Sertraline hydrochloride is a selective serotonin reuptake inhibitor (SSRI) for oral administration. It has a molecular weight of 342.7, mg chemical name: (1S-cis)-4-(3,4-dichlorophenyl)-1,2,3,4-tetrahydro-N-methyl-1-naphthalenamine hydrochloride. The empirical formula \( C_{17}H_{17}NC_{17}HCl \) is represented by the following structural formula:

![Structural formula of sertraline hydrochloride](image)

Sertraline hydrochloride, USP is a white crystalline powder that is slightly soluble in water and isopropyl alcohol and sparingly soluble in ethanol.

Sertraline tablets, USP are supplied for oral administration as scored tablets containing sertraline hydrochloride equivalent to 25 mg, 50 mg and 100 mg of sertraline and the following inactive ingredients: dibasic calcium phosphate dihydrate, hydroxypropyl cellulose, microcrystalline cellulose, magnesium stearate, opadry yellow (hypromellose 3cP, hypromellose 6cP, titanium dioxide, Macrogol/Peg 400, Polysorbate 80 for 100mg tablet) and sodium starch glycolate.

Sertraline hydrochloride tablets are not approved for the treatment of major depressive disorder in pediatric patients. (See WARNINGS: Clinical Worsening and Suicide Risk, PRECAUTIONS: Information for Patients, and PRECAUTIONS: Pediatric Use).

### DESCRIPTION

Sertraline hydrochloride is a selective serotonin reuptake inhibitor (SSRI) for oral administration. It has a molecular weight of 342.7, mg chemical name: (1S-cis)-4-(3,4-dichlorophenyl)-1,2,3,4-tetrahydro-N-methyl-1-naphthalenamine hydrochloride. The empirical formula \( C_{17}H_{17}NC_{17}HCl \) is represented by the following structural formula:

![Structural formula of sertraline hydrochloride](image)

Sertraline hydrochloride, USP is a white crystalline powder that is slightly soluble in water and isopropyl alcohol and sparingly soluble in ethanol.

Sertraline tablets, USP are supplied for oral administration as scored tablets containing sertraline hydrochloride equivalent to 25 mg, 50 mg and 100 mg of sertraline and the following inactive ingredients: dibasic calcium phosphate dihydrate, hydroxypropyl cellulose, microcrystalline cellulose, magnesium stearate, opadry yellow (hypromellose 3cP, hypromellose 6cP, titanium dioxide, Macrogol/Peg 400, Polysorbate 80 for 100mg tablet) and sodium starch glycolate.

### CLINICAL PHARMACOLOGY

#### Pharmacodynamics

The mechanism of action of sertraline is presumed to be linked to its inhibition of CNS neuronal uptake of serotonin (5HT). Studies at clinically relevant doses in man have demonstrated that sertraline blocks the uptake of serotonin into human platelets. In vitro studies in animals also suggest that sertraline is a potent and selective inhibitor of neuronal serotonin reuptake and has only very weak effects on norepinephrine and dopamine neuronal uptake. In vitro studies have shown that sertraline has no significant affinity for adrenergic (alpha_1, alpha_2, beta), cholinergic, GABA, dopaminergic, histaminergic, serotonergic (5HT_1A, 5HT_1B, 5HT_2), or benzodiazepine receptors; antagonism of such receptors has been hypothesized to be associated with various anticholinergic, sedative, and cardiovascular effects for other psychotropic drugs. The chronic administration of sertraline was found in animals to downregulate brain norepinephrine receptors, as has been observed with other drugs effective in the treatment of major depressive disorder. Sertraline does not inhibit monoamine oxidase.

#### Pharmacokinetics

### Systemic Bioavailability

In man, following oral once-daily dosing over the range of 50 to 200 mg for 14 days, mean peak plasma concentrations (C_{max}) of sertraline occurred between 4.5 to 8.4 hours post-dosing. The average terminal elimination half-life of plasma sertraline is about 26 hours. Based on this pharmacokinetic parameter, steady-state sertraline plasma levels should be achieved after approximately one week of once-daily dosing. Linear dose-proportional pharmacokinetics were demonstrated in a single dose study in which the C_{max} and area under the plasma concentration-time curve (AUC) of sertraline were proportional to dose over a range of 50 to 200 mg. Consistent with the terminal elimination half-life, there is an approximately two-fold accumulation, compared to a single dose, of sertraline with repeated dosing over a 50 to 200 mg dose range. The single dose bioavailability of sertraline tablets is approximately equal to an equivalent dose of solution.

In a relative bioavailability study comparing the pharmacokinetics of 100 mg sertraline as the oral solution to a 100 mg sertraline tablet in 16 healthy adults, the solution to tablet ratio of geometric mean AUC and C_{max} values were 114.8% and 120.6%, respectively. 90% confidence intervals (CI) were within the range of 80-125% with the exception of the upper 90% CI limit for C_{max} which was
The effects of food on the bioavailability of the sertraline tablet and oral concentrate were studied in subjects administered a single dose with and without food. AUC was slightly increased when drug was administered with food but the C_{max} was 25% greater, while the time to reach peak plasma concentration (T_{max}) decreased from 8 hours post-dosing to 5.5 hours. For the oral concentrate, T_{max} was slightly prolonged from 5.5 hours to 7.0 hours with food.

Metabolism—Sertraline undergoes extensive first pass metabolism. The principal initial pathway of metabolism for sertraline is N-desmethylation. N-desmethylsertraline has a plasma terminal elimination half-life of 62 to 104 hours. Both in vitro biochemical and in vivo pharmacological testing have shown N-desmethylsertraline to be substantially less active than sertraline. Both sertraline and N-desmethylsertraline undergo oxidative deamination and subsequent reduction, hydroxylation, and glucuronide conjugation. In a study of radiolabeled sertraline involving two healthy male subjects, sertraline accounted for less than 5% of the plasma radioactivity. About 40-45% of the administered radioactivity was recovered in urine in 9 days. Unchanged Sertraline was not detectable in the urine. For the same period, about 40-45% of the administered radioactivity was accounted for in feces, including 12-14% unchanged sertraline.

Desmethylsertraline exhibits time-related, dose dependent increases in AUC (0-24 hour), C_{max} and C_{min} with about a 5-9 fold increase in these pharmacokinetic parameters between day 1 and day 14.

**Protein Binding**—In vitro protein binding studies performed with radiolabeled 3H-sertraline showed that sertraline is highly bound to serum proteins (98%) in the range of 20 to 500 ng/mL. However, at up to 300 and 200 mg/day concentrations, respectively, sertraline and N-desmethylsertraline did not alter the plasma protein binding of two other highly protein bound drugs, viz., warfarin and propranolol (see PRECAUTIONS).

**Pediatric Pharmacokinetics**—Sertraline pharmacokinetics were evaluated in a group of 61 pediatric patients (29 aged 6 to 12 years, 32 aged 13 to 17 years). Patients included both males (N=28) and females (N=33). During 42 days of chronic sertraline dosing, sertraline was titrated up to 200 mg/day and maintained at that dose for a minimum of 11 days. On the final day of sertraline 200 mg/day, the 6-12 year old group exhibited a mean sertraline AUC (0-24 hr) of 3107 ng-hr/mL, mean C_{max} of 165 ng/mL, and mean C_{min} of 123 ng/mL, mean C_{max} of 123 ng/mL, and mean half-life of 26.2 hr. The 13-17 year old group exhibited a mean sertraline AUC (0-24 hr) of 2296 ng-hr/mL, mean C_{max} of 123 ng/mL, and mean half-life of 27.8 hr. Higher plasma levels in the 6-12 year old group were largely attributable to patients with lower body weights. No gender associated differences were observed. By comparison, a group of 22 separately studied adults between 18 and 45 years of age (11 male, 11 female) received 30 days of 200 mg/day sertraline and exhibited a mean sertraline AUC (0-24 hr) of 2570 ng-hr/mL, mean C_{max} of 142 ng/mL, and mean half-life of 27.2 hr. Relative to the adults, both the 6-12 year olds and the 13-17 year olds showed about 22% lower AUC (0-24 hr) and C_{max} values when plasma concentration was adjusted for weight. These data suggest that pediatric patients metabolize sertraline with slightly greater efficiency than adults. Nevertheless, lower doses may be advisable for pediatric patients given their lower body weights, especially in very young patients, in order to avoid excessive plasma levels (see DOSAGE AND ADMINISTRATION).

**Age**—Sertraline plasma clearance in a group of 16 (8 male, 8 female) elderly patients treated for 14 days at a dose of 100 mg/day was approximately 40% lower than in a similarly studied group of younger (25 to 32 y.o.) individuals. Steady-state, therefore, should be achieved after 2 to 3 weeks in older patients. The same study showed a decreased clearance of desmethysertaline in older males, but not in older females.

**Liver Disease**—As might be predicted from its primary site of metabolism, liver impairment can affect the elimination of sertraline. In patients with chronic mild liver impairment (N=10, 8 patients with Child-Pugh scores of 5-6 and 2 patients with Child-Pugh scores of 7-8) who received 50 mg sertraline per day maintained for 21 days, sertraline clearance was reduced, resulting in 3-fold greater exposure compared to age-matched volunteers with no hepatic impairment (N=10). The exposure to desmethyl-sertraline was approximately 2-fold greater compared to age-matched volunteers with no hepatic impairment. There were no significant differences in plasma protein binding observed between the two groups. The effects of sertraline in patients with moderate and severe hepatic impairment have not been studied. The results suggest that the use of sertraline in patients with liver disease must be approached with caution. If sertraline is administered to patients with liver impairment, a lower or less frequent dose should be used (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

**Renal Disease**—Sertraline is extensively metabolized and excretion of unchanged drug in urine is a minor route of elimination. In volunteers with mild to moderate (CLcr =30-60 mL/min), moderate to severe (CLcr <30 mL/min) or severe (receiving hemodialysis) renal impairment (N=10 each group), the pharmacokinetics and protein binding of 200 mg sertraline per day maintained for 21 days were not altered compared to age-matched volunteers (N=12) with no renal impairment. Thus sertraline multiple dose pharmacokinetics appear to be unaffected by renal impairment (see PRECAUTIONS).

**Clinical Trials**

**Major Depressive Disorder**—The efficacy of Sertraline hydrochloride as a treatment for major depressive disorder was established in two placebo-controlled studies in adult outpatients meeting DSM-III criteria for major depressive disorder. Study 1 was an 8-week study with flexible dosing of sertraline hydrochloride in a range of 50 to 200 mg/day; the mean dose for completers was 145 mg/day. Study 2 was a 6-week fixed-dose study, including sertraline hydrochloride doses of 50, 100, and 200 mg/day. Overall, these studies demonstrated sertraline hydrochloride to be superior to placebo on the Hamilton Depression Rating Scale and the Clinical Global Impression Severity and Improvement scales. Study 2 was not readily interpretable regarding a dose response relationship for effectiveness.

Study 3 involved depressed outpatients who had responded by the end of an initial 8-week open treatment phase on sertraline hydrochloride 50-200 mg/day. These patients (N=295) were randomized to continuation for 44 weeks on double-blind sertraline hydrochloride 50-200 mg/day or placebo. A statistically significant drug by placebo interaction was observed for patients taking sertraline hydrochloride compared to those on placebo. The mean dose for completers was 70 mg/day. Analyses for gender effects on outcome did not suggest any differential responsiveness on the basis of sex.

**Obsessive-Compulsive Disorder (OCD)**—The effectiveness of Sertraline hydrochloride in the treatment of OCD was demonstrated in three multicenter placebo-controlled studies in adult outpatients (Studies 1-3). Patients in all three studies had moderate to severe OCD (DSM-II-R or DSM-III-R) with mean baseline ratings on the Yale-Brown Obsessive-Compulsive Scale (YBOCS) total score ranging from 23 to 25.

Study 1 was an 8-week study with flexible dosing of Sertraline hydrochloride in a range of 50 to 200 mg/day; the mean dose for completers was 186 mg/day. Patients receiving Sertraline hydrochloride experienced a mean reduction of approximately 4 points on the YBOCS total score which was significantly greater than the mean reduction of 2 points in placebo-treated patients. Study 2 was a 12-week fixed-dose study, including Sertraline hydrochloride doses of 50, 100, and 200
mg/day. Patients receiving Sertraline hydrochloride doses of 50 and 200 mg/day experienced mean reductions of approximately 6 points on the YBOCS total score which were significantly greater than the approximately 3 point reduction in placebo-treated patients.

Study 3 was a 12-week study with flexible dosing of Sertraline hydrochloride in a range of 50 to 200 mg/day; the mean dose for completers was 185 mg/day. Patients receiving Sertraline hydrochloride experienced a mean reduction of approximately 7 points on the YBOCS total score which was significantly greater than the mean reduction of approximately 4 points in placebo-treated patients.

Analyses for age and gender effects on outcome did not suggest any differential responsiveness on the basis of age or sex.

The effectiveness of Sertraline hydrochloride for the treatment of OCD was also demonstrated in a 12-week, multicenter, placebo-controlled, parallel group study in a pediatric outpatients population (adolescents, ages 13-17). Patients receiving Sertraline hydrochloride in this study were initiated at doses of either 25 mg/day (children, ages 6-12) or 50 mg/day (adolescents, ages 13-17), and then titrated over the next four weeks to a maximum dose of 200 mg/day, as tolerated. The mean dose for completers was 178 mg/day. Dosing was once a day in the morning or evening. Patients in this study had moderate to severe OCD (DSM-III-R) with mean baseline ratings on the Children's Yale-Brown Obsessive-Compulsive Scale (CYBOCS) total score of 22. Patients receiving sertraline experienced a mean reduction of approximately 7 units on the CYBOCS total score which was significantly greater than the 3 unit reduction for placebo patients. Analyses for age and gender effects on outcome did not suggest any differential responsiveness on the basis of age or sex.

In a longer-term study, patients meeting DSM-III-R criteria for OCD who had responded during a 52-week single-blind trial on Sertraline hydrochloride 50-200 mg/day (n=224) were randomized to continuation of Sertraline hydrochloride or to substitution of placebo for up to 28 weeks of observation for discontinuation due to relapse or insufficient clinical response. Response during the open-label phase was defined as a decrease in the CYBOCS score of ≥ 25% compared to baseline and a CGI-I of 1 (very much improved), 2 (much improved) or 3 (minimally improved). Relapse during the double-blind phase was defined as the following conditions being met (on three consecutive visits for 1 and 2, and for visit 3 for condition 3): (1) YBOCS score increased by > 5 points, to a minimum of 20, relative to baseline; (2) CGI-I increased by > 1 point; and (3) worsening of the patient's condition in the investigator's judgment, to justify alternative treatment. Insufficient clinical response indicated a worsening of the patient's condition that resulted in study discontinuation, as assessed by the investigator. Patients receiving continued Sertraline hydrochloride treatment experienced a significantly lower rate of discontinuation due to relapse or insufficient clinical response over the subsequent 28 weeks compared to those receiving placebo. This pattern was demonstrated in male and female subjects.

Panic Disorder—The effectiveness of Sertraline hydrochloride in the treatment of panic disorder was demonstrated in three double-blind, placebo-controlled studies (Studies 1-3) of adult outpatients who had a primary diagnosis of panic disorder (DSM-III-R), with or without agoraphobia. Studies 1 and 2 were 10-week flexible dose studies. Sertraline hydrochloride was initiated at 25 mg/day for the first week, and then patients were dosed in a range of 50-200 mg/day on the basis of clinical response and toleration. The mean Sertraline hydrochloride doses for completers to 10 weeks were 131 mg/day and 144 mg/day, respectively, for Studies 1 and 2. In these studies, Sertraline hydrochloride was shown to be significantly more effective than placebo on change from baseline in panic attack frequency and on the Clinical Global Impression Severity of Illness and Global Improvement scores. The difference between Sertraline hydrochloride and placebo in reduction from baseline in the number of full panic attacks was approximately 2 panic attacks per week in both studies.

Study 3 was a 12-week fixed-dose study, including Sertraline hydrochloride doses of 50, 100, and 200 mg/day. Patients receiving Sertraline hydrochloride experienced a significantly greater reduction in panic attack frequency than patients receiving placebo. Study 3 was not readily interpretable regarding a dose response relationship for effectiveness.

Subgroup analyses did not indicate that there were any differences in treatment outcomes as a function of age, race, or gender.

In a longer-term study, patients meeting DSM-III-R criteria for Panic Disorder who had responded during a 52-week open-label on Sertraline hydrochloride 50-200 mg/day (n=183) were randomized to continuation of Sertraline hydrochloride or to substitution of placebo for up to 28 weeks of observation for discontinuation due to relapse or insufficient clinical response. Response during the open-label phase was defined as a CGI-I score of 1 (very much improved) or 2 (much improved). Relapse during the double-blind phase was defined as the following conditions being met on three consecutive visits: (1) CGI-I ≥ 3; (2) meets DSM-III-R criteria for Panic Disorder; (3) number of panic attacks greater than at baseline. Insufficient clinical response indicated a worsening of the patient's condition that resulted in study discontinuation, as assessed by the investigator. Patients receiving continued Sertraline hydrochloride treatment experienced a significantly lower rate of discontinuation due to relapse or insufficient clinical response over the subsequent 28 weeks compared to those receiving placebo. This pattern was demonstrated in male and female subjects.

Posttraumatic Stress Disorder (PTSD)—The effectiveness of Sertraline hydrochloride in the treatment of PTSD was established in two multicenter placebo-controlled studies (Studies 1-2) of adult outpatients who met DSM-III-R criteria for PTSD. The mean duration of PTSD for these patients was 12 years (Studies 1 and 2 combined) and 44% of patients (169 of the 385 patients treated) had secondary depressive disorder.

Studies 1 and 2 were 12-week flexible dose studies. Sertraline hydrochloride was initiated at 25 mg/day for the first week, and patients were then dosed in the range of 50-200 mg/day on the basis of clinical response and toleration. The mean Sertraline hydrochloride dose for completers was 146 mg/day and 151 mg/day, respectively for Studies 1 and 2. Study outcome was assessed by the Clinician Administered PTSD Scale Part 2 (CAPS) which is a multi-item instrument that measures the three PTSD symptom clusters of reexperiencing/ intrusion, avoidance/numbing, and hyperarousal as well as the patient-rated Impact of Event Scale (IES) which measures intrusion and avoidance symptoms. Sertraline hydrochloride was shown to be significantly more effective than placebo on change from baseline to endpoint on the CAPS, IES and on the Clinical Global Impressions (CGI) Severity of Illness and Global Improvement scores. In two additional placebo-controlled PTSD trials, the difference in response to treatment between patients receiving Sertraline hydrochloride and patients receiving placebo was not statistically significant. One of these additional studies was conducted in patients similar to those recruited for Studies 1 and 2, while the second additional study was conducted in predominantly male veterans.

As PTSD is a more common disorder in women than men, the majority (76%) of patients in these trials were women (152 and 139 women on sertraline and placebo versus 29 and 25 men on sertraline and placebo; Studies 1 and 2 combined). Post hoc exploratory analyses revealed a significant difference between Sertraline hydrochloride and placebo on the CAPS, IES and CGI in women, regardless of baseline diagnosis of comorbid major depressive disorder, but essentially no effect in the relatively smaller number of men in these studies. The clinical significance of this apparent gender interaction is unknown at this time. There was insufficient information to determine the effect of race or age on...
In a longer-term study, patients meeting DSM-III-R criteria for PTSD who had responded during a 24-week open trial on Sertraline hydrochloride 50-200 mg/day (n=96) were randomized to continuation of Sertraline hydrochloride or to substitution of placebo for up to 28 weeks of observation for relapse. Response during the open phase was defined as a CGI-I of 1 (very much improved) or 2 (much improved), and a decrease in the CAPS-2 score of > 30% compared to baseline. Relapse during the double-blind phase was defined as the following conditions being met on two consecutive visits: (1) CGI-I ≥ 3; (2) CAPS-2 score increased by ≥ 30% and by ≥ 15 points relative to baseline; and (3) worsening of the patient's condition in the investigator's judgment. Patients receiving continued Sertraline hydrochloride treatment experienced significantly lower relapse rates over the subsequent 28 weeks compared to those receiving placebo. This pattern was demonstrated in male and female subjects.

Premenstrual Dysphoric Disorder (PMDD) – The effectiveness of Sertraline hydrochloride for the treatment of PMDD was established in two double-blind, parallel group, placebo-controlled flexible dose trials (Studies 1 and 2) conducted over 3 menstrual cycles. Patients in Study 1 met DSM-III-R criteria for Late Luteal Phase Dysphoric Disorder (LLPDD), the clinical entity now referred to as Premenstrual Dysphoric Disorder (PMDD) in DSM-IV. Patients in Study 2 met DSM-IV criteria for PMDD. Study 1 utilized daily dosing throughout the study, while Study 2 utilized luteal phase dosing for the 2 weeks prior to the onset of menses. The mean duration of PMDD symptoms for these patients was approximately 10.5 years in both studies. Patients on oral contraceptives were excluded from these trials; therefore, the efficacy of sertraline in combination with oral contraceptives for the treatment of PMDD is unknown.

Efficacy was assessed with the Daily Record of Severity of Problems (DRSP), a patient-rated instrument that mirrors the diagnostic criteria for PMDD as identified in the DSM-IV, and includes assessments for mood, physical symptoms, and other symptoms. Other efficacy assessments included the Hamilton Depression Rating Scale (HAM-D-17), and the Clinical Global Impression Severity of Illness (CGI-S) and Improvement (CGI-I) scores.

In Study 1, involving 251 randomized patients, Sertraline hydrochloride treatment was initiated at 50 mg/day and administered throughout the menstual cycle. In subsequent cycles, patients were dosed in the range of 50-150 mg/day on the basis of clinical response and toleration. The mean dose for completers was 102 mg/day. Sertraline hydrochloride administered daily throughout the menstrual cycle was significantly more effective than placebo on change from baseline to endpoint on the DRSP total score, the HAM-D-17 total score, and the CGI-S score, as well as the CGI-I score at endpoint.

In Study 2, involving 281 randomized patients, Sertraline hydrochloride treatment was initiated at 50 mg/day in the late luteal phase (last 2 weeks) of each menstrual cycle and then discontinued at the onset of menses. In subsequent cycles, patients were dosed in the range of 50-100 mg/day in the luteal phase of each cycle, on the basis of clinical response and toleration. Patients who were titrated to 100 mg/day received 50 mg/day for the first 3 days of the cycle, then 100 mg/day for the remainder of the cycle. The mean sertraline hydrochloride dose for completers was 74 mg/day. Sertraline hydrochloride administered in the late luteal phase of the menstrual cycle was significantly more effective than placebo on change from baseline to endpoint on the DRSP total score and the CGI-S score, as well as the CGI-I score at endpoint.

There was insufficient information to determine the effect of race or age on outcome in these studies.

Social Anxiety Disorder – The effectiveness of Sertraline hydrochloride in the treatment of social anxiety disorder (also known as social phobia) was established in two multicenter placebo-controlled studies (Study 1 and 2) of adult outpatients who met DSM-IV criteria for social anxiety disorder. Study 1 was a 12-week, multicenter, flexible dose study comparing Sertraline hydrochloride (50-200 mg/day) to placebo, in which Sertraline hydrochloride was initiated at 25 mg/day for the first week. Study outcome was assessed by (a) the Liebowitz Social Anxiety Scale (LSAS), a 24-item clinician administered instrument that measures fear, anxiety and avoidance of social and performance situations, and by (b) the proportion of responders as defined by the Clinical Global Impression of Improvement (CGI-I) criterion of CGI-I ≤ 2 (very much or much improved). Sertraline hydrochloride was statistically significantly more effective than placebo as measured by the LSAS and the percentage of responders.

Study 2 was a 20-week, multicenter, flexible dose study that compared Sertraline hydrochloride (50-200 mg/day) to placebo. Study outcome was assessed by the (a) Duke Brief Social Phobia Scale (BSPP), a multi-item clinician-rated instrument that measures fear, avoidance and physiologic response to social or performance situations, (b) the Marks Fear Questionnaire Social Phobia Subscale (FQ-SPS), a 5-item patient-rated instrument that measures change in the severity of phobic avoidance and distress, and (c) the CGI-I responder criteria of ≥ 2. Sertraline hydrochloride was shown to be statistically significantly more effective than placebo as measured by the BSPP total score and fear, avoidance and physiologic factor scores, as well as the FQ-SPS total score, and to have significantly more responders than placebo as defined by the CGI-I.

Subgroup analyses did not suggest differences in treatment outcome on the basis of gender. There was insufficient information to determine the effect of race or age on outcome.

In a longer-term study, patients meeting DSM-IV criteria for social anxiety disorder who had responded while assigned to Sertraline hydrochloride (CGI-I of 1 or 2) during a 20-week placebo-controlled trial on Sertraline hydrochloride 50-200 mg/day were randomized to continuation of Sertraline hydrochloride or to substitution of placebo for up to 24 weeks of observation for relapse. Relapse was defined as ≥ 2 point increase in the Clinical Global Impression – Severity of Illness (CGI-S) score compared to baseline or study discontinuation due to lack of efficacy. Patients receiving Sertraline hydrochloride continuation treatment experienced a statistically significantly lower relapse rate over this 24-week study than patients randomized to placebo substitution.

INDICATIONS AND USAGE

Major Depressive Disorder – Sertraline hydrochloride is indicated for the treatment of major depressive disorder in adults.

The efficacy of Sertraline hydrochloride in the treatment of a major depressive episode was established in six to eight-week controlled trials of adult outpatients whose diagnoses corresponded most closely to the DSM-III category of major depressive disorder (see Clinical Trials under CLINICAL PHARMACOLOGY).

A major depressive episode implies a prominent and relatively persistent depressed or dysphoric mood that usually interferes with daily functioning (nearly every day for at least 2 weeks); it should include at least 4 of the following 8 symptoms: change in appetite, change in sleep, psychomotor agitation or retardation, loss of interest in usual activities or decrease in sexual drive, increased fatigue, feelings of guilt or worthlessness, slowed thinking or impaired concentration, and a suicide attempt or suicidal ideation.

The antidepressant action of sertraline hydrochloride in hospitalized depressed patients has not been adequately studied.
The efficacy of sertraline hydrochloride in maintaining an antidepressant response for up to 44 weeks following 28 weeks of open-label acute treatment (52 weeks total) was demonstrated in a placebo-controlled trial. The usefulness of the drug in patients receiving sertraline hydrochloride for extended periods should be reevaluated periodically (see Clinical Trials under CLINICAL PHARMACOLOGY).

**Obsessive-Compulsive Disorder**—Sertraline hydrochloride is indicated for the treatment of obsessive-compulsive disorder in patients with obsessive-compulsive disorder (OCD), as defined in the DSM-III-R; i.e., the obsessions or compulsions cause marked distress, are time-consuming, or significantly interfere with social or occupational functioning.

The efficacy of Sertraline hydrochloride was established in 12-week trials with obsessive-compulsive outpatients having diagnoses of obsessive-compulsive disorder as defined according to DSM-III or DSM-III-R criteria (see Clinical Trials under CLINICAL PHARMACOLOGY).

Obsessive-compulsive disorder is characterized by recurrent and persistent ideas, thoughts, impulses, or images (obessions) that are ego-dystonic and/or repetitive, purposeful, and intentional behaviors (compulsions) that are recognized by the person as excessive or unreasonable.

The efficacy of Sertraline hydrochloride in maintaining a response, in patients with OCD who responded during a 52-week treatment phase while taking Sertraline hydrochloride and were then observed for relapse during a period of up to 28 weeks, was demonstrated in a placebo-controlled trial (see Clinical Trials under CLINICAL PHARMACOLOGY). Nevertheless, the physician who elects to use Sertraline hydrochloride for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see DOSAGE AND ADMINISTRATION).

**Panic Disorder**—Sertraline hydrochloride is indicated for the treatment of panic disorder in adults, with or without agoraphobia, as defined in DSM-IV. Panic disorder is characterized by the occurrence of unexpected panic attacks and associated concern about having additional attacks, worry about the implications or consequences of the attacks, and/or a significant change in behavior related to the attacks.

The efficacy of Sertraline hydrochloride in maintaining a response, in adults patients with panic disorder who responded during a 52-week treatment phase while taking Sertraline hydrochloride and were then observed for relapse during a period of up to 28 weeks, was demonstrated in a placebo-controlled trial (see Clinical Trials under CLINICAL PHARMACOLOGY). Nevertheless, the physician who elects to use Sertraline hydrochloride for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see DOSAGE AND ADMINISTRATION).

**Posttraumatic Stress Disorder (PTSD)**—Sertraline hydrochloride (sertraline hydrochloride) is indicated for the treatment of posttraumatic stress disorder in adults.

The efficacy of Sertraline hydrochloride in the treatment of PTSD was established in two 12-week placebo-controlled trials of adult outpatients whose diagnosis met criteria for the DSM-III-R category of PTSD (see Clinical Trials under CLINICAL PHARMACOLOGY).

PTSD, as defined by DSM-III-R/IV, requires exposure to a traumatic event that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others, and a response which involves intense fear, helplessness, or horror. Symptoms that occur as a result of exposure to the traumatic event include reexperiencing of the event in the form of intrusive thoughts, flashbacks or dreams, and intense psychological distress and physiological reactivity on exposure to cues to the event; avoidance of situations reminiscent of the traumatic event, inability to recall details of the event, and/or numbing of general responsiveness manifested as diminished interest in significant activities, estrangement from others, restricted range of affect, or sense of foreshortened future; and symptoms of autonomic arousal including hypervigilance, exaggerated startle response, sleep disturbance, impaired concentration, and irritability or outbursts of anger. A PTSD diagnosis requires that the symptoms are present for at least a month and that they cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The efficacy of Sertraline hydrochloride in maintaining a response in adult patients with PTSD for up to 28 weeks following 24 weeks of open-label treatment was demonstrated in a placebo-controlled trial. Nevertheless, the physician who elects to use Sertraline hydrochloride for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see DOSAGE AND ADMINISTRATION).

**Premenstrual Dysphoric Disorder (PMDD)**—Sertraline hydrochloride is indicated for the treatment of premenstrual dysphoric disorder (PMDD) in adults.

The efficacy of sertraline hydrochloride in the treatment of PMDD was established in 2 placebo-controlled trials of female adult outpatients treated for 3 menstrual cycles who met criteria for the DSM-III-R/IV category of PMDD (see Clinical Trials under CLINICAL PHARMACOLOGY).

The essential features of PMDD include markedly depressed mood, anxiety or tension, affective lability, and persistent anger or irritability. Other features include decreased interest in activities, difficulty concentrating, lack of energy, change in appetite or sleep, and feeling out of control. Physical symptoms associated with PMDD include breast tenderness, headache, joint and muscle pain, bloating and weight gain. These symptoms occur regularly during the luteal phase and remit within a few days following onset of menses; the disturbance markedly interferes with work or school or with usual social activities and relationships with others. In making the diagnosis, care should be taken to rule out other cyclical mood disorders that may be exacerbated by treatment with an antidepressant.

The effectiveness of Sertraline hydrochloride in long-term use, that is, for more than 3 menstrual cycles, has not been systematically evaluated in controlled trials. Therefore, the physician who elects to use Sertraline hydrochloride for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see DOSAGE AND ADMINISTRATION).

**Social Anxiety Disorder**—Sertraline hydrochloride is indicated for the treatment of social anxiety disorder, also known as social phobia in adults.

The efficacy of Sertraline hydrochloride in the treatment of social anxiety disorder was established in two placebo-controlled trials of adult outpatients with a diagnosis of social anxiety disorder as defined...
by DSM-IV criteria (see Clinical Trials under CLINICAL PHARMACOLOGY).

Social anxiety disorder, as defined by DSM-IV, is characterized by marked and persistent fear of social or performance situations involving exposure to unfamiliar people or possible scrutiny by others and by fears of acting in a humiliating or embarrassing way. Exposure to the feared social situation almost always provokes anxiety and feared social or performance situations are avoided or else are endured with intense anxiety or distress. In addition, patients recognize that the fear is excessive or unreasonable and the avoidance and anticipatory anxiety of the feared situation is associated with functional impairment or marked distress.

The efficacy of Sertraline hydrochloride in maintaining a response in adult patients with social anxiety disorder for up to 24 weeks following 20 weeks of Sertraline hydrochloride treatment was demonstrated in a placebo-controlled trial. Physicians who prescribe Sertraline hydrochloride for extended periods should periodically reevaluate the long-term usefulness of the drug for the individual patient (see Clinical Trials under CLINICAL PHARMACOLOGY).

CONTRAINDICATIONS

All Dosage Forms of Sertraline:

The use of MAOIs intended to treat psychiatric disorders with Sertraline hydrochloride or within 14 days of stopping treatment with Sertraline hydrochloride is contraindicated because of an increased risk if serotonin syndrome. The use of Sertraline hydrochloride within 14 days of stopping an MAO intended to treat psychiatric disorders is also contraindicated (see WARNINGS and DOSAGE AND ADMINISTRATION).

Starting Sertraline hydrochloride in a patient who is being treated with MAOIs such as linezolid or intravenous methylene blue is also contraindicated because of an increased risk of serotonin syndrome (see WARNINGS and DOSAGE AND ADMINISTRATION).

Concomitant use in patients taking pimozide is contraindicated (see PRECAUTIONS).

Sertraline is contraindicated in patients with a hypersensitivity to sertraline or any of the inactive ingredients in sertraline hydrochloride tablets.

WARNINGS

Clinical Worsening and Suicide Risk

Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medication, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment.

Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older.

The pooled analyses of placebo-controlled trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 29 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) are provided in Table 1.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>-14 additional cases</td>
</tr>
<tr>
<td>18-24</td>
<td>5 additional cases</td>
</tr>
<tr>
<td>25-64</td>
<td>-1 fewer case</td>
</tr>
<tr>
<td>&gt;65</td>
<td>-6 fewer cases</td>
</tr>
</tbody>
</table>

No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide.

It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression.

All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality.

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient’s presenting symptoms.

If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is
occurrence of gastrointestinal bleeding. Bleeding events related to SSRIs and SNRIs use have ranged
demonstrated an association between use of drugs that interfere with serotonin reuptake and the
Concomitant use of aspirin, nonsteroidal anti-inflammatory drugs, warfarin, and other anticoagulants
SSRIs and SNRIs, including Sertraline hydrochloride, may increase the risk of bleeding events.

**Abnormal Bleeding**

Administration

may continue decreasing the dose but at a more gradual rate (see

Discontinuation of Treatment with Sertraline hydrochloride should be considered.

Abnormal Bleeding: The development of a potentially life-threatening serotonin syndrome has been reported with SNRIs and SSRIs, including Sertraline hydrochloride, alone but particularly with concomitant use of other serotonergic drugs (including triptans, tricyclic antidepressants, fentanyl, lithium, tramadol, tryptophan, buspirone, and St. John's Wort) and with drugs that impair metabolism of serotonin (in particular, MAOIs, both those intended to treat psychiatric disorders and also others, such as linezolid and intravenous methylene blue).

Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, delirium, and coma), neuropsychiatric symptoms (e.g., dysphoric mood, derealization, disorientation), autonomic instability (e.g., tachycardia, labile blood pressure, diaphoresis, flushing, hyperthermia), neuromuscular symptoms (e.g., tremor, rigidity, myoclonus, hyperreflexia, incoordination), seizures, and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). Patients should be monitored for the emergence of serotonin syndrome.

The concomitant use of sertraline hydrochloride with MAOIs intended to treat psychiatric disorders is contraindicated. Sertraline hydrochloride should also not be started in a patient who is being treated with MAOIs such as linezolid or intravenous methylene blue. All reports with methylene blue that provided information on the route of administration involved intravenous administration in the dose range of 1 mg/kg to 8 mg/kg. No reports involved the administration of methylene blue by other routes (such as oral tablets or local tissue injection) or at lower doses. There may be circumstances when it is necessary to initiate treatment with a MAOI such as linezolid or intravenous methylene blue in a patient taking sertraline hydrochloride. Sertraline hydrochloride should be discontinued before initiating treatment with the MAOI (see CONTRAINDICATIONS and DOSAGE AND ADMINISTRATION).

If concomitant use of sertraline hydrochloride with other serotonergic drugs including triptans, tricyclic antidepressants, fentanyl, lithium, tramadol, buspirone, tryptophan, and St. John's Wort is clinically warranted, patients should be made aware of a potential increased risk for serotonin syndrome, particularly during treatment initiation and dose increases.

Treatment with Sertraline hydrochloride and any concomitant serotonergic agents should be discontinued immediately if the above events occur and supportive symptomatic treatment should be initiated.

**Angle-Closure Glaucoma:** The pupillary dilation that occurs following use of many antidepressant drugs including sertraline may trigger an angle closure attack in a patient with anatomically narrow angles who does not have a patent iridectomy.

**PRECAUTIONS**

**General**

Activation of Mania/Hypomania—During premarketing testing, hypomania or mania occurred in approximately 0.4% of sertraline hydrochloride treated patients.

Weight Loss—Significant weight loss may be an undesirable result of treatment with Sertraline for some patients, but on average, patients in controlled trials had minimal, 1 to 2 pound weight loss, versus smaller changes on placebo. Only rarely have sertraline patients been discontinued for weight loss.

Seizure—Sertraline hydrochloride has not been evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarket testing. No seizures were observed among approximately 3000 patients treated with sertraline hydrochloride in the development program for major depressive disorder. However, 4 patients out of approximately 1800 (220 <18 years of age) exposed during the development program for another disorder experienced seizures, representing a crude incidence of 0.2%. Three of these patients were adolescents, two with a seizure disorder and one with a family history of seizure disorder, none of whom were receiving anticonvulsant medication. Accordingly, sertraline hydrochloride should be introduced with care in patients with a seizure disorder.

Discontinuation of Treatment with Sertraline hydrochloride

During marketing of Sertraline hydrochloride and other SSRIs and SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, somnolence, hypomania, and mania. While these events are generally self-limiting, there have been reports of serious discontinuation syndromes. Patients should be monitored for these symptoms when discontinuing treatment with sertraline hydrochloride. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. 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 (see DOSAGE AND ADMINISTRATION).

Abnormal Bleeding

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

Patients should be cautioned about the risk of bleeding associated with the concomitant use of sertraline hydrochloride and NSAIDs, aspirin, or other drugs that affect coagulation.

**Weak Uricosuric Effect**—Sertraline hydrochloride is associated with a mean decrease in serum uric acid of approximately 7%. The clinical significance of this weak uricosuric effect is unknown.

**Use in Patients with Concomitant Illness**—Clinical experience with sertraline hydrochloride in patients with certain concomitant systemic illness is limited. Caution is advisable in using sertraline hydrochloride in patients with diseases or conditions that could affect metabolism or hemodynamic responses.

Patients with a recent history of myocardial infarction or unstable heart disease were excluded from clinical studies during the product's premarket testing. However, the electrocardiogram of 774 patients who received sertraline hydrochloride in double-blind trials were evaluated and the data indicate that sertraline hydrochloride is not associated with the development of significant ECG abnormalities.

Sertraline hydrochloride administered in a flexible dose range of 50 to 200 mg/day (mean dose of 89 mg/day) was evaluated in a post-marketing, placebo-controlled trial of 372 randomized subjects with a DSM-IV diagnosis of major depressive disorder and recent history of myocardial infarction or unstable angina requiring hospitalization. Exclusion from this trial included, among others, patients with uncontrolled hypertension, need for cardiac surgery, history of CABG within 3 months of index event, severe or symptomatic bradycardia, non-atherosclerotic cause of angina, clinically significant renal impairment (creatinine > 2.5 mg/dl), and clinically significant hepatic dysfunction. Sertraline hydrochloride treatment initiated during the acute phase of recovery (within 30 days post-MI or post-hospitalization for unstable angina) was indistinguishable from placebo in this study on the following week 16 treatment endpoints: left ventricular ejection fraction, total cardiovascular events (angina, chest pain, edema, palpitations, syncope, postural dizziness, CHF, MI, tachycardia, bradycardia, and changes in BP), and major cardiovascular events involving death or requiring hospitalization (for MI, CHF, stroke, or angina).

Sertraline hydrochloride is extensively metabolized by the liver. In patients with chronic mild liver impairment, sertraline clearance was reduced, resulting in increased AUC, Cmax, and elimination half-life. The effects of sertraline in patients with moderate and severe hepatic impairment have not been studied. The use of sertraline in patients with liver disease must be approached with caution. If sertraline is administered to patients with liver impairment, a lower or less frequent dose should be used (see CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION).

Since Sertraline hydrochloride is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. A clinical study comparing sertraline pharmacokinetics in healthy volunteers to that in patients with renal impairment ranging from mild to severe (requiring dialysis) indicated that the pharmacokinetics and protein binding are unaffected by renal disease. Based on the pharmacokinetic results, there is no need for dosage adjustment in patients with renal impairment (see CLINICAL PHARMACOLOGY).

**Interference with Cognitive and Motor Performance**—In controlled studies, Sertraline hydrochloride did not cause sedation and did not interfere with psychomotor performance. (See Information for Patients.)

**Hyponatremia**—Hyponatremia may occur as a result of treatment with SSRIs and SNRIs, including sertraline hydrochloride. In many cases, this hyponatremia appears to be the result of the syndrome of inappropriate antidiuretic hormone secretion (SIADH). Cases with serum sodium lower than 110 mEq/L have been reported. Elderly patients may be at greater risk of developing hyponatremia with SSRIs and SNRIs. Also, patients taking diuretics or who are otherwise volume depleted may be at greater risk (see GERIATRIC USE). Discontinuation of sertraline hydrochloride should be considered in patients with symptomatic hyponatremia and appropriate medical intervention should be instituted.

Signs and symptoms of hyponatremia 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.

**Platelet Function**—There have been rare reports of altered platelet function and/or abnormal results from laboratory studies in patients taking sertraline hydrochloride. While there have been reports of abnormal bleeding or purpura in several patients taking sertraline hydrochloride, it is unclear whether sertraline hydrochloride had a causative role.

**Information for Patients**

Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with sertraline hydrochloride and should counsel them in its appropriate use. A patient Medication Guide about "Antidepressant Medicines, Depression and Other Serious Mental Illness, and Suicidal Thoughts or Actions" is available for sertraline hydrochloride. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. The complete text of the Medication Guide is reprinted at the end of this document.

Patients should be advised of the following issues and asked to alert their prescriber if these occur while taking Sertraline hydrochloride.

**Clinical Worsening and Suicide Risk:** Patients, their families, and their caregivers should be encouraged to alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation especially early during antidepressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to look for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication.

Patients should be cautioned about the risk of serotonin syndrome with the concomitant use of SNRIs and SSRIs, including sertraline hydrochloride, and triptans, tramadol, or other serotonergic agents.

Patients should be told that although Sertraline hydrochloride has not been shown to impair the ability of normal subjects to perform tasks requiring complex motor and mental skills in laboratory experiments, drugs that act upon the central nervous system may affect some individuals adversely. Therefore, patients should be told that until they learn how they respond to Sertraline hydrochloride they should be careful doing activities when they need to be alert, such as driving a car or operating machinery.
Patients should be cautioned about the concomitant use of sertraline hydrochloride and NSAIDs, aspirin, warfarin, or other drugs that affect coagulation since combined use of psychotropic drugs that interfere with serotonin reuptake and these agents has been associated with an increased risk of bleeding.

Patients should be told that although sertraline hydrochloride has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of sertraline hydrochloride and alcohol is not advised.

Patients should be told that while no adverse interactions of sertraline hydrochloride with over-the-counter (OTC) drug products is known to occur, the potential for potential exists. Thus, the use of any OTC product should be initiated cautiously according to the directions of use given for the OTC product.

Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy.

Patients should be advised to notify their physician if they are breast feeding an infant.

Laboratory 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.

Drug Interactions
Potential Effects of Coadministration of Drugs Highly Bound to Plasma Proteins—Because sertraline is tightly bound to plasma protein, the administration of sertraline hydrochloride to a patient taking another drug which is tightly bound to protein (e.g., warfarin, digitoxin) may cause a shift in plasma concentrations potentially resulting in an adverse effect. Conversely, adverse effects may result from displacement of protein-bound sertraline hydrochloride by other tightly bound drugs.

In a study comparing prothrombin time AUC (0-120 hr) following dosing with warfarin (0.75 mg/kg) and placebo, there was a mean increase in prothrombin time of 8% relative to baseline for sertraline hydrochloride compared to a 1% decrease for placebo (p<0.03). The normalization of prothrombin time for the sertraline hydrochloride group was delayed compared to the placebo group. The clinical significance of this change is unknown. Accordingly, prothrombin time should be carefully monitored when sertraline hydrochloride therapy is initiated or stopped.

Cimetidine—In a study assessing disposition of sertraline hydrochloride (100 mg) on the second of 8 days of cimetidine administration (800 mg daily), there were significant increases in sertraline hydrochloride mean AUC (50%), C∞ (24%) and half-life (26%) compared to the placebo group. The clinical significance of these changes is unknown.

CNS Active Drugs—In a study comparing the disposition of intravenously administered diazepam before and after 21 days of dosing with either sertraline hydrochloride (50 to 200 mg/day) or placebo, there was a 32% decrease relative to baseline in diazepam clearance for the sertraline hydrochloride group compared to a 19% decrease relative to baseline for the placebo group (p<0.03). There was a 23% increase in T1/2 for desmethyldiazepam in the sertraline hydrochloride group compared to a 20% decrease in the placebo group (p<0.03). The clinical significance of these changes is unknown.

In a placebo-controlled trial in normal volunteers, the administration of two doses of Sertraline hydrochloride did not significantly alter steady-state lithium levels or the renal clearance of lithium. Nonetheless, at this time, it is recommended that plasma lithium levels be monitored following initiation of Sertraline hydrochloride therapy with appropriate adjustments to the lithium dose.

In a controlled study of a single dose (2 mg) of pimozide, 200 mg sertraline (q.d) co-administration to steady state was associated with a mean increase in pimozide AUC and Cmax of about 40%, but was not associated with any changes in EKG. Since the highest recommended pimozide dose (10 mg) has not been evaluated in combination with sertraline, the effect on QT interval and PK parameters at doses higher than 2 mg at this time are not known. While the mechanism of this interaction is unknown, due to the narrow therapeutic index of pimozide and due to the interaction noted at a low dose of pimozide, concomitant administration of Sertraline hydrochloride and pimozide should be contraindicated (see CONTRAINDICATIONS).

Results of a placebo-controlled trial in normal volunteers suggest that chronic administration of sertraline 200 mg/day does not produce clinically important inhibition of phenytoin metabolism. Nonetheless, at this time, it is recommended that plasma phenytoin concentrations be monitored following initiation of Sertraline Hydrochloride therapy with appropriate adjustments to the phenytoin dose, particularly in patients with multiple underlying medical conditions and/or those receiving multiple concomitant medications.

The effect of Sertraline hydrochloride on valproate levels has not been evaluated in clinical trials. In the absence of such data, it is recommended that plasma valproate levels be monitored following initiation of Sertraline hydrochloride therapy with appropriate adjustments to the valproate dose.

The risk of using sertraline hydrochloride in combination with other CNS active drugs has not been systematically evaluated. Consequently, caution is advised if the concomitant administration of sertraline hydrochloride and such drugs is required.

There is limited controlled experience regarding the optimal timing of switching from other drugs effective in the treatment of major depressive disorder, premenstrual dysphoric disorder to sertraline hydrochloride. Care and prudent medical judgment should be exercised when switching, particularly from long-acting agents. The duration of an appropriate washout period which should intervene before switching from one selective serotonin reuptake inhibitor (SSRI) to another has not been established.

Monoamine Oxidase Inhibitors—See CONTRAINDICATIONS, WARNINGS and DOSAGE AND ADMINISTRATION.

Drugs Metabolized by P450 3A4—In three separate in vivo interaction studies, sertraline was co-administered with cytochrome P450 3A4 substrates, terfenadine, carbamazepine, or cisapride under steady-state conditions. The results of these studies indicated that sertraline did not increase plasma concentrations of terfenadine, carbamazepine, or cisapride. These data indicate that sertraline’s extent of inhibition of P450 3A4 activity is not likely to be of clinical significance. Results of the interaction study with cisapride indicate that sertraline 200 mg (q.d.) induces the metabolism of cisapride (cisapride AUC and Cmax were reduced by about 35%).

Drugs Metabolized by P450 2D6—Many drugs effective in the treatment of major depressive disorder, e.g., the SSRIs, including sertraline, and most tricyclic antidepressant drugs effective in the treatment of major depressive disorder inhibit the biochemical activity of the drug metabolizing
female rats received sertraline during the last third of gestation and throughout lactation, there was an extension of organogenesis, delayed ossification was observed in fetuses at doses of 10 mg/kg (0.5 times the maximum recommended human dose (MRHD) on a mg/m² basis). These doses correspond to approximately 4 times the maximum recommended human dose of sertraline hydrochloride in male mice receiving sertraline at 10-40 mg/kg (0.25-1.0 times the MRHD on a mg/m² basis) in rabbits. When concomitant treatment with sumatriptan and an SSRI (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline) is clinically warranted, appropriate observation of the patient is advised.

Tricyclic Antidepressant Drugs Effective in the Treatment of Major Depressive Disorder (TCAs) — The extent to which SSRI–TCA interactions may pose clinical problems will depend on the degree of inhibition and the pharmacokinetics of the SSRI involved. Nevertheless, caution is indicated in the co-administration of TCAs with sertraline hydrochloride, because sertraline may inhibit TCA metabolism. Plasma TCA concentrations may need to be monitored, and the dose of TCA may need to be reduced, if a TCA is co-administered with sertraline hydrochloride (see Drugs Metabolized by P450 2D6 under PRECAUTIONS).

Hypoglycemic Drugs — In a placebo-controlled trial in normal volunteers, administration of sertraline hydrochloride for 22 days (including 200 mg/day for the last 13 days) caused a statistically significant 16% decrease in the clearance of tolbutamide following an intravenous 1000 mg dose. Sertraline hydrochloride administration did not noticeably change either the plasma protein binding or the apparent volume of distribution of tolbutamide, suggesting that the decreased clearance was due to a change in the metabolism of the drug. The clinical significance of this decrease in tolbutamide clearance is unknown.

Ate bromide — Sertraline hydrochloride (100 mg) when administered to 10 healthy male subjects had no effect on the beta-adrenergic blocking ability of atenolol.

Digoxin — In a placebo-controlled trial in normal volunteers, administration of sertraline hydrochloride for 17 days (including 200 mg/day for the last 10 days) did not change serum digoxin levels or digoxin renal clearance.

Microsomal Enzyme Induction — Preclinical studies have shown sertraline hydrochloride to induce hepatic microsomal enzymes. In clinical studies, sertraline hydrochloride was shown to induce hepatic enzymes minimally as determined by a small (5%) but statistically significant decrease in antipyrine half-life following administration of 200 mg/day for 21 days. This small change in antipyrine half-life reflects a clinically insignificant change in hepatic metabolism.

Diazepam — Sertraline had no genotoxic effects, with or without metabolic activation, based on the following assays: bacterial mutation assay; mouse lymphoma mutation assay, and tests for cytogenetic aberrations in vivo in mouse bone marrow and in vitro in human lymphocytes.

Impairment of Fertility — A decrease in fertility was seen in one of two rat studies at a dose of 80 mg/kg (4 times the maximum recommended human dose on a mg/m² basis).
increase in the number of stillborn pups and in the number of pups dying during the first 4 days after
birth. Pup body weights were also decreased during the first four days after birth. These effects
occurred at a dose of 20 mg/kg (1 times the MRHD on a mg/m² basis). The no effect dose for rat pup
mortality was 10 mg/kg (0.5 times the MRHD on a mg/m² basis). The decrease in pup survival was
shown to be a dose-dependent exposure to sertraline. The clinical significance of these effects is
unknown. There are no adequate and well-controlled studies in pregnant women. Sertraline
hydrochloride should be used during pregnancy only if the potential benefit justifies the potential risk
to the fetus.

**Pregnancy-Nonteratogenic Effects**

Neonates exposed to sertraline hydrochloride and other SSRIs or SNRIs, late in the third trimester have
developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. These findings are based on postmarketing reports. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hyperglycemia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with
serotonin syndrome (see WARNINGS:Serotonin Syndrome).

Infants exposed to SSRIs in pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1 – 2 per 1,000 live births in the general population and is associated with substantial neonatal morbidity and mortality. Several recent epidemiologic studies suggest a positive statistical association between SSRI use (including sertraline hydrochloride) in pregnancy and PPHN. Other studies do not show a significant statistical association.

Physicians should also note the results of a prospective longitudinal study of 201 pregnant women with a
history of major depression, who were either on antidepressants or had received antidepressants less
than 12 weeks prior to their last menstrual period, and were in remission. Women who discontinued
antidepressant medication during pregnancy showed a significant increase in relapse of their major
depression compared to those women who remained on antidepressant medication throughout
pregnancy.

When treating a pregnant woman with sertraline hydrochloride, the physician should carefully consider
both the potential risks of taking an SSRI, along with the established benefits of treating depression with
an antidepressant. This decision can only be made on a case by case basis (see DOSAGE AND
ADMINISTRATION).

**Labor and Delivery**

The effect of sertraline hydrochloride on labor and delivery in humans is unknown.

**Nursing Mothers**

It is not known whether, and if so in what amount, sertraline or its metabolites are
excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised
when sertraline hydrochloride is administered to a nursing woman.

**Pediatric Use**

The efficacy of Sertraline hydrochloride for the treatment of obsessive-compulsive
disorder was demonstrated in a 12-week, multicenter, placebo-controlled study with 187 outpatients
ages 6-17 (see Clinical Trials under CLINICAL PHARMACOLOGY). Safety and effectiveness in the
pediatric population other than pediatric patients with OCD have not been established (see BOX
WARNING and WARNINGS:Clinical Worsening and Suicide Risk). Two placebo controlled trials
(n=373) in pediatric patients with MDD have been conducted with sertraline hydrochloride, and the data
were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of
Sertraline hydrochloride in a child or adolescent must balance the potential risks with the clinical need.

The safety of Sertraline hydrochloride use in children and adolescents with OCD, ages 6-18, was
evaluated in a 12-week, multicenter, placebo-controlled study with 187 outpatients, ages 6-17, and in a
flexible dose, 52 week open extension study of 137 patients, ages 6-18, who had completed the initial
12week, double-blind, placebo-controlled study. Sertraline hydrochloride was administered at doses of
either 25 mg/day (children, ages 6-12) or 50 mg/day (adolescents, ages 13-18) and then titrated in
weekly 25 mg/day or 50 mg/day increments, respectively, to a maximum dose of 200 mg/day based upon
clinical response. The mean dose for completers was 157 mg/day. In the acute 12 week pediatric study
and in the 52 week study, Sertraline hydrochloride had an adverse event profile generally similar to that
observed in adults.

Sertraline pharmacokinetics were evaluated in 61 pediatric patients between 6 and 17 years of age
with major depressive disorder or OCD and revealed similar drug exposures to those of adults when plasma
concentration was adjusted for weight (see Pharmacokinetics under CLINICAL PHARMACOLOGY).

Approximately 600 patients with major depressive disorder or OCD between 6 and 17 years of age
have received Sertraline hydrochloride in clinical trials, both controlled and uncontrolled. The adverse
event profile observed in these patients was generally similar to that observed in adult studies with
sertraline hydrochloride (see ADVERSE REACTIONS). As with other SSRIs, decreased appetite and
weight loss have been observed in association with the use of Sertraline hydrochloride. In a pooled
analysis of two 10-week, double-blind, placebo-controlled, flexible dose (50-200 mg) outpatient trials
for major depressive disorder (n=373), there was a difference in weight change between sertraline and
placebo of roughly 1 kilogram, for both children (ages 6-11) and adolescents (ages 12-17), in both
cases representing a slight weight loss for sertraline compared to a slight gain for placebo. At baseline
the mean weight for children was 39.0 kg for sertraline and 38.5 kg for placebo. At baseline the mean
weight for adolescents was 61.4 kg for sertraline and 62.5 kg for placebo. There was a bigger
difference between sertraline and placebo in the proportion of outliers for clinically important weight
loss in children than in adolescents. For children, about 7% had a weight loss > 7% of body weight
compared to none of the placebo patients; for adolescents, about 2% had a weight loss > 7% of body
weight compared to about 1% of the placebo patients. A subset of these patients who completed the
randomized controlled trials (sertraline n=99, placebo n=122) were continued into a 24-week, flexible-
dose, open-label, extension study. A mean weight loss of approximately 0.5 kg was seen during the first
eight weeks of treatment for subjects with first exposure to sertraline during the open-label extension
study, similar to mean weight loss observed among sertraline treated subjects during the first eight
weeks of the randomized controlled trials. The subjects continuing in the open label study began gaining
weight compared to baseline by week 12 of sertraline treatment. Those subjects who completed 34
weeks of sertraline treatment (10 weeks in a placebo controlled trial + 24 weeks open label, n=68) had
weight gain that was similar to that expected using data from age-adjusted peers. Regular monitoring of
weight and growth is recommended if treatment of a pediatric patient with an SSRI is to be continued
long term. Safety and effectiveness in pediatric patients below the age of 6 have not been established.

The risks, if any, that may be associated with Sertraline hydrochloride's use beyond 1 year in children
and adolescents with OCD or major depressive disorder have not been systematically assessed. The
prescriber should be mindful that the evidence relied upon to conclude that sertraline is safe for use in
children and adolescents derives from clinical studies that were 10 to 52 weeks in duration and from the
extrapolation of experience gained with adult patients. In particular, there are no studies that directly
evaluate the effects of long-term sertraline use on the growth, development, and maturation of children
and adolescents. Although there is no affirmative finding to suggest that sertraline possesses a capacity
to adversely affect growth, development or maturation, the absence of such findings is not compelling evidence of the absence of the potential of sertraline to have adverse effects in chronic use (see WARNINGS – Clinical Worsening and Suicide Risk).

Geriatric Use—U.S. geriatric clinical studies of Sertraline hydrochloride in major depressive disorder included 663 Sertraline hydrochloride -treated subjects ≥ 65 years of age, of those, 180 were ≥ 75 years of age. No overall differences in the pattern of adverse reaction were observed in the geriatric clinical trial subjects relative to those reported in younger subjects (see ADVERSE REACTIONS), and other reported experience has not identified differences in safety patterns between the elderly and younger subjects. As with all medications, greater sensitivity of some older individuals cannot be ruled out. There were 947 subjects in placebo-controlled geriatric clinical studies of Sertraline hydrochloride in major depressive disorder. No overall differences in the pattern of efficacy were observed in the geriatric clinical trial subjects relative to those reported in younger subjects.

Other Adverse Events in Geriatric Patients. In 354 geriatric subjects treated with Sertraline hydrochloride in placebo-controlled trials, the overall profile of adverse events was generally similar to that shown in Tables 2 and 3. Urinary tract infection was the only adverse event not appearing in Tables 2 and 3 and reported at an incidence of at least 2% and at a rate greater than placebo in placebo-controlled trials.

SSRIS and SNRIs, including Sertraline hydrochloride, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse event (see PRECAUTIONS, Hyponatremia).

ADVERSE REACTIONS

During its premarketing assessment, multiple doses of sertraline hydrochloride were administered to over 4000 adult subjects as of February 18, 2000. The conditions and duration of exposure to sertraline hydrochloride varied greatly, and included (in overlapping categories) clinical pharmacology studies, open and double-blind studies, uncontrolled and controlled studies, inpatient and outpatient studies, fixed-dose and titration studies, and studies for multiple indications, including major depressive disorder and PMDD.

Untoward events associated with this exposure were recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of untoward events into a smaller number of standardized event categories.

In the tabulations that follow, a World Health Organization dictionary of terminology has been used to classify reported adverse events. The frequencies presented, therefore, represent the proportion of the over 4000 adult subjects exposed to multiple doses of sertraline hydrochloride who experienced a treatment-emergent adverse event of the type cited on at least one occasion while receiving sertraline hydrochloride. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. It is important to emphasize that events reported during therapy were not necessarily caused by it.

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

Incidence in Placebo-Controlled Trials—Table 2 enumerates the most common treatment-emergent adverse events associated with the use of Sertraline hydrochloride (incidence of at least 5% for Sertraline hydrochloride and at least twice that for placebo within at least one of the indications) for the treatment of adult patients with major depressive disorder/other*, OCD, panic disorder, PTSD, PMDD and social anxiety disorder in placebo-controlled clinical trials. Most patients in major depressive disorder/other*, OCD, panic disorder, PTSD and social anxiety disorder studies received doses of 50 to 200 mg/day. Patients in the PMDD study with daily dosing throughout the menstrual cycle received doses of 50 to 150 mg/day, and in the PMDD study with dosing during the luteal phase of the menstrual cycle received doses of 50 to 100 mg/day. Table 3 enumerates treatment-emergent adverse events that occurred in 2% or more of adult patients treated with Sertraline hydrochloride and with incidence greater than placebo who participated in controlled clinical trials comparing Sertraline hydrochloride with placebo in the treatment of major depressive disorder/other*, OCD, panic disorder, PTSD, PMDD and social anxiety disorder. Table 3 provides combined data for the pool of studies that are provided separately by indication in Table 2.

<table>
<thead>
<tr>
<th>Body System/Adverse Event</th>
<th>Percentage of Patients Reporting Event</th>
<th>Major</th>
<th>Depressive Disorder/Other*</th>
<th>OCD</th>
<th>Panic Disorder</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomic Nervous System Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ejaculation Failure (1)</td>
<td></td>
<td>7</td>
<td>&lt;1</td>
<td>17</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Mouth Dry</td>
<td></td>
<td>16</td>
<td>9</td>
<td>14</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Sweating Increased</td>
<td></td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Center. &amp; Peripheral Nervous. System Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somnolence</td>
<td></td>
<td>13</td>
<td>6</td>
<td>15</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Tremor</td>
<td></td>
<td>11</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td>12</td>
<td>7</td>
<td>17</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td>11</td>
<td>8</td>
<td>14</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Malaise</td>
<td></td>
<td>&lt;1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td></td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Anorexia</td>
<td></td>
<td>3</td>
<td>2</td>
<td>11</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Diarrhea/Loose Stools</td>
<td></td>
<td>16</td>
<td>9</td>
<td>24</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td></td>
<td>6</td>
<td>3</td>
<td>10</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td>26</td>
<td>12</td>
<td>30</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>Psychiatric Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agitation</td>
<td></td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
<td>16</td>
<td>9</td>
<td>28</td>
<td>12</td>
<td>25</td>
</tr>
</tbody>
</table>
Table 4 lists the adverse events associated with discontinuation of Sertraline hydrochloride treatment in placebo-controlled clinical trials. The table presents the percentage of patients reporting each adverse event, categorized by body system and adverse event. The adverse events are reported for various disorders, including major depressive disorder, other mood disorders, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), premenstrual dysphoric disorder (PMDD), and social anxiety disorder. The table also includes a comparison between placebo and sertraline treatment groups.

### TABLE 4 MOST COMMON ADVERSE EVENTS ASSOCIATED WITH DISCONTINUATION IN PLACEBO-CONTROLLED CLINICAL TRIALS

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>Major Depressive Disorder/Other*</th>
<th>OCD</th>
<th>Panic Disorder</th>
<th>PTSD</th>
<th>PMDD Daily</th>
<th>PMDD Luteal Phase Dosing</th>
<th>Social Anxiety Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive Disorder/Other*</td>
<td>Sertraline (N=2799)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>OCD</td>
<td>N=121</td>
<td>N=122</td>
<td>N=136</td>
<td>N=127</td>
<td>N=344</td>
<td>N=268</td>
<td></td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>N=430</td>
<td>N=374</td>
<td>N=344</td>
<td>N=136</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>N=861</td>
<td>N=121</td>
<td>N=121</td>
<td>N=121</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMDD Daily</td>
<td>N=344</td>
<td>N=121</td>
<td>N=121</td>
<td>N=121</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Anxiety Disorder</td>
<td>N=344</td>
<td>N=121</td>
<td>N=121</td>
<td>N=121</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Male and Female Sexual Dysfunction with SSRIs

Although changes in sexual desire, sexual performance and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that selective serotonin reuptake inhibitors (SSRIs) can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling, are likely to underestimate their actual incidence.

Table 5 below displays the incidence of sexual side effects reported by at least 2% of patients taking Sertraline hydrochloride in placebo-controlled trials.

<table>
<thead>
<tr>
<th>TABLE 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adverse Event</strong></td>
</tr>
<tr>
<td>Ejaculation failure (primarily delayed ejaculation)</td>
</tr>
<tr>
<td>Decreased libido*</td>
</tr>
</tbody>
</table>

*Denominator used was for male patients only (N=1118 Sertraline hydrochloride; N=926 placebo)

**Denominator used was for male and female patients (N=2793 Sertraline hydrochloride; N=2394 placebo)

There are no adequate and well-controlled studies examining sexual dysfunction with sertraline treatment.

Priapism has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects.

Other Adverse Events in Pediatric Patients—In over 600 pediatric patients treated with Sertraline hydrochloride, the overall profile of adverse events was generally similar to that seen in adult studies. However, the following adverse events, from controlled trials, not appearing in Tables 2 and 3, were reported at an incidence of at least 2% and occurred at a rate of at least twice the placebo rate (N=281 patients treated with Sertraline hydrochloride): fever, hyperkinesia, urinary incontinence, aggressive reaction, sinusitis, epistaxis and purpura.

Other Events Observed During the Premarketing Evaluation of Sertraline hydrochloride—Following is a list of treatment-emergent adverse events reported during premarketing assessment of Sertraline hydrochloride in clinical trials (over 4000 adult subjects) except those already listed in the previous tables or elsewhere in labeling.

In the tabulations that follow, a World Health Organization dictionary of terminology has been used to classify reported adverse events. The frequencies presented, therefore, represent the proportion of the over 4000 adult individuals exposed to multiple doses of Sertraline hydrochloride who experienced an event of the type cited on at least one occasion while receiving Sertraline hydrochloride. All events are over 4000 adult individuals exposed to multiple doses of Sertraline hydrochloride who experienced an event of the type cited on at least one occasion while receiving Sertraline hydrochloride. All events are categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. Events of major clinical importance are also described in the PRECAUTIONS section.

Autonomic Nervous System Disorders—Frequent: impotence; Infrequent: flushing, increased saliva, cold clammy skin, mydriasis; Rare: paller, glaucoma, priapism, vasodilatation.

Body as a Whole—General Disorders—Rare: allergic reaction, allergy.

Cardiovascular—Frequent: palpitation, chest pain; Infrequent: hypertension, tachycardia, postural dizziness, postural hypotension, periorbital edema, peripheral edema, hypoesthesia, peripheral ischemia, syncope, edema, dependent edema; Rare: precordial chest pain, substernal chest pain, aggravated hypertension, myocardial infarction, cerebrovascular disorder.

Central and Peripheral Nervous System Disorders—Frequent: hypertonia, hyporeflexia; Infrequent: twitching, confusion, hypokinesia, vertigo, ataxia, migraine, abnormal coordination, hyperesthesia, leg cramps, abnormal gait, nystagmus, dysphonia, dizziness, hypotonia, ptosis, choreathetosis, dyskinesia.

Disorders of Skin and Appendages—Infrequent: puritus, acne, urticaria, alopecia, dry skin, erythematous rash, photosensitivity reaction, maculopapular rash; Rare: follicular rash, eczema, dermatitis, contact dermatitis, bullous eruption, hypertrichosis, skin discoloration, purpura.

Endocrine Disorders—Rare: exophthalmus, gynecomastia.
Gastrointestinal Disorders—Frequent: appetite increased; Infrequent: dysphagia, tooth carries
aggravated, eructation, esophagitis, gastroenteritis; Rare: melena, glossitis, gum hyperplasia, hiccup,
 stomatitis, pancreatitis, colitis, diverticulitis, fecal incontinence, gastritis, rectum hemorrhage,
 hemorrhagic peptic ulcer, proctitis, ulcerative stomatitis, tongue edema, tongue ulceration.

General—Frequent: back pain, asthenia, malaise, weight increase; Infrequent: fever, rigors, generalized
 edema; Rare: face edema, aphthous stomatitis.

Hearing and Vestibular Disorders—Rare: hyperacusis, labyrinthine disorder.

Hematopoietic and Lympathic—Rare: anaemia, anterior chamber eye hemorrhage.

Liver and Biliary System Disorders—Rare: abnormal hepatic function.

Metabolic and Nutritional Disorders—Infrequent: thirst; Rare: hypoglycemia, hypoglycemia reaction.

Musculoskeletal System Disorders—Frequent: myalgia; Infrequent: arthralgia, dystonia,
arthritis, muscle cramps, muscle weakness.

Psychiatric Disorders—Frequent: yawning, other male sexual dysfunction, other female sexual
dysfunction; Infrequent: depression, amnesia, paroniria, teeth-grinding, emotional lability, apathy,
 abnormal dream, euphoria, paranoid reaction, hallucination, aggressive reaction, aggravated
depression, delusions; Rare: withdrawal syndrome, suicide ideation, libido increased, somnambulism,
ilusion.

Reproductive—Frequent: menstrual disorder, dysmenorrhea, intermenstrual bleeding, vaginal
hemorrhage, amenorrhea, leukorrhea; Rare: female breast pain, menorrhagia, balanoposthitis, breast
enlargement, atrophic vaginitis, acute female mastitis.

Respiratory System Disorders—Frequent: rhinitis; Infrequent: coughing, dyspnea, upper respiratory
track infection, epistaxis, bronchospasm, sinusitis; Rare: hyperventilation, bradypnea, stridor, apnea,
bronchiitis, hemoptysis, hyperventilation, laryngismus, laryngitis.

Special Senses—Frequent: tinnitus; Infrequent: conjunctivitis, earache, eye pain, abnormal
accommodation; Rare: xerophthalmia, photophobia, diplopia, abnormal lacrimation, scotoma, visual
field defect.

Urinary System Disorders—Infrequent: micturition frequency, polyuria, urinary retention, dysuria,
octuria, urinary incontinence; Rare: cystitis, oliguria, pyelonephritis, hematuria, renal pain, strangury.

Laboratory Tests—In man, asymptomatic elevations in serum transaminases (SGOT [or AST] and SGPT
[or ALT]) have been reported infrequently (approximately 0.8%) in association with sertraline
hydrochloride administration. These hepatic enzyme elevations usually occurred within the first 1 to 9
weeks of drug treatment and promptly diminished upon drug discontinuation.

Sertraline hydrochloride therapy was associated with small mean increases in total cholesterol
(approximately 3%) and triglycerides (approximately 5%), and a small mean decrease in serum uric acid
(approximately 7%) of no apparent clinical importance.

The safety profile observed with Sertraline hydrochloride treatment in patients with major depressive
disorder, OCD, panic disorder, PTSD, PMDD and social anxiety disorder is similar.

Other Events Observed During the Postmarketing Evaluation of Sertraline hydrochloride—
Reports of adverse events temporally associated with Sertraline hydrochloride that have been received
since market introduction, that are not listed above and that may have no causal relationship with the
drug, include the following: acute renal failure, anaphylactoid reaction, angioedema, blindness, optic
neuritis, cataract, increased coagulation times, bradycardia, AV block, atrial arrhythmias, QT-interval
prolongation, bulbar tachycardia (including torsade de pointes-like arrhythmias), hyperthyroidism,
agranulocytosis, aplastic anemia and pancytopenia, leukopenia, thrombocytopenia, lupus-like syndrome,
serum sickness, hyperglycemia, galactorrhea, hyperprolactinemia, extrapyramidal symptoms,
oculargyric crisis, psychosis, pulmonary hypertension, severe skin reactions, which potentially can be
fatal, such as Stevens-Johnson syndrome, vasculitis, photosensitivity and other severe cutaneous
disorders, rare reports of pancreatitis, and liver events—clinical features (which in the majority of
cases appeared to be reversible with discontinuation of sertraline hydrochloride) occurring in one or
more patients include: elevated enzymes, increased bilirubin, hepatomegaly, jaundice,
adrenaline, abdominal pain, vomiting, liver failure and death.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class—Sertraline hydrochloride is not a controlled substance.

Physical and Psychological Dependence—In a placebo-controlled, double-blind, randomized study of
the comparative abuse liability of Sertraline hydrochloride, alprazolam, and d-amphetamine in humans,
Sertraline hydrochloride did not produce the positive subjective effects indicative of abuse potential,
such as euphoria or drug liking, that were observed with the other two drugs. Premarketing clinical
experience with Sertraline hydrochloride did not reveal any tendency for a withdrawal syndrome or any
drug-seeking behavior. In animal studies sertraline hydrochloride does not demonstrate stimulant or
abuse liability. As with any CNS active drug, however, physicians should
experience with Sertraline hydrochloride did not reveal any tendency for a withdrawal syndrome or any

OVERDOSAGE

Human Experience—Of 1,027 cases of overdose involving sertraline hydrochloride worldwide, alone
or with other drugs, there were 72 deaths (circa 1999).

Among 634 overdoses in which sertraline hydrochloride was the only drug ingested, 8 resulted in fatal
outcome; 75 completely recovered, and 27 patients experienced sequelae after overdose to include
alopecia, decreased libido, diarrhea, ejaculation disorder, fatigue, insomnia, somnolence and serotonin
syndrome. The remaining 524 cases had an unknown outcome. The most common signs and symptoms
associated with non-fatal sertraline hydrochloride overdose were somnolence, vomiting, tachycardia,
nausea, dizziness, agitation and tremor.

The largest known ingestion was 13.5 grams in a patient who took sertraline hydrochloride alone and
subsequently recovered. However, another patient who took 2.5 grams of sertraline hydrochloride
alone experienced a fatal outcome.

Other important adverse events reported with sertraline hydrochloride overdose (single or multiple
drugs) include bradycardia, bundle branch block, coma, convulsions, delirium, hallucinations,
hypertension, hypotension, manic reaction, pancreatitis, QT-interval prolongation, serotonin syndrome,
stupor and syncope.

Overdose Management—Treatment should consist of those general measures employed in the
PHARMACOLOGY

While a relationship between dose and effect has not been established for PMDD, patients were dosed in the range of 50-150 mg/day with dose increases at the onset of each new menstrual cycle (see Clinical Trials under CLINICAL PHARMACOLOGY). Patients not responding to a 50 mg dose may benefit from dose increases (at 50 mg increments/ menstrual cycle) up to 150 mg/day when dosing daily throughout the menstrual cycle, or 100 mg/day when dosing during the luteal phase of the menstrual cycle. If a 100 mg/day dose has been established with luteal phase dosing, a 50 mg/day titration step for three days should be utilized at the beginning of each luteal phase dosing period.

Premenstrual Dysphoric Disorder– Sertraline hydrochloride treatment should be initiated with a dose of 50 mg/day, either daily throughout the menstrual cycle or limited to the luteal phase of the menstrual cycle, depending on physician assessment.

While a relationship between dose and effect has not been established for FMDD, patients were dosed in the range of 50-150 mg/day with dose increases at the onset of each new menstrual cycle (see Clinical Trials under CLINICAL PHARMACOLOGY). Patients not responding to a 50 mg dose may benefit from dose increases (at 50 mg increments/ menstrual cycle) up to 150 mg/day when dosing daily throughout the menstrual cycle, or 100 mg/day when dosing during the luteal phase of the menstrual cycle. If a 100 mg/day dose has been established with luteal phase dosing, a 50 mg/day titration step for three days should be utilized at the beginning of each luteal phase dosing period.

Sertraline hydrochloride should be administered once daily, either in the morning or evening.

Dosage for Pediatric Population (Children and Adolescents)

Obsessive-Compulsive Disorder– Sertraline hydrochloride treatment should be initiated with a dose of 25 mg once daily in children (ages 6-12) and at a dose of 50 mg once daily in adolescents (ages 13-17).

While a relationship between dose and effect has not been established for OCD, patients were dosed in the range of 25-200 mg/day in the clinical trials demonstrating the effectiveness of Sertraline hydrochloride for pediatric patients (6-17 years) with OCD. Patients not responding to an initial dose of 25 or 50 mg/day may benefit from dose increases up to a maximum of 200 mg/day. For children with OCD, their generally lower body weights compared to adults should be taken into consideration in advancing the dose, in order to avoid excess dosing. Given the 24 hour elimination half-life of Sertraline hydrochloride, dose changes should not occur at intervals of less than 1 week.

Sertraline hydrochloride should be administered once daily, either in the morning or evening.

Maintenance/Continuation/Extended Treatment

Major Depressive Disorder–It is generally agreed that acute episodes of major depressive disorder require several months or longer of sustained pharmacologic therapy beyond response to the acute episode. Systematic evaluation of sertraline hydrochloride has demonstrated that its antidepressant efficacy is maintained for periods of up to 44 weeks following 8 weeks of initial treatment at a dose of 50-200 mg/day (see Clinical Trials under CLINICAL PHARMACOLOGY). It is not known whether the dose of sertraline hydrochloride needed for maintenance treatment is identical to the dose needed to achieve an initial response. Patients should be periodically reassessed to determine the need for maintenance treatment.

Posttraumatic Stress Disorder–It is generally agreed that PTSD requires several months or longer of sustained pharmacological therapy beyond response to initial treatment. Systematic evaluation of Sertraline hydrochloride has demonstrated that its efficacy in PTSD is maintained for periods of up to 28 weeks following 24 weeks of treatment at a dose of 50-200 mg/day (see Clinical Trials under CLINICAL PHARMACOLOGY). It is not known whether the dose of Sertraline hydrochloride needed for maintenance treatment is identical to the dose needed to achieve an initial response. Patients should be periodically reassessed to determine the need for maintenance treatment.

Social Anxiety Disorder–Social anxiety disorder is a chronic condition that may require several months or longer of sustained pharmacological therapy beyond response to initial treatment. Systematic evaluation of Sertraline hydrochloride has demonstrated that its efficacy in social anxiety disorder is maintained for periods of up to 24 weeks following 20 weeks of treatment at a dose of 50-200 mg/day (see Clinical Trials under CLINICAL PHARMACOLOGY). Dosage adjustments should be made to maintain patients on the lowest effective dose and patients should be periodically reassessed to determine the need for long-term treatment.

Obsessive-Compulsive Disorder and Panic Disorder–It is generally agreed that OCD and Panic Disorder require several months or longer of sustained pharmacological therapy beyond response to initial treatment. Systematic evaluation of continuing Sertraline hydrochloride for periods of up to 28 weeks in patients with OCD and Panic Disorder who have responded while taking Sertraline hydrochloride during initial treatment phases of 24 to 52 weeks of treatment at a dose range of 50-200 mg/day has demonstrated a benefit of such maintenance treatment (see Clinical Trials under CLINICAL PHARMACOLOGY). It is not known whether the dose of Sertraline hydrochloride needed for maintenance treatment is identical to the dose needed to achieve an initial response. Nevertheless, patients should be periodically reassessed to determine the need for maintenance treatment.

Premenstrual Dysphoric Disorder–The effectiveness of sertraline hydrochloride in long-term use, that is, for more than 3 menstrual cycles, has not been systematically evaluated in controlled trials. However, as women commonly report that symptoms worsen with age until relieved by the onset of menopause, it is reasonable to consider continuation of a responding patient. Dosage adjustments, which may include changes between dosage regimens (e.g., daily throughout the menstrual cycle versus during the luteal phase of the menstrual cycle), may be needed to maintain the patient on the lowest
effective dosage and patients should be periodically reassessed to determine the need for continued treatment.

Switching a Patient To or From a Monoamine Oxidase Inhibitor (MAOI) Intended to Treat Psychiatric Disorders: At least 14 days should elapse between discontinuation of an MAOI intended to treat psychiatric disorders and initiation of therapy with Sertraline hydrochloride. Conversely, at least 14 days should be allowed after stopping Sertraline hydrochloride before starting an MAOI intended to treat psychiatric disorders (see CONTRAINDICATIONS).

Use of Sertraline Hydrochloride With Other MAOIs Such as Linezolid or Methylene Blue: Do not start Sertraline hydrochloride in a patient who is being treated with linezolid or intravenous methylene blue because there is increased risk of serotonin syndrome. In a patient who requires more urgent treatment of a psychiatric condition, other interventions, including hospitalization, should be considered (see CONTRAINDICATIONS).

In some cases, a patient already receiving Sertraline hydrochloride may require urgent treatment with linezolid or intravenous methylene blue. If acceptable alternatives to linezolid or intravenous methylene blue treatment are not available and the potential benefits of linezolid or intravenous methylene blue treatment are judged to outweigh the risks of serotonin syndrome in a particular patient, Sertraline hydrochloride should be stopped promptly, and linezolid or intravenous methylene blue can be administered. The patient should be monitored for symptoms of serotonin syndrome for 2 weeks or until 24 hours after the last dose of linezolid or intravenous methylene blue, whichever comes first.

Discontinuation of Treatment with Sertraline hydrochloride

Symptoms associated with discontinuation of Sertraline hydrochloride and other SSRIs and SNRIs, have been reported (see PRECAUTIONS). Patients should be monitored for these symptoms when discontinuing treatment. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. 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.

HOW SUPPLIED

Sertraline tablets, USP are available with each tablet containing sertraline hydrochloride, USP equivalent to 50 mg and of sertraline.

Sertraline 50 mg Tablets: Light Blue film coated Modified oval biconvex tablets debossed with I on the left side of bisect and G on the right side of bisect on one side and “213” on other

NDC 68071-3071-2 Bottles of 20
NDC 68071-3071-8 Bottles of 28
NDC 68071-3071-3 Bottles of 30
NDC 68071-3071-5 Bottles of 56
NDC 68071-3071-6 Bottles of 60
NDC 68071-3071-9 Bottles of 90

Store at 20°C to 25°C (68°F to 77°F) [see USP Controlled Room Temperature].

Revised: 07/2016

MEDICATION GUIDE

Sertraline Tablets, USP
(SIR-trah-leen)

Read the Medication Guide that comes with Sertraline hydrochloride before you start taking it and each time you get a refill. There may be new information. This Medication Guide does not take the place of talking to your healthcare provider about your medical condition or treatment. Talk with your healthcare provider if there is something you do not understand or want to learn more about.

What is the most important information I should know about Sertraline tablets?

Sertraline hydrochloride and other antidepressant medicines may cause serious side effects, including:

1. Suicidal thoughts or actions:
   - Sertraline tablets and other antidepressant medicines may increase suicidal thoughts or actions in some children, teenagers or young adults within the first few months of treatment or when the dose is changed.
   - Depression or other serious mental illnesses are the most important causes of suicidal thoughts or actions.
   - Watch for these changes and call your healthcare provider right away if you notice:
     - New or sudden changes in mood, behavior, action, thoughts or feelings, especially if severe.
     - Pay particular attention to such changes when sertraline tablets is started or when the dose is changed.

Keep all follow-up visits with your healthcare provider and call between visits if you are worried about symptoms. Call your healthcare provider right away if you have any of the following symptoms, or call 911 if an emergency, especially if they are new, worse or worry you:

- attempts to commit suicide
- acting on dangerous impulses
• acting aggressive or violent
• thoughts about suicide or dying
• new or worse depression
• new or worse anxiety or panic attacks
• feeling agitated, restless, angry or irritable
• trouble sleeping
• an increase in activity or talking more than what is normal for you
• other unusual changes in behavior or mood

Call your healthcare provider right away if you have any of the following symptoms, or call 911 if an emergency. Sertraline tablets may be associated with these serious side effects:

2. Serotonin Syndrome. This condition can be life threatening and may include:
• agitation, hallucinations, coma or other changes in mental status
• coordination problems or muscle twitching (overactive reflexes)
• racing heartbeat, high or low blood pressure
• sweating or fever
• nausea, vomiting, or diarrhea
• muscle rigidity

3. Severe allergic reactions:
• trouble breathing
• swelling of the face, tongue, eyes or mouth
• rash, itchy welts (hives) or blisters, alone or with fever or joint pain

4. Abnormal bleeding: Sertraline tablets and other antidepressant medicines may increase your risk of bleeding or bruising, especially if you take the blood thinner warfarin (Coumadin®, Jantoven®†), a non-steroidal anti-inflammatory drug (NSAIDs, like ibuprofen or naproxen), or aspirin.

5. Seizures or convulsions

6. Manic episodes:
• greatly increased energy
• severe trouble sleeping
• racing thoughts
• reckless behavior
• unusually grand ideas
• excessive happiness or irritability
• talking more or faster than usual

7. Changes in appetite or weight. Children and adolescents should have height and weight monitored during treatment.

8. Low salt (sodium) levels in the blood. Elderly people may be at greater risk for this. Symptoms may include:
• headache
• weakness or feeling unsteady
• confusion, problems concentrating or thinking or memory problems

9. Visual problems
• eye pain
• changes in vision
• swelling or redness in or around the eye

Only some people are at risk for these problems. You may want to undergo an eye examination to see if you are at risk and receive preventative treatment if you are.

Do not stop sertraline tablets without first talking to your healthcare provider. Stopping sertraline tablets too quickly may cause serious symptoms including:
• anxiety, irritability, high or low mood, feeling restless or changes in sleep habits
• headache, sweating, nausea, dizziness
• electric shock-like sensations, shaking, confusion

What are sertraline tablets?

Sertraline tablets are a prescription medicine used to treat depression. It is important to talk with your healthcare provider about the risks of treating depression and also the risks of not treating it. You should discuss all treatment choices with your healthcare provider. Sertraline tablets are also used to treat:

• Major Depressive Disorder (MDD)
• Obsessive Compulsive Disorder (OCD)
• Panic Disorder
• Posttraumatic Stress Disorder (PTSD)
• Social Anxiety Disorder
• Premenstrual Dysphoric Disorder (PMDD)

Talk to your healthcare provider if you do not think that your condition is getting better with sertraline tablet treatment.

Who should not take sertraline tablets?

Do not take sertraline tablets if you:
• are allergic to sertraline or any of the ingredients in sertraline tablets. See the end of this Medication Guide for a complete list of ingredients in sertraline tablets.
• take the antipsychotic medicine pimozide (Orap®†) because this can cause serious heart problems.
• take Antabuse®† (disulfiram) (if you are taking the liquid form of sertraline) due to the alcohol content.
• take a monoamine oxidase inhibitor (MAOI). Ask your healthcare provider or pharmacist if you are not sure if you take an MAOI, including the antibiotic linezolid.
• Do not take an MAOI within 2 weeks of stopping sertraline tablets unless directed to do so by your physician.
• Do not start sertraline tablets if you stopped taking an MAOI in the last 2 weeks unless directed to do so by your physician.
People who take sertraline tablets close in time to an MAOI may have serious or even life-threatening side effects. Get medical help right away if you have any of these symptoms:

- high fever
- uncontrolled muscle spasms
- stiff muscles
- rapid changes in heart rate or blood pressure
- confusion
- loss of consciousness (pass out)

What should I tell my healthcare provider before taking sertraline tablets?

Ask if you are not sure.

Before starting sertraline tablets, tell your healthcare provider if you:

- Are taking certain drugs such as:
  - Medicines used to treat migraine headaches such as:
    - triptans
  - Medicines used to treat mood, anxiety, psychotic or thought disorders, such as:
    - tricyclic antidepressants
    - lithium
    - diazepam
    - SSRIs
    - SNRIs
    - antipsychotic drugs
    - valproate
  - Medicines used to treat seizures such as:
    - phenytoin
  - Medicines used to treat pain such as:
    - tramadol
  - Medicines used to thin your blood such as:
    - warfarin
  - Medicines used to control your heartbeat such as:
    - propafenone
    - flecainide
    - digitoxin
  - Medicines used to treat type II diabetes such as:
    - tolbutamide
  - Cimetidine used to treat heartburn
  - Over-the-counter medicines or supplements such as:
    - Aspirin or other NSAIDs
    - Tryptophan
    - St. John's Wort
    - have liver problems
    - have kidney problems.
    - have heart problems
    - have or had seizures or convulsions
    - have bipolar disorder or mania
    - have low sodium levels in your blood
    - have a history of a stroke
    - have high blood pressure
    - have or had bleeding problems
  - are pregnant or plan to become pregnant. It is not known if sertraline will harm your unborn baby. Talk to your healthcare provider about the benefits and risks of treating depression during pregnancy.
  - are breast-feeding or plan to breast-feed. Some sertraline may pass into your breast milk. Talk to your healthcare provider about the best way to feed your baby while taking sertraline tablets.

Tell your healthcare provider about all the medicines that you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. Sertraline tablets and some medicines may interact with each other, may not work as well, or may cause serious side effects.

Your healthcare provider or pharmacist can tell you if it is safe to take sertraline tablets with your other medicines. Do not start or stop any medicine while taking sertraline tablets without talking to your healthcare provider first.

If you take sertraline tablets, you should not take any other medicines that contain sertraline (sertraline HCl, sertraline hydrochloride, etc.).

How should I take sertraline tablets?

- Take sertraline tablets exactly as prescribed. Your healthcare provider may need to change the dose of sertraline tablets until it is the right dose for you.
- Sertraline tablets may be taken with or without food.
- If you miss a dose of sertraline tablets, take the missed dose as soon as you remember. If it is almost time for the next dose, skip the missed dose and take your next dose at the regular time. Do not take two doses of sertraline tablets at the same time.
- If you take too many sertraline tablets, call your healthcare provider or poison control center right away, or get emergency treatment.

What should I avoid while taking sertraline tablets?
Sertraline tablets can cause sleepiness or may affect your ability to make decisions, think clearly, or react quickly. You should not drive, operate heavy machinery, or do other dangerous activities until you know how sertraline tablets affect you. Do not drink alcohol while using sertraline tablets.

What are the possible side effects of sertraline tablets?

Sertraline tablets may cause serious side effects, including:

- See "What is the most important information I should know about sertraline tablets?"
- Feeling anxious or trouble sleeping

Common possible side effects in people who take sertraline tablets include:
- nausea, loss of appetite, diarrhea or indigestion
- change in sleep habits including increased sleepiness or insomnia
- increased sweating
- sexual problems including decreased libido and ejaculation failure
- tremor or shaking
- feeling tired or fatigued
- agitation

Other side effects in children and adolescents include:
- abnormal increase in muscle movement or agitation
- nose bleed
- urinary incontinence
- aggressive reaction
- heavy menstrual periods
- possible slowed growth rate and weight change. Your child's height and weight should be monitored during treatment with sertraline tablets.

Tell your healthcare provider if you have any side effect that bothers you or that does not go away. These are not all the possible side effects of sertraline tablets. For more information, ask your healthcare provider or pharmacist.

CALL YOUR DOCTOR FOR MEDICAL ADVICE ABOUT SIDE EFFECTS. YOU MAY REPORT SIDE EFFECTS TO THE FDA AT 1-800-FDA-1088.

How should I store sertraline tablets?
- Store sertraline tablets at room temperature between 20°C to 25°C (68°F to 77°F).
- Keep sertraline tablets bottle closed tightly.

Keep sertraline tablets and all medicines out of the reach of children.

General information about sertraline tablets

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use sertraline tablets for a condition for which it was not prescribed. Do not give sertraline tablets to other people, even if they have the same condition. It may harm them.

This Medication Guide summarizes the most important information about sertraline tablets. If you would like more information, talk with your healthcare provider. You may ask your healthcare provider or pharmacist for information about sertraline tablets that is written for healthcare professionals.

For more information about sertraline tablets call Cipla Ltd. at 1-866-604-3268.

What are the ingredients in sertraline tablets?

Active ingredient: sertraline hydrochloride, USP

Inactive ingredients: dibasic calcium phosphate dihydrate, hydroxypropyl cellulose, microcrystalline cellulose, magnesium stearate, opadry green (titanium dioxide, hypromellose 3cP, hypromellose 6cP, Macrogol/Peg 400, polysorbate 80, D&C Yellow #10 Aluminum Lake, and FD&C Blue #2/Indigo Carmine Aluminum Lake for 25 mg tablet), opadry light blue (hypromellose 3cP, hypromellose 6cP, titanium dioxide, Macrogol/Peg 400, FD&C Blue #2/Indigo Carmine Aluminum Lake and polysorbate 80 for 50 mg tablet), opadry yellow (hypromellose 3cP, hypromellose 6cP, titanium dioxide, Macrogol/Peg 400, polysorbate 80, Iron Oxide Yellow, Iron oxide Red for 100 mg tablet) and sodium starch glycolate.

† The brand names mentioned in this Medication Guide are registered trademarks of their respective manufacturers.

This Medication Guide has been approved by the U.S. Food and Drug Administration.

Manufactured for:

Cipla USA Inc.,
9100 S. Dadeland Blvd., Suite 1500
Miami, FL 33156

Manufactured by:

InvGen Pharmaceuticals, Inc.
(a subsidiary of Cipla Ltd.)
Hauppauge, NY 11788

or

Ascent Pharmaceuticals, Inc.
Central Islip, NY 11722

Revised: 07/2016
SERTRALINE HYDROCHLORIDE
sertraline hydrochloride tablet

Product Information
Product Type: HUMAN PRESCRIPTION DRUG Item Code (Source): NDC:68071-3071(NDC:69097-834)
Route of Administration: ORAL

Active Ingredient/Active Moiety

<table>
<thead>
<tr>
<th>Ingredient Name</th>
<th>Basis of Strength</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERTRALINE HYDROCHLORIDE</td>
<td>(SERTRALINE - UNII:QUC7NX6WMB)</td>
<td>SERTRALINE 50 mg</td>
</tr>
</tbody>
</table>

Inactive Ingredients

<table>
<thead>
<tr>
<th>Ingredient Name</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIBASIC CALCIUM PHOSPHATE DIHYDRATE</td>
<td>(UNII: OTS7S9P)</td>
</tr>
<tr>
<td>HYDROXYPROPYLCELLULOSE</td>
<td>(1040000 WAMW)</td>
</tr>
<tr>
<td>CELLULOSE, MICROCRYSTALLINE</td>
<td>(UNII:OP1R32D61U)</td>
</tr>
<tr>
<td>MAGNESIUM STEARATE</td>
<td>(UNII:70997MK8D)</td>
</tr>
<tr>
<td>SODIUM STARCH GLYCOLATE TYPE A POTATO</td>
<td>(UNII:55676G2G2A)</td>
</tr>
<tr>
<td>TITANIUM DIOXIDE</td>
<td>(UNII:15FIX9V2JP)</td>
</tr>
<tr>
<td>HYROMELLOSE 2910 (4 MPa.S)</td>
<td>(UNII:4VU37PIJW)</td>
</tr>
<tr>
<td>HYROMELLOSE 2910 (6 MPa.S)</td>
<td>(UNII:4D6I8W6J9P)</td>
</tr>
<tr>
<td>POLYETHYLENE GLYCOL 400</td>
<td>(UNII:B697894SGQ)</td>
</tr>
<tr>
<td>POLYSORBATE 80</td>
<td>(UNII:6OZP39ZG8H)</td>
</tr>
<tr>
<td>D&amp;C YELLOW NO. 10</td>
<td>(UNII:35SW5USQ3G)</td>
</tr>
<tr>
<td>FD&amp;C BLUE NO. 2</td>
<td>(UNII:L06K8R7DQK)</td>
</tr>
</tbody>
</table>

Product Characteristics
Color: blue (Light Blue) Score: 2 pieces
Shape: OVAL (modified, bevel) Size: 10mm
Flavor: Contains

Packaging

<table>
<thead>
<tr>
<th>#</th>
<th>Item Code</th>
<th>Package Description</th>
<th>Marketing Start Date</th>
<th>Marketing End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NDC:68071-3071-8</td>
<td>28 in 1 BOTTLE; Type 0: Not a Combination Product</td>
<td>03/23/2017</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>NDC:68071-3071-2</td>
<td>20 in 1 BOTTLE; Type 0: Not a Combination Product</td>
<td>03/23/2017</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>NDC:68071-3071-9</td>
<td>90 in 1 BOTTLE; Type 0: Not a Combination Product</td>
<td>03/23/2017</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>NDC:68071-3071-3</td>
<td>30 in 1 BOTTLE; Type 0: Not a Combination Product</td>
<td>03/23/2017</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>NDC:68071-3071-5</td>
<td>56 in 1 BOTTLE; Type 0: Not a Combination Product</td>
<td>03/23/2017</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>NDC:68071-3071-6</td>
<td>60 in 1 BOTTLE; Type 0: Not a Combination Product</td>
<td>03/23/2017</td>
<td></td>
</tr>
</tbody>
</table>

Marketing Information
Marketing Category: ANDA Application Number or Monograph Citation: ANDA077397 Marketing Start Date: 07/21/2016 Marketing End Date: |

Labeler - NuCare Pharmaceuticals, Inc. (01063200)

Establishment

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>ID/FEI</th>
<th>Business Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>NuCare Pharmaceuticals, Inc.</td>
<td>01063200</td>
<td>repack(68071-3071)</td>
<td></td>
</tr>
</tbody>
</table>