, patients with missing *H. pylori* tests post-treatment, and patients that were not assessed for *H. pylori* eradication because they were found to have an ulcer at the end of treatment.

The combination of omeprazole and clarithromycin was effective in eradicating *H. pylori*.

Table 7

H. pylori Eradication Rates (Per-Protocol Analysis at 4 to 6 Weeks) % of Patients Cured [95% Confidence Interval]

	Omeprazole + Clarithromycin	Omeprazole	Clarithromycin
U.S. Studies			
Study 4	74 [60, 85] †‡ (n = 53)	0 [0, 7] (n = 54)	31 [18, 47] (n = 42)
Study 5	64 [51, 76] †‡ (n = 61)	0 [0, 6] (n = 59)	39 [24, 55] (n = 44)
Non U.S. Studies			
Study 6	83 [71, 92] ‡ (n = 60)	1 [0, 7] (n = 74)	N/A
Study 7	74 [64, 83] ‡ (n = 86)	1 [0, 6] (n = 90)	N/A

†Statistically significantly higher than clarithromycin monotherapy ($p < 0.05$)
‡Statistically significantly higher than omeprazole monotherapy ($p < 0.05$)

Ulcer healing was not significantly different when clarithromycin was added to omeprazole therapy compared with omeprazole therapy alone.

The combination of omeprazole and clarithromycin was effective in eradicating *H. pylori* and reduced duodenal ulcer recurrence.

Table 8

Duodenal Ulcer Recurrence Rates by *H. pylori* Eradication Status % of Patients with Ulcer Recurrence

	H. pylori eradicated#	*H. pylori* not eradicated#
U.S. Studies †		
6 months post-treatment		
Study 4	*35 (n = 49)	60 (n = 88)
Study 5	*8 (n = 53)	60 (n = 106)
Non U.S. Studies ‡		
6 months post-treatment		
Study 6	*5 (n = 43)	46 (n = 78)
	*6	43

Study 7	*6 (n = 53)	43 (n = 107)
12 months post-treatment		
Study 6	*5 (n = 39)	68 (n = 71)

#*H. pylori* eradication status assessed at same time point as ulcer recurrence

†Combined results for omeprazole + clarithromycin, omeprazole, and clarithromycin treatment arms

‡Combined results for omeprazole + clarithromycin and omeprazole treatment arms

*($p \leq 0.01$) versus proportion with duodenal ulcer recurrence who were not *H. pylori* eradicated

In a U.S. multicenter, double-blind, study of omeprazole 40 mg once daily, 20 mg once daily, and placebo in 520 patients with endoscopically diagnosed gastric ulcer, the following results were obtained.

Treatment of Gastric Ulcer % of Patients Healed (All Patients Treated)

	Omeprazole 20 mg once daily (n = 202)	Omeprazole 40 mg once daily (n = 214)	Placebo (n = 104)
Week 4	47.5**	55.6**	30.8
Week 8	74.8**	82.7**,+	48.1

**($p < 0.01$) omeprazole 40 mg or 20 mg versus placebo

+($p < 0.05$) omeprazole 40 mg versus 20 mg

For the stratified groups of patients with ulcer size less than or equal to 1 cm, no difference in healing rates between 40 mg and 20 mg was detected at either 4 or 8 weeks. For patients with ulcer size greater than 1 cm, 40 mg was significantly more effective than 20 mg at 8 weeks.

In a foreign, multinational, double-blind study of 602 patients with endoscopically diagnosed gastric ulcer, omeprazole 40 mg once daily, 20 mg once daily, and ranitidine 150 mg twice a day were evaluated.

Treatment of Gastric Ulcer % of Patients Healed (All Patients Treated)

	Omeprazole 20 mg once daily (n = 200)	Omeprazole 40 mg once daily (n = 187)	Ranitidine 150 mg twice daily (n = 199)
Week 4	63.5	78.1**,++	56.3

Week 8	81.5	91.4**,++	78.4

** ($p < 0.01$) omeprazole 40 mg versus ranitidine

++ ($p < 0.01$) omeprazole 40 mg versus 20 mg

Symptomatic GERD

A placebo-controlled study was conducted in Scandinavia to compare the efficacy of omeprazole 20 mg or 10 mg once daily for up to 4 weeks in the treatment of heartburn and other symptoms in GERD patients without erosive esophagitis. Results are shown below.

	% Successful Symptomatic Outcome[a]		
	Omeprazole 20 mg a.m.	Omeprazole 10 mg a.m.	Placebo a.m.
All patients	46*,† (n = 205)	31† (n = 199)	13 (n = 105)
Patients with confirmed GERD	56*,† (n = 115)	36† (n = 109)	14 (n = 59)

[a]Defined as complete resolution of heartburn

*($p < 0.005$) versus 10 mg

†($p < 0.005$) versus placebo

In a U.S. multicenter double-blind placebo controlled study of 20 mg or 40 mg of omeprazole delayed-release capsules in patients with symptoms of GERD and endoscopically diagnosed erosive esophagitis of grade 2 or above, the percentage healing rates (per protocol) were as follows:

Week	20 mg Omeprazole (n = 83)	40 mg Omeprazole (n = 87)	Placebo (n = 43)
4	39**	45**	7
8	74**	75**	14

**($p < 0.01$)

Omeprazole versus placebo.

In this study, the 40 mg dose was not superior to the 20 mg dose of omeprazole in the percentage healing rate. Other controlled clinical trials have also shown that omeprazole is effective in severe GERD. In comparisons with histamine H_2-receptor antagonists in patients with erosive esophagitis, grade 2 or above, omeprazole in a dose of 20 mg was significantly more effective than the active controls. Complete daytime and nighttime heartburn relief occurred significantly faster ($p < 0.01$) in patients treated with omeprazole than in those taking placebo or histamine H_2- receptor antagonists.

In this and five other controlled GERD studies, significantly more patients taking 20 mg omeprazole (84%) reported complete relief of GERD symptoms than patients receiving placebo (12%).

Long Term Maintenance Of Healing of Erosive Esophagitis

In a U.S. double-blind, randomized, multicenter, placebo controlled study, two dose regimens of omeprazole were studied in patients with endoscopically confirmed healed esophagitis. Results to determine maintenance of healing of erosive esophagitis are shown below.

Life Table Analysis

	Omeprazole 20 mg once daily (n = 138)	Omeprazole 20 mg 3 days per week (n = 137)	Placebo (n = 131)
Percent in endoscopic remission at 6 months	*70	34	11

*($p < 0.01$) omeprazole 20 mg once daily versus omeprazole 20 mg 3 consecutive days per week or placebo.

In an international multicenter double-blind study, omeprazole 20 mg daily and 10 mg daily were compared with ranitidine 150 mg twice daily in patients with endoscopically confirmed healed esophagitis. The table below provides the results of this study for maintenance of healing of erosive esophagitis.

Life Table Analysis

	Omeprazole 20 mg once daily (n = 131)	Omeprazole 10 mg once daily (n = 133)	Ranitidine 150 mg twice daily (n = 128)
Percent in			

endoscopic remission at 12 months	*77	‡58	46

* (p = 0.01) Omeprazole 20 mg once daily . versus Omeprazole 10 mg once daily or Ranitidine.
‡ (p = 0.03) Omeprazole 10 mg once daily . versus Ranitidine.

In patients who initially had grades 3 or 4 erosive esophagitis, for maintenance after healing 20 mg daily of omeprazole was effective, while 10 mg did not demonstrate effectiveness.

In open studies of 136 patients with pathological hypersecretory conditions, such as Zollinger-Ellison (ZE) syndrome with or without multiple endocrine adenomas, omeprazole delayed-release capsules significantly inhibited gastric acid secretion and controlled associated symptoms of diarrhea, anorexia, and pain. Doses ranging from 20 mg every other day to 360 mg per day maintained basal acid secretion below 10 mEq/hr in patients without prior gastric surgery, and below 5 mEq/hr in patients with prior gastric surgery.

Initial doses were titrated to the individual patient need, and adjustments were necessary with time in some patients [*See Dosage and Administration (2)*] omeprazole was well tolerated at these high dose levels for prolonged periods (> 5 years in some patients). In most ZE patients, serum gastrin levels were not modified by omeprazole. However, in some patients serum gastrin increased to levels greater than those present prior to initiation of omeprazole therapy. At least 11 patients with ZE syndrome on long-term treatment with omeprazole developed gastric carcinoids. These findings are believed to be a manifestation of the underlying condition, which is known to be associated with such tumors, rather than the result of the administration of omeprazole. [*See Adverse Reactions (6)*]

Symptomatic GERD

The effectiveness of omeprazole for the treatment of nonerosive GERD in pediatric patients 2 to 16 years of age is based in part on data obtained from 125 pediatric patients in an uncontrolled Phase III study. [*See Use in Specific Populations (8.4)*]

The study enrolled 113 pediatric patients 2 to 16 years of age with a history of symptoms suggestive of nonerosive GERD. Patients were administered a single dose of omeprazole (10 mg or 20 mg, based on body weight) for 4 weeks either as an intact capsule or as an open capsule in applesauce. Successful response was defined as no moderate or severe episodes of either pain-related symptoms or vomiting/regurgitation during the last 4 days of treatment. Results showed success rates of 60% (9/15; 10 mg omeprazole) and 59% (58/98; 20 mg omeprazole), respectively.

Healing of Erosive Esophagitis

In an uncontrolled, open-label dose-titration study, healing of erosive esophagitis in pediatric patients 2

to 16 years of age required doses that ranged from 0.7 to 3.5 mg/kg/day (80 mg/day). Doses were initiated at 0.7 mg/kg/day. Doses were increased in increments of 0.7 mg/kg/day (if intraesophageal pH showed a pH of < 4 for less than 6% of a 24-hour study). After titration, patients remained on treatment for 3 months. Forty-four percent of the patients were healed on a dose of 0.7 mg/kg body weight; most of the remaining patients were healed with 1.4 mg/kg after an additional 3 months' treatment. Erosive esophagitis was healed in 51 of 57 (90%) children who completed the first course of treatment in the healing phase of the study. In addition, after 3 months of treatment, 33% of the children had no overall symptoms, 57% had mild reflux symptoms, and 40% had less frequent regurgitation/vomiting.

Maintenance of Healing of Erosive Esophagitis

In an uncontrolled, open-label study of maintenance of healing of erosive esophagitis in 46 pediatric patients, 54% of patients required half the healing dose. The remaining patients increased the healing dose (0.7 to a maximum of 2.8 mg/kg/day) either for the entire maintenance period, or returned to half the dose before completion. Of the 46 patients who entered the maintenance phase, 19 (41%) had no relapse. In addition, maintenance therapy in erosive esophagitis patients resulted in 63% of patients having no overall symptoms.

REFERENCES

1. National Committee for Clinical Laboratory Standards. Methods for Dilution Antimicrobial Susceptibility Tests for Bacteria That Grow Aerobically—Fifth Edition. Approved Standard NCCLS Document M7-A5, Vol, 20, No. 2, NCCLS, Wayne, PA, January 2000.

HOW SUPPLIED

Omeprazole Delayed-release Capsules, USP 10 mg, are opaque, hard gelatin, light green and white colored capsules, imprinted “Andrx 610” on cap and “10 mg” on the body. They are supplied as follows:

NDC 62037-610-07 sample bottles of 7
NDC 62037-610-30 unit of use bottles of 30
NDC 62037-610-01 bottles of 100
NDC 62037-610-10 bottles of 1000

Omeprazole Delayed-release Capsules, USP 20 mg, are opaque, hard gelatin, dark green and white colored capsules, imprinted “Andrx 620” on cap and “20 mg” on body. They are supplied as follows:

NDC 62037-620-07 sample bottles of 7
NDC 62037-620-30 unit of use bottles of 30
NDC 62037-620-01 bottles of 100
NDC 62037-620-10 bottles of 1000

Omeprazole Delayed-release Capsules, USP 40 mg, are opaque, hard gelatin, dark green and light green colored capsules, imprinted “Andrx 640” on cap and “40 mg” on the body. They are supplied as follows:

NDC 62037-640-07 sample bottles of 7
NDC 62037-640-30 unit of use bottles of 30
NDC 62037-640-01 bottles of 100
NDC 62037-640-10 bottles of 1000

Storage

Store Omeprazole delayed-release capsules in a tight container protected from light and moisture. Store at 20° - 25°C (68° – 77°F). [See USP Controlled Room Temperature.]

INFORMATION FOR PATIENTS

Omeprazole delayed-release capsules should be taken before eating. Patients should be informed that the omeprazole delayed-release capsule should be swallowed whole.

For patients who have difficulty swallowing capsules, the contents of an omeprazole delayed-release capsule can be added to applesauce. One tablespoon of applesauce should be added to an empty bowl and the capsule should be opened. All of the pellets inside the capsule should be carefully emptied on the applesauce. The pellets should be mixed with the applesauce and then swallowed immediately with a glass of cool water to ensure complete swallowing of the pellets. The applesauce used should not be hot and should be soft enough to be swallowed without chewing. The pellets should not be chewed or crushed. The pellets/applesauce mixture should not be stored for future use.

Advise patients to immediately report and seek care for any cardiovascular or neurological symptoms including palpitations, dizziness, seizures, and tetany as these may be signs of hypomagnesemia [*see Warnings and Precautions(5.7)*].

Manufactured by:

Watson Laboratories, Inc.
Corona, CA 92880. USA

Distributed by:
Watson Pharma, Inc.
Corona, CA 92880. USA

Rev. Date: 05/12 174697-3

SPL PATIENT PACKAGE INSERT

Omeprazole Delayed-Release Capsules

Read the patient information that comes with omeprazole delayed-release capsules before you start taking it and each time you get a refill. There may be new information. This leaflet does not take the place of talking with your doctor about your medical condition or your treatment.

If you have any questions about omeprazole delayed-release capsules, ask your doctor.

WHAT IS OMEPRAZOLE?

Omeprazole is a prescription medicine called a proton pump inhibitor (PPI). Omeprazole reduces the amount of acid in your stomach. Omeprazole is used in adults:

- for up to 4 weeks to treat heartburn and other symptoms that happen with gastroesophageal reflux disease (GERD).

GERD is a chronic condition (lasts a long time) that occurs when acid from the stomach backs up into the esophagus (food pipe) causing symptoms, such as heartburn, or damage to the lining of the esophagus. Common symptoms include frequent heartburn that will not go away, a sour or bitter taste in the mouth, and difficulty swallowing.

- for up to 8 weeks to heal acid-related damage to the lining of the esophagus (called erosive

esophagitis or EE)
- to maintain healing of the esophagus. Omeprazole has not been studied for treatment lasting longer than 12 months (1 year)
- for up to 8 weeks for healing stomach ulcers
- for up to 8 weeks for healing ulcers in the first part of the small bowel (duodenal ulcers)
- to treat patients with a stomach infection (Helicobacter pylori), along with the antibiotics amoxicillin and clarithromycin.
- for lowering the amount of stomach acid in people with certain conditions which cause them to make too much acid, including those with Zollinger-Ellison Syndrome.

For children and adolescents 2 to 17 years of age, omeprazole is used:
- for up to 4 weeks to treat the symptoms of gastroesophageal reflux disease (GERD).
- for up to 8 weeks to heal acid-related damage to the lining of the esophagus (called erosive esophagitis or EE)
- to maintain healing of the esophagus

Omeprazole is not recommended for children under the age of 1 year. Omeprazole may help your acid-related symptoms, but you could still have serious stomach problems. Talk with your doctor.

WHO SHOULD NOT TAKE OMEPRAZOLE DELAYED-RELEASE CAPSULES?

Do not take omeprazole delayed-release capsules if you:
- are allergic to any of the ingredients in omeprazole delayed-release capsules. See the end of this leaflet for a complete list of ingredients in omeprazole delayed-release capsules.
- are allergic to any other Proton Pump Inhibitor (PPI) medicine.

WHAT SHOULD I TELL MY DOCTOR BEFORE TAKING OMEPRAZOLE DELAYED-RELEASE CAPSULES?

Tell your doctor about all your medical conditions, including if you:
- have been told that you have low magnesium levels in your blood.
- have liver problems
- are pregnant or plan to become pregnant. It is not known if omeprazole delayed-release capsules will harm your unborn baby. Talk to your doctor if you are pregnant or plan to become pregnant.
- are breastfeeding or planning to breastfeed. You and your doctor should decide if you will take omeprazole delayed-release capsules or breastfeed. You should not do both.

Tell your doctor about all of the medicines you take including prescription and non-prescription drugs, anti-cancer drugs, vitamins and herbal supplements. Omeprazole delayed-release capsules may affect how other medicines work, and other medicines may affect how omeprazole delayed-release capsules works. In some cases, a drug you may be taking may need to be temporarily withdrawn. Especially tell your doctor if you take:
- atazanavir (Reyataz)
- nelfinavir (Viracept)
- saquinavir (Fortovase)
- cilostazol (Pletal)
- ketoconazole (Nizoral)
- voriconazole (Vfend)
- ampicillin (Unasyn)
- products that contain iron
- warfarin (Coumadin)
- digoxin (Lanoxin, Lanoxincaps)
- tacrolimus (Prograf)

- diazepam (Valium)
- phenytoin (Dilantin)
- disulfiram (Antabuse)
- clopidogrel (Plavix)
- St. John's Wort (*Hypericum perforatum*)
- rifampin
- erlotinib
- methotrexate

HOW SHOULD I TAKE OMEPRAZOLE DELAYED-RELEASE CAPSULES?

- Take omeprazole delayed-release capsules exactly as prescribed by your doctor.
- Do not change your dose or stop omeprazole delayed-release capsules without talking to your doctor.
- Take omeprazole delayed-release capsules at least 1 hour before a meal.
- Swallow omeprazole delayed-release capsules whole. **Never chew or crush omeprazole delayed-release capsules.**
- If you have difficulty swallowing omeprazole delayed-release capsules, you may open the capsule and empty the contents into a tablespoon of applesauce. Be sure to swallow the applesauce right away. Do not store it for later use.
- If you forget to take a dose of omeprazole delayed-release capsules, take it as soon as you remember. If it is almost time for your next dose, do not take the missed dose. Take the next dose on time. Do not take a double dose to make up for a missed dose.
- If you take too much omeprazole delayed-release capsules, tell your doctor right away.

WHAT ARE THE POSSIBLE SIDE EFFECTS OF OMEPRAZOLE DELAYED-RELEASE CAPSULES?

- **Serious allergic reactions.** Tell your doctor if you get any of the following symptoms with omeprazole delayed-release capsules.
- rash
- face swelling
- throat tightness
- difficulty breathing

Your doctor may stop omeprazole delayed-release capsules if these symptoms happen.

Low magnesium levels in your body. This problem can be serious. Low magnesium can happen in some people who take a proton pump inhibitor medicine for at least 3 months. If low magnesium levels happen, it is usually after a year of treatment. You may or may not have symptoms of low magnesium.

Tell your doctor right away if you have any of these symptoms:

- seizures
- dizziness
- abnormal or fast heart beat
- jitteriness
- jerking movements or shaking (tremors)
- muscle weakness
- spasms of the hands and feet
- cramps or muscle aches
- spasm of the voice box

Your doctor may check the level of magnesium in your body before you start taking omeprazole delayed-release capsules or during treatment if you will be taking omeprazole delayed-release capsules for a long period of time.

The most common side effects with omeprazole delayed-release capsules in adults and children include:

- Headache
- Abdominal pain
- Nausea
- Diarrhea
- Vomiting
- Gas
- Respiratory system events
- Fever

People who are taking multiple daily doses of proton pump inhibitor medicines for a long period of time may have an increased risk of fractures of the hip, wrist or spine.

Tell your doctor about any side effects that bother you or that do not go away. These are not all the possible side effects with omeprazole delayed-release capsules. Talk with your doctor or pharmacist if you have any questions about side effects. You may report side effects to the FDA at 1-800-FDA-1088.

HOW SHOULD I STORE OMEPRAZOLE DELAYED-RELEASE CAPSULES?

Store Omeprazole delayed-release capsules at 20° - 25°C (68° – 77°F). [See USP Controlled Room Temperature.]

Keep the container of omeprazole closed tightly.

Keep omeprazole delayed-release capsules and all medicines out of the reach of children.

GENERAL ADVICE

Medicines are sometimes prescribed for purposes other than those listed in the Patient Information leaflet. Do not use omeprazole delayed-release capsules for a condition for which it was not prescribed. Do not give omeprazole delayed-release capsules to other people, even if they have the same symptoms you have. It may harm them.

This Patient Information leaflet provides a summary of the most important information about omeprazole delayed-release capsules. For more information, ask your doctor. You can ask your doctor or pharmacist for information that is written for healthcare professionals. For more information, go to www.watson.com or call toll free 1-800-595-1883.

PATIENT INSTRUCTIONS FOR USE

For instructions on taking Delayed-Release Capsules, please see **“HOW SHOULD I TAKE OMEPRAZOLE DELAYED-RELEASE CAPSULES?”**

WHAT ARE THE INGREDIENTS IN OMEPRAZOLE DELAYED-RELEASE CAPSULES?

Active ingredient in Omeprazole Delayed-Release Capsules:

omeprazole

Inactive ingredients in Omeprazole Delayed-Release Capsules

(including the capsule shells): ammonium hydroxide, cetyl alcohol, disodium phosphate, D&C Yellow #10, FD&C Blue #2 Aluminium Lake, FD&C Green #3, gelatin, hydroxy propyl methylcellulose phthalate, lactose anhydrous, povidone, propylene glycol, shellac, sodium lauryl sulfate, sucrose, talc and titanium dioxide.

Manufactured by:

Watson Laboratories, Inc.

Corona, CA 92880. USA

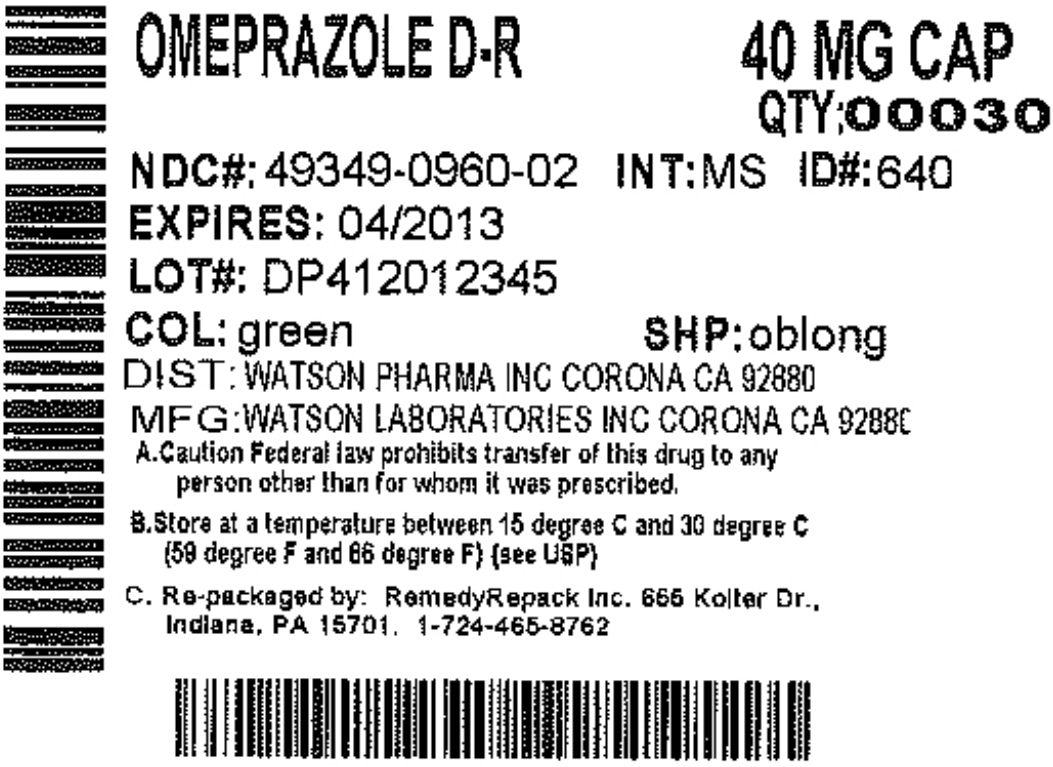
Distributed by:

Watson Pharma, Inc.

Corona, CA 92880. USA

Rev. date: 05/12 174697-3

PACKAGE LABEL.PRINCIPAL DISPLAY PANEL SECTION
DRUG: Omeprazole
GENERIC: Omeprazole
DOSAGE: CAPSULE, DELAYED RELEASE PELLETS
ADMINSTRATION: ORAL
NDC: 49349-960-02
STRENGTH:40 mg
COLOR: green
SHAPE: CAPSULE
SCORE: No score
SIZE: 22 mm
IMPRINT: 30
QTY: 30

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OMEPRAZOLE

omeprazole capsule, delayed release pellets

Product Information

Product Type	HUMAN PRESCRIPTION DRUG LABEL	**Item Code (Source)**	NDC:49349-960(NDC:62037-640)
Route of Administration	ORAL	**DEA Schedule**	

Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
OMEPRAZOLE (OMEPRAZOLE)	OMEPRAZOLE	40 mg

Inactive Ingredients

Ingredient Name	Strength
CETYL ALCOHOL	
SODIUM PHOSPHATE, DIBASIC, ANHYDROUS	
HYPROMELLOSE PHTHALATE (31% PHTHALATE, 40 CST)	
ANHYDROUS LACTOSE	
POVIDONE K90	
SODIUM LAURYL SULFATE	
SUCROSE 1,6-DISTEARATE	
TALC	
AMMONIA N-13	
D&C YELLOW NO. 10	
FD&C BLUE NO. 2	
FD&C GREEN NO. 3	
GELATIN HYDROLYSATE (PORCINE SKIN, MW 3000)	
PROPYLENE GLYCOL 1,2-DISTEARATE	
SHELLAC	
TITANIUM DIOXIDE	

Product Characteristics

Color	green	**Score**	no score
Shape	CAPSULE (CAPSULE, DELAYED RELEASE PELLETS)	**Size**	22mm
Flavor		**Imprint Code**	Andrx;640;40;mg
Contains			

Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:49349-960-02	30 in 1 BLISTER PACK		

Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA075347	02/15/2013	

Labeler - REMEDYREPACK INC. (829572556)

Revised: 2/2013 REMEDYREPACK INC.