

**MORPHINE SULFATE- morphine sulfate capsule, extended release**  
**Actavis Pharma, Inc.**

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**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use MORPHINE SULFATE EXTENDED-RELEASE CAPSULES safely and effectively. See full prescribing information for MORPHINE SULFATE EXTENDED-RELEASE CAPSULES.

**MORPHINE SULFATE extended-release capsules, for oral use, CII**  
**(Once Daily)**

Initial U.S. Approval: 1941

**WARNING: SERIOUS AND LIFE-THREATENING RISKS FROM USE OF MORPHINE SULFATE EXTENDED-RELEASE CAPSULES**

*See full prescribing information for complete boxed warning.*

- Morphine sulfate extended-release capsules expose users to risks of addiction, abuse, and misuse, which can lead to overdose and death. Assess patient's risk before prescribing, and reassess regularly for these behaviors and conditions. (5.1)
- Serious, life-threatening, or fatal respiratory depression may occur, especially upon initiation or following a dosage increase. To reduce the risk of respiratory depression, proper dosing and titration of morphine sulfate Extended-Release Capsules are essential. Instruct patients to swallow morphine sulfate Extended-Release Capsules whole to avoid exposure to a potentially fatal dose of morphine. (5.2)
- Accidental ingestion of morphine sulfate extended-release Capsules, especially by children, can result in fatal overdose of morphine. (5.2)
- Instruct patients not to consume alcohol or any products containing alcohol while taking morphine sulfate extended-release capsules because co-ingestion can result in fatal plasma morphine levels. (5.3)
- Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing for use in patients for whom alternative treatment options are inadequate. (5.3, 7)
- Advise pregnant women using opioids for an extended period of time of the risk of Neonatal Opioid Withdrawal Syndrome, which may be life-threatening if not recognized and treated. Ensure that management by neonatology experts will be available at delivery. (5.4)
- Healthcare providers are strongly encouraged to complete a REMS compliant education program and to counsel patients and caregivers on serious risks, safe use, and the importance of reading the Medication Guide with each prescription. (5.5)

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**RECENT MAJOR CHANGES**  
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Boxed Warning	08/2025
Indications and Usage (1)	08/2025
Dosage and Administration (2.2, 2.3, 2.5)	08/2025
Warnings and Precautions (5.1, 5.2, 5.3, 5.12, 5.14)	08/2025

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**INDICATIONS AND USAGE**  
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Morphine sulfate extended-release capsules are an opioid agonist indicated for the management of severe and persistent pain that requires an opioid analgesic and that cannot be adequately treated with alternative options, including immediate-release opioids. (1)

Limitations of Use

- Because of the risks of addiction, abuse, misuse, overdose, and death, which can occur at any dosage or duration and persist over the course of therapy, reserve opioid analgesics, including morphine sulfate extended-release capsules for use in patients for whom alternative treatment options are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. (1, 5.1)
- Morphine sulfate extended-release capsules are not indicated as an as-needed (prn) analgesic. (1)

## DOSAGE AND ADMINISTRATION

- Morphine sulfate extended-release capsules should be prescribed only by healthcare professionals who are knowledgeable about the use of extended-release/long-acting opioids and how to mitigate the associated risks. (2.1)
- Morphine sulfate extended-release 90 mg and 120 mg capsules, are only for use in patients in whom tolerance to an opioid of comparable potency is established. (2.1)
- Patients considered opioid-tolerant are those taking, for one week or longer, at least 60 mg of morphine per day, 25 mcg transdermal fentanyl per hour, 30 mg of oral oxycodone per day, 8 mg of oral hydromorphone per day, 25 mg oral oxymorphone per day, 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid. (2.1)
- Use the lowest effective dosage for the shortest duration of time consistent with individual patient treatment goals. Reserve titration to higher doses of morphine sulfate extended-release capsules for patients in whom lower doses are insufficiently effective and in whom the expected benefits of using a higher dose opioid clearly outweigh the substantial risks. (2.1, 5.1)
- Initiate the dosing regimen for each patient individually, taking into account the patient's underlying cause and severity of pain, prior analgesic treatment and response, and risk factors for addiction, abuse, and misuse. (2.1,5.1)
- Respiratory depression can occur at any time during opioid therapy, especially when initiating and following dosage increases with morphine sulfate extended-release capsules. Consider this risk when selecting an initial dose and when making dose adjustments. (2.1, 5.2)
- Must swallow morphine sulfate extended-release capsules intact, or sprinkle the capsule contents on applesauce and immediately swallow. (2.1, 2.5)
- Do not cut, break, chew, crush, or dissolve the pellets in morphine sulfate extended-release capsules (risk of potentially fatal overdose) (2.1, 2.5, 5.1)
- Discuss opioid overdose reversal agents and options for acquiring them with the patient and/or caregiver, both when initiating and renewing treatment with morphine sulfate extended-release capsules, especially if the patient has additional risk factors for overdose, or close contacts at risk for exposure and overdose. (2.2, 5.1, 5.2, 5.3)
- Morphine sulfate extended-release capsules are administered at a frequency of once daily (every 24 hours). (2.3)
- Periodically reassess patients receiving morphine sulfate extended-release capsules to evaluate the continued need for opioid analgesics to maintain pain control, for the signs or symptoms of adverse reactions, and for the development of addiction, abuse, or misuse. (2.4)
- Do not rapidly reduce or abruptly discontinue morphine sulfate extended-release capsules in a physically-dependent patient because rapid reduction or abrupt discontinuation of opioid analgesics has resulted in serious withdrawal symptoms, uncontrolled pain, and suicide. (2.5, 5.14)

## DOSAGE FORMS AND STRENGTHS

Extended-release capsules: 30 mg, 45 mg, 60 mg, 75 mg, 90 mg, 120 mg (3)

## CONTRAINDICATIONS

- Significant respiratory depression (4)
- Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment (4)
- Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days (4)
- Known or suspected gastrointestinal obstruction, including paralytic ileus (4)
- Hypersensitivity to morphine (4)

## WARNINGS AND PRECAUTIONS

- Opioid Induced Hyperalgesia (OIH) and Allodynia: Opioid-Induced Hyperalgesia (OIH) occurs when an opioid analgesic paradoxically causes an increase in pain, or an increase in sensitivity to pain. If OIH is suspected, carefully consider appropriately decreasing the dose of the current opioid analgesic, or opioid rotation (5.6)
- Life-Threatening Respiratory Depression in Patients with Chronic Pulmonary Disease or in Elderly, Cachectic, Debilitated Patients: Regularly evaluate closely, particularly during initiation and titration. (5.7)
- Adrenal Insufficiency: If diagnosed, treat with physiologic replacement of corticosteroids, and wean patient off of the opioid. (5.9)
- Severe Hypotension: Regularly evaluate during dose initiation and titration. Avoid use of morphine sulfate extended-release capsules in patients with circulatory shock. (5.10)
- Risks of Use in Patients with Increased Intracranial Pressure, Brain Tumors, Head Injury or Impaired Consciousness: Monitor for sedation and respiratory depression. Avoid use of morphine sulfate extended-release capsules in patients with impaired consciousness or coma. (5.11)

## ADVERSE REACTIONS

Most common adverse reactions (greater than or equal to 10%) are constipation, nausea, somnolence, vomiting and headache. (6.1)

**To report SUSPECTED ADVERSE REACTIONS, contact Teva at 1-888-838-2872 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

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## DRUG INTERACTIONS

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- Serotonergic Drugs: Concomitant use may result in serotonin syndrome. Discontinue morphine sulfate extended-release capsules if serotonin syndrome is suspected. (7)
- Mixed Agonist/Antagonist and Partial Agonist Opioid Analgesics: Avoid use with mixed agonist/antagonist because they may reduce analgesic effect of morphine sulfate extended-release capsules or precipitate withdrawal symptoms. (5.14, 7)

## USE IN SPECIFIC POPULATIONS

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- Pregnancy: May cause fetal harm. (8.1)
- Lactation: Not recommended. (8.2)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 3/2026

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## **FULL PRESCRIBING INFORMATION**

## **WARNING: SERIOUS AND LIFE-THREATENING RISKS FROM USE OF MORPHINE SULFATE EXTENDED-RELEASE CAPSULES**

### **Addiction, Abuse, and Misuse**

Because the use of morphine sulfate extended-release capsules exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death, assess each patient's risk prior to prescribing and reassess all patients regularly for the development of these behaviors and conditions [*see Warnings and Precautions (5.1)*].

### **Life-Threatening Respiratory Depression**

Serious, life-threatening, or fatal respiratory depression may occur with use of morphine sulfate extended-release capsules, especially during initiation or following a dosage increase. To reduce the risk of respiratory depression, proper dosing and titration of morphine sulfate extended-release capsules are essential. Instruct patients to swallow morphine sulfate extended-release capsules whole; or to sprinkle the contents of the capsule on applesauce and swallow immediately without chewing. Crushing, chewing, or dissolving the pellets in morphine sulfate extended-release capsules can cause rapid release and absorption of a potentially fatal dose of morphine [*see Warnings and Precautions (5.2)*].

### **Accidental Ingestion**

Accidental ingestion of even one dose of morphine sulfate extended-release capsules, especially by children, can result in a fatal overdose of morphine [*see Warnings and Precautions (5.2)*].

### **Risks from Concomitant Use with Benzodiazepines or Other CNS Depressants**

Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing of morphine sulfate extended-release capsules and benzodiazepines or other CNS depressants for use in patients for whom alternative treatment options are inadequate [*see Warnings and Precautions (5.3), Drug Interactions (7)*].

### **Neonatal Opioid Withdrawal Syndrome (NOWS)**

Advise pregnant women using opioids for an extended period of time of the risk of Neonatal Opioid Withdrawal Syndrome, which may be life-threatening if not recognized and treated. Ensure that management by neonatology experts will be available at delivery [*see Warnings and Precautions (5.4)*].

### **Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)**

Healthcare providers are strongly encouraged to complete a REMS compliant education program and to counsel patients and caregivers on serious risks, safe use, and the importance of reading the Medication Guide with each prescription [*see Warnings and Precautions (5.5)*].

### **Interaction with Alcohol**

Instruct patients not to consume alcoholic beverages or use prescription or non-prescription products that contain alcohol while

**taking morphine sulfate extended-release capsules. The co-ingestion of alcohol with morphine sulfate extended-release capsules may result in increased plasma levels and a potentially fatal overdose of morphine [see Warnings and Precautions (5.3)].**

## 1 INDICATIONS AND USAGE

Morphine sulfate extended-release capsules are indicated for the management of severe and persistent pain that requires an opioid analgesic and that cannot be adequately treated with alternative options, including immediate-release opioids.

### Limitations of Use

- Because of the risks of addiction, abuse, misuse, overdose, and death, which can occur at any dosage or duration and persist over the course of therapy [see *Warnings and Precautions (5.1)*], reserve opioid analgesics, including morphine sulfate extended-release capsules for use in patients for whom alternative treatment options are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Morphine sulfate extended-release capsules are not indicated as an as-needed (prn) analgesic.

## 2 DOSAGE AND ADMINISTRATION

### 2.1 Important Dosage and Administration Instructions

- Morphine sulfate extended-release capsules should be prescribed only by healthcare professionals who are knowledgeable about the use of extended-release/long-acting opioids and how to mitigate the associated risks.
- Morphine sulfate extended-release 90 mg and 120 mg capsules are only for use in patients in whom tolerance to an opioid of comparable potency has been established. Patients considered opioid tolerant are those taking, for one week or longer, at least 60 mg oral morphine per day, 25 mcg transdermal fentanyl per hour, 30 mg oral oxycodone per day, 8 mg oral hydromorphone per day, 25 mg oral oxymorphone per day, 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid.
- Use the lowest effective dosage for the shortest duration of time consistent with individual patient treatment goals [see *Warnings and Precautions (5)*]. Because the risk of overdose increases as opioid doses increase, reserve titration to higher doses of morphine sulfate extended-release capsules for patients in whom lower doses are insufficiently effective and in whom the expected benefits of using a higher dose opioid clearly outweigh the substantial risks.
- Initiate the dosing regimen for each patient individually, taking into account the patient's underlying cause and severity of pain, prior analgesic treatment and response, and risk factors for addiction, abuse, and misuse [see *Warnings and Precautions (5.1)*].
- Respiratory depression can occur at any time during opioid therapy, especially when initiating and following dosage increases with morphine sulfate extended-release capsules. Consider this risk when selecting an initial dose and when making dose adjustments [see *Warnings and Precautions (5)*].
- Morphine sulfate extended-release capsules are administered at a frequency of once daily (every 24 hours).
- Instruct patients to swallow morphine sulfate extended-release capsules whole [see *Patient Counseling Information (17)*]. Crushing, chewing, or dissolving the pellets in morphine sulfate extended-release capsules will result in uncontrolled delivery of morphine and can lead to overdose or death [see *Warnings and Precautions (5.1)*].

- Instruct patients who are unable to swallow morphine sulfate extended-release capsules to sprinkle the capsule contents on applesauce and immediately swallow without chewing [see Dosage and Administration (2.5)].

## **2.2 Patient Access to an Opioid Overdose Reversal Agent for the Emergency Treatment of Opioid Overdose**

Inform patients and caregivers about opioid overdose reversal agents (e.g., naloxone, nalmefene). Discuss the importance of having access to an opioid overdose reversal agent, especially if the patient has risk factors for overdose (e.g., concomitant use of CNS depressants, a history of opioid use disorder, or prior opioid overdose) or if there are household members (including children) or other close contacts at risk for accidental ingestion or opioid overdose. The presence of risk factors for overdose should not prevent the management of pain in any patient [see *Warnings and Precautions* (5.1, 5.2, 5.3)].

Discuss the options for obtaining an opioid overdose reversal agent (e.g., prescription, over-the-counter, or as part of a community-based program) [see *Warnings and Precautions* (5.2)].

There are important differences among the opioid overdose reversal agents, such as route of administration, product strength, approved patient age range, and pharmacokinetics. Be familiar with these differences, as outlined in the approved labeling for those products, prior to recommending or prescribing such an agent.

## **2.3 Initial Dosage**

It is safer to underestimate a patient's 24-hour oral morphine dosage and provide rescue medication (e.g. immediate-release morphine) than to overestimate the 24-hour oral morphine dosage and manage an adverse reaction due to an overdose. While useful tables of opioid equivalents are readily available, there is inter-patient variability in the potency of opioid drugs and formulations. Frequently reevaluate patients for signs and symptoms of opioid withdrawal and for signs of oversedation/toxicity after converting patients to morphine sulfate extended-release capsules.

### Use of morphine sulfate extended-release capsules in Patients who are not Opioid Tolerant

The starting dose of morphine sulfate extended-release capsules for patients who are not opioid tolerant is 30 mg orally every 24 hours.

Use of higher starting doses in patients who are not opioid tolerant may cause fatal respiratory depression [see *Warnings and Precautions* (5.2)].

### Conversion from Other Oral Morphine Formulations to morphine sulfate extended-release capsules

Patients receiving other oral morphine formulations may be converted to morphine sulfate extended-release capsules by administering the patient's total daily oral morphine dose as morphine sulfate extended-release capsules once-daily. Morphine sulfate extended-release capsules should not be given more frequently than every 24 hours.

### Conversion from Parenteral Morphine or Other Parenteral Opioid Analgesics to morphine sulfate extended-release capsules

When converting from parenteral morphine or other parenteral non-morphine opioids to morphine sulfate extended-release capsules, consider the following general points:

*Parenteral to oral morphine ratio:*

Between 2 to 6 mg of oral morphine may be required to provide analgesia equivalent to 1 mg of parenteral morphine. Typically, a dose of morphine that is approximately three times the previous daily parenteral morphine requirement is sufficient.

*Other parenteral non-morphine opioid analgesics to oral morphine sulfate:*

Specific recommendations are not available because of a lack of systematic evidence for these types of analgesic substitutions. Published relative potency data are available, but such ratios are approximations. In general, begin with half of the estimated daily morphine requirement as the initial dose, managing inadequate analgesia by supplementation with immediate-release morphine.

Conversion from Methadone to morphine sulfate extended-release capsules

Regular evaluation is of particular importance when converting from methadone to other opioid agonists. The ratio between methadone and other opioid agonists may vary widely as a function of previous dose exposure. Methadone has a long half-life and can accumulate in the plasma.

Conversion from Other Oral Opioid Analgesics to morphine sulfate extended-release capsules

When Morphine sulfate extended-release capsules therapy is initiated, discontinue all opioid analgesics other than those used on an as needed basis for breakthrough pain when appropriate.

There are no established conversion ratios from other opioid analgesics to morphine sulfate extended-release capsules defined by clinical trials. Initiate dosing using morphine sulfate extended-release capsules 30 mg orally every 24 hours.

The first dose of morphine sulfate extended-release capsules may be taken with the last dose of any immediate-release opioid medication due to the extended-release characteristics of the morphine sulfate extended-release capsules formulation.

## **2.4 Titration and Maintenance of Therapy**

Individually titrate morphine sulfate extended-release capsules to a dose that provides adequate analgesia and minimizes adverse reactions. Continually reevaluate patients receiving morphine sulfate extended-release capsules to assess the maintenance of pain control, signs and symptoms of opioid withdrawal, and other adverse reactions as well as to reassess for the development of addiction, abuse, or misuse [see *Warnings and Precautions (5.1, 5.14)*]. Frequent communication is important among the prescriber, other members of the healthcare team, the patient, and the caregiver/family during periods of changing analgesic requirements, including initial titration. During use of opioid therapy for an extended period of time, periodically reassess the continued need for opioid analgesics.

Patients who experience breakthrough pain may require a dose increase of morphine sulfate extended-release capsules, or may need rescue medication with an appropriate dose of an immediate-release analgesic. If the level of pain increases after dose stabilization, attempt to identify the source of increased pain before increasing the morphine sulfate extended-release capsules dosage. Because steady-state plasma concentrations are approximated within 2 to 3 days, morphine sulfate extended-release capsules dosage adjustments may be done every 3 to 4 days.

The daily dose of morphine sulfate extended-release capsules must be limited to a maximum of 1600 mg/day. Morphine sulfate extended-release capsules doses of over 1600 mg/day contain a quantity of fumaric acid that has not been demonstrated to be safe, and which may result in serious renal toxicity.

If after increasing the dosage, unacceptable opioid-related adverse reactions are observed (including an increase in pain after dosage increase), consider reducing the dosage [see *Warnings and Precautions (5)*]. Adjust the dosage to obtain an appropriate balance between management of pain and opioid-related adverse reactions.

## **2.5 Safe Reduction or Discontinuation of morphine sulfate extended-release capsules**

Do not rapidly reduce or abruptly discontinue morphine sulfate extended-release capsules in patients who may be physically dependent on opioids. Rapid reduction or abrupt discontinuation of opioid analgesics in patients who are physically dependent on opioids has resulted in serious withdrawal symptoms, uncontrolled pain, and suicide. Rapid reduction or abrupt discontinuation has also been associated with attempts to find other sources of opioid analgesics, which may be confused with drug-seeking for abuse. Patients may also attempt to treat their pain or withdrawal symptoms with illicit opioids, such as heroin, and other substances.

When a decision has been made to decrease the dose or discontinue therapy in an opioid-dependent patient taking morphine sulfate extended-release capsules, there are a variety of factors that should be considered, including the total daily dose of opioid (including morphine sulfate extended-release capsules) the patient has been taking, the duration of treatment, the type of pain being treated, and the physical and psychological attributes of the patient. It is important to ensure ongoing care of the patient and to agree on an appropriate tapering schedule and follow-up plan so that patient and provider goals and expectations are clear and realistic. When opioid analgesics are being discontinued due to a suspected substance use disorder, evaluate and treat the patient, or refer for evaluation and treatment of the substance use disorder. Treatment should include evidence-based approaches, such as medication assisted treatment of opioid use disorder. Complex patients with co-morbid pain and substance use disorders may benefit from referral to a specialist.

There are no standard opioid tapering schedules that are suitable for all patients. Good clinical practice dictates a patient-specific plan to taper the dose of the opioid gradually. For patients on morphine sulfate extended-release capsules who are physically opioid-dependent, initiate the taper by a small enough increment (e.g., no greater than 10% to 25% of the total daily dose) to avoid withdrawal symptoms, and proceed with dose-lowering at an interval of every 2 to 4 weeks. Patients who have been taking opioids for briefer periods of time may tolerate a more rapid taper.

It may be necessary to provide the patient with lower dosage strengths to accomplish a successful taper. Reassess the patient frequently to manage pain and withdrawal symptoms, should they emerge. Common withdrawal symptoms include restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, myalgia, and mydriasis. Other signs and symptoms also may develop, including irritability, anxiety, backache, joint pain, weakness, abdominal cramps, insomnia, nausea, anorexia, vomiting, diarrhea, or increased blood pressure, respiratory rate, or heart rate. If withdrawal symptoms arise, it may be necessary to pause the taper for a period of time or raise the dose of the opioid analgesic to the previous dose, and then proceed with a slower taper. In addition, evaluate patients for any changes in mood, emergence of suicidal thoughts, or use of other substances.

When managing patients taking opioid analgesics, particularly those who have been treated for an extended period of time, and/or with high doses for chronic pain, ensure that a multimodal approach to pain management, including mental health support (if needed), is in place prior to initiating an opioid analgesic taper. A multimodal approach to pain management may optimize the treatment of chronic pain, as well as assist with the successful tapering of the opioid analgesic [see *Warnings and Precautions (5.14)*, *Drug Abuse and Dependence (9.3)*].

## 2.6 Administration of morphine sulfate extended-release capsules

Morphine sulfate extended-release capsules must be taken whole. Crushing, chewing, or dissolving the pellets in morphine sulfate extended-release capsules will result in uncontrolled delivery of morphine and can lead to overdose or death [see *Warnings and Precautions (5.1)*].


Alternatively, the contents of the morphine sulfate extended-release capsules (pellets) may be sprinkled over applesauce and then swallowed. This method is appropriate only for patients able to reliably swallow the applesauce without chewing. Other foods have not been tested and should not be substituted for applesauce. Instruct the patient to:


- Sprinkle the pellets onto a small amount of applesauce and consume immediately without chewing.
- Rinse the mouth to ensure all pellets have been swallowed.
- Discard any unused portion of the morphine sulfate extended-release capsules after the contents have been sprinkled on applesauce.


Do not administer morphine sulfate extended-release capsules pellets through a nasogastric or gastric tubes.


## 3 DOSAGE FORMS AND STRENGTHS


Morphine sulfate extended-release capsules, USP (once daily) contain pellets of morphine sulfate and are available as follows:


30 mg capsule with a dark blue opaque cap and body, printed with  and 3090 on both the cap and body in black ink.

45 mg capsule with a violet opaque cap and body, printed with  and 3116 on both the cap and body in black ink.

60 mg capsule with a light green opaque cap and body, printed with  and 3091 on both the cap and body in black ink.

75 mg capsule with a brown opaque cap and body, printed with  and 3117 on both the cap and body in black ink.

90 mg capsule with a green opaque cap and body, printed with  and 3092 on both the cap and body in black ink.

120 mg capsule with a light blue opaque cap and body, printed with  and 3093 on both the cap and body in black ink.

## 4 CONTRAINDICATIONS

Morphine sulfate extended-release capsules are contraindicated in patients with:

- Significant respiratory depression [see *Warnings and Precautions (5.2)*]
- Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment [see *Warnings and Precautions (5.7)*]
- Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days [see *Warnings and Precautions (5.8)*].
- Known or suspected gastrointestinal obstruction, including paralytic ileus [see *Warnings and Precautions (5.12)*]
- Hypersensitivity (e.g., anaphylaxis) to morphine [see *Adverse Reactions (6.2)*]

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Addiction, Abuse, and Misuse

Morphine sulfate extended-release capsules contain morphine, a Schedule II controlled

substance. As an opioid, morphine sulfate extended-release capsules exposes users to the risks of addiction, abuse, and misuse.

Although the risk of addiction in any individual is unknown, it can occur in patients appropriately prescribed morphine sulfate extended-release capsules. Addiction can occur at recommended doses and if the drug is misused or abused. The risk of opioid-related overdose or overdose-related death is increased with higher opioid doses, and this risk persists over the course of therapy. In postmarketing studies, addiction, abuse, misuse, and fatal and non-fatal opioid overdose were observed in patients with long-term opioid use [see *Adverse Reactions (6.2)*].

Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing morphine sulfate extended-release capsules, and reassess all patients receiving morphine sulfate extended-release capsules for the development of these behaviors and conditions. Risks are increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). The potential for these risks should not, however, prevent morphine sulfate extended-release capsules the proper management of pain in any given patient. Patients at increased risk may be prescribed opioids such as morphine sulfate extended-release capsules, but use in such patients necessitates intensive counseling about the risks and proper use of morphine sulfate extended-release capsules along with frequent reevaluation for signs of addiction, abuse, and misuse. Consider recommending or prescribing an opioid overdose reversal agent [see *Dosage and Administration (2.2)*, *Warnings and Precautions (5.2)*].

Abuse or misuse of morphine sulfate extended-release capsules by crushing, chewing, snorting, or injecting the dissolved product will result in the uncontrolled delivery of the morphine and can result in overdose and death [see *Overdosage (10)*].

Opioids are sought for nonmedical use and are subject to diversion from legitimate prescribed use. Consider these risks when prescribing or dispensing morphine sulfate extended-release capsules. Strategies to reduce these risks include prescribing the drug in the smallest appropriate quantity and advising the patient on careful storage of the drug during the course of treatment and proper disposal of unused drug. Contact local state professional licensing board or state-controlled substances authority for information on how to prevent and detect abuse or diversion of this product.

## **5.2 Life-Threatening Respiratory Depression**

Serious, life-threatening, or fatal respiratory depression has been reported with the use of opioids, even when used as recommended. Respiratory depression, if not immediately recognized and treated, may lead to respiratory arrest and death.

Management of respiratory depression may include close observation, supportive measures, and use of opioid overdose reversal agents, depending on the patient's clinical status [see *Overdosage (10)*]. Carbon dioxide (CO<sub>2</sub>) retention from opioid-induced respiratory depression can exacerbate the sedating effects of opioids.

While serious, life-threatening, or fatal respiratory depression can occur at any time during the use of morphine sulfate extended-release capsules, the risk is greatest during the initiation of therapy or following a dosage increase.

To reduce the risk of respiratory depression, proper dosing and titration of morphine sulfate extended-release capsules are essential [see *Dosage and Administration (2)*]. Overestimating the morphine sulfate extended-release capsules dose when converting patients from another opioid product can result in fatal overdose with the first dose.

Accidental ingestion of even one dose of morphine sulfate extended-release capsules, especially by children, can result in respiratory depression and death due to an overdose

of morphine.

Educate patients and caregivers on how to recognize respiratory depression and emphasize the importance of calling 911 or getting emergency medical help right away in the event of a known or suspected overdose [see *Patient Counseling Information (17)*].

Opioids can cause sleep-related breathing disorders including central sleep apnea (CSA) and sleep-related hypoxemia. Opioid use increases the risk of CSA in a dose-dependent fashion. In patients who present with CSA, consider decreasing the opioid dosage using best practices for opioid taper [see *Dosage and Administration (2.5)*].

#### Patient Access to an Opioid Overdose Reversal Agent for the Emergency Treatment of Opioid Overdose

Inform patients and caregivers about opioid overdose reversal agents (e.g., naloxone, nalmefene). Discuss the importance of having access to an opioid overdose reversal agent, especially if the patient has risk factors for overdose (e.g., concomitant use of CNS depressants, a history of opioid use disorder, or prior opioid overdose) or if there are household members (including children) or other close contacts at risk for accidental ingestion or opioid overdose. The presence of risk factors for overdose should not prevent the management of pain in any patient [see *Warnings and Precautions (5.1, 5.3)*].

Discuss the options for obtaining an opioid overdose reversal agent (e.g., prescription, over-the-counter, or as part of a community-based program).

There are important differences among the opioid overdose reversal agents, such as route of administration, product strength, approved patient age range, and pharmacokinetics. Be familiar with these differences, as outlined in the approved labeling for those products, prior to recommending or prescribing such an agent.

Educate patients and caregivers on how to recognize respiratory depression, and how to use an opioid overdose reversal agent for the emergency treatment of opioid overdose. Emphasize the importance of calling 911 or getting emergency medical help, even if an opioid overdose reversal agent is administered [see *Dosage and Administration (2.2)*, *Warnings and Precautions (5.1, 5.3)*, *Overdosage (10)*].

### **5.3 Risks from Concomitant Use with Benzodiazepines or Other CNS Depressants**

Patients must not consume alcoholic beverages or prescription or non-prescription products containing alcohol while on morphine sulfate extended-release capsules therapy. The co-ingestion of alcohol with morphine sulfate extended-release capsules may result in increased plasma levels and a potentially fatal overdose of morphine [see *Clinical Pharmacology (12.3)*].

Profound sedation, respiratory depression, coma, and death may result from the concomitant use of morphine sulfate extended-release capsules with benzodiazepines and/or other CNS depressants, including alcohol (e.g., non-benzodiazepine sedatives/hypnotics, anxiolytics, tranquilizers, muscle relaxants, general anesthetics, antipsychotics, gabapentinoids [gabapentin or pregabalin], other opioids). Because of these risks, reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate.

Observational studies have demonstrated that concomitant use of opioid analgesics and benzodiazepines increases the risk of drug-related mortality compared to use of opioid analgesics alone. Because of similar pharmacological properties, it is reasonable to expect similar risk with the concomitant use of other CNS depressant drugs with opioid analgesics [see *Drug Interactions (7)*].

If the decision is made to prescribe a benzodiazepine or other CNS depressant concomitantly with an opioid analgesic, prescribe the lowest effective dosages and minimum durations of concomitant use. In patients already receiving an opioid analgesic, prescribe a lower initial dose of the benzodiazepine or other CNS depressant than indicated in the absence of an opioid, and titrate based on clinical response. If an opioid analgesic is initiated in a patient already taking a benzodiazepine or other CNS depressant, prescribe a lower initial dose of the opioid analgesic, and titrate based on clinical response. Inform patients and caregivers of this potential interaction, educate them on the signs and symptoms of respiratory depression (including sedation).

If concomitant use is warranted, consider recommending or prescribing an opioid overdose reversal agent [*see Dosage and Administration (2.2), Warnings and Precautions (5.2), Overdosage (10)*].

Advise both patients and caregivers about the risks of respiratory depression and sedation when morphine sulfate extended-release capsules is used with benzodiazepines or other CNS depressants (including alcohol and illicit drugs). Advise patients not to drive or operate heavy machinery until the effects of concomitant use of the benzodiazepine or other CNS depressant have been determined. Screen patients for risk of substance use disorders, including opioid abuse and misuse, and warn them of the risk for overdose and death associated with the use of additional CNS depressants including alcohol and illicit drugs [*see Drug Interactions (7), Patient Counseling Information (17)*].

#### **5.4 Neonatal Opioid Withdrawal Syndrome**

Use of morphine sulfate extended-release capsules for an extended period of time during pregnancy can result in withdrawal signs in the neonate. Neonatal opioid withdrawal syndrome, unlike opioid withdrawal syndrome in adults, may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. Observe newborns for signs of neonatal opioid withdrawal syndrome and manage accordingly. Advise pregnant women using opioids for an extended period of time of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available [*see Use in Specific Populations (8.1), Patient Counseling Information (17)*].

#### **5.5 Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)**

To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse, the Food and Drug Administration (FDA) has required a Risk Evaluation and Mitigation Strategy (REMS) for these products. Under the requirements of the REMS, drug companies with approved opioid analgesic products must make REMS-compliant education programs available to healthcare providers. Healthcare providers are strongly encouraged to do all of the following:

- Complete a REMS-compliant education program offered by an accredited provider of continuing education (CE) or another education program that includes all the elements of the FDA Education Blueprint for Health Care Providers Involved in the Management or Support of Patients with Pain.
- Discuss the safe use, serious risks, and proper storage and disposal of opioid analgesics with patients and/or their caregivers every time these medicines are prescribed. The Patient Counseling Guide (PCG) can be obtained at this link: [www.fda.gov/OpioidAnalgesicREMSPCG](http://www.fda.gov/OpioidAnalgesicREMSPCG).
- Emphasize to patients and their caregivers the importance of reading the Medication Guide that they will receive from their pharmacist every time an opioid analgesic is dispensed to them.
- Consider using other tools to improve patient, household, and community safety, such as patient-prescriber agreements that reinforce patient-prescriber responsibilities.

To obtain further information on the opioid analgesic REMS and for a list of accredited REMS CME/CE, call 800-503-0784, or log on to [www.opioidanalgesicrems.com](http://www.opioidanalgesicrems.com). The FDA Blueprint can be found at [www.fda.gov/OpioidAnalgesicREMSBlueprint](http://www.fda.gov/OpioidAnalgesicREMSBlueprint).

## **5.6 Opioid-Induced Hyperalgesia and Allodynia**

Opioid-Induced Hyperalgesia (OIH) occurs when an opioid analgesic paradoxically causes an increase in pain, or an increase in sensitivity to pain. This condition differs from tolerance, which is the need for increasing doses of opioids to maintain a defined effect [see *Dependence (9.3)*]. Symptoms of OIH include (but may not be limited to) increased levels of pain upon opioid dosage increase, decreased levels of pain upon opioid dosage decrease, or pain from ordinarily non-painful stimuli (allodynia). These symptoms may suggest OIH only if there is no evidence of underlying disease progression, opioid tolerance, opioid withdrawal, or addictive behavior.

Cases of OIH have been reported, both with short-term and longer-term use of opioid analgesics. Though the mechanism of OIH is not fully understood, multiple biochemical pathways have been implicated. Medical literature suggests a strong biologic plausibility between opioid analgesics and OIH and allodynia. If a patient is suspected to be experiencing OIH, carefully consider appropriately decreasing the dose of the current opioid analgesic, or opioid rotation (safely switching the patient to a different opioid moiety) [see *Dosage and Administration (2.5)*; *Warnings and Precautions (5.6)*].

## **5.7 Life-Threatening Respiratory Depression in Patients with Chronic Pulmonary Disease or in Elderly, Cachectic, or Debilitated Patients**

The use of morphine sulfate extended-release capsules in patients with acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment is contraindicated.

Patients with Chronic Pulmonary Disease: Morphine sulfate extended-release capsules-treated patients with significant chronic obstructive pulmonary disease or cor pulmonale, and those with a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression are at increased risk of decreased respiratory drive including apnea, even at recommended dosages of morphine sulfate extended-release capsules [see *Warnings and Precautions (5.2)*].

Elderly, Cachectic, or Debilitated Patients: Life-threatening respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients as they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients [see *Warnings and Precautions (5.2)*].

Regularly evaluate patients, particularly when initiating and titrating morphine sulfate extended-release capsules and when morphine sulfate extended-release capsules are given concomitantly with other drugs that depress respiration [see *Warnings and Precautions (5.2)*, *Drug Interaction (7)*]. Alternatively, consider the use of non-opioid analgesics in these patients.

## **5.8 Interaction with Monoamine Oxidase Inhibitors**

Monoamine oxidase inhibitors (MAOIs) may potentiate the effects of morphine, including respiratory depression, coma, and confusion. Morphine sulfate extended-release capsules should not be used in patients taking MAOIs or within 14 days of stopping such treatment.

## **5.9 Adrenal Insufficiency**

Cases of adrenal insufficiency have been reported with opioid use, more often following greater than one 1 month of use. Presentation of adrenal insufficiency may include non-specific symptoms and signs including nausea, vomiting, anorexia, fatigue, weakness,

dizziness, and low blood pressure. If adrenal insufficiency is suspected, confirm the diagnosis with diagnostic testing as soon as possible. If adrenal insufficiency is diagnosed, treat with physiologic replacement doses of corticosteroids. Wean the patient off of the opioid to allow adrenal function to recover and continue corticosteroid treatment until adrenal function recovers. Other opioids may be tried as some cases reported use of a different opioid without recurrence of adrenal insufficiency. The information available does not identify any particular opioids as being more likely to be associated with adrenal insufficiency.

### **5.10 Severe Hypotension**

Morphine sulfate extended-release capsules may cause severe hypotension including orthostatic hypotension and syncope in ambulatory patients. There is an increased risk in patients whose ability to maintain blood pressure has already been compromised by a reduced blood volume or concurrent administration of certain CNS depressant drugs (e.g. phenothiazines or general anesthetics) [see *Drug Interactions (7)*]. Regularly evaluate these patients for signs of hypotension after initiating or titrating the dose of morphine sulfate extended-release capsules. In patients with circulatory shock, morphine sulfate extended-release capsules may cause vasodilation that can further reduce cardiac output and blood pressure. Avoid the use of morphine sulfate extended-release capsules in patients with circulatory shock.

### **5.11 Risks of Use in Patients with Increased Intracranial Pressure, Brain Tumors, Head Injury, or Impaired Consciousness**

In patients who may be susceptible to the intracranial effects of CO<sub>2</sub> retention (e.g., those with evidence of increased intracranial pressure or brain tumors), morphine sulfate extended-release capsules may reduce respiratory drive, and the resultant CO<sub>2</sub> retention can further increase intracranial pressure. Monitor such patients for signs of sedation and respiratory depression, particularly when initiating therapy with morphine sulfate extended-release capsules.

Opioids may also obscure the clinical course in a patient with a head injury. Avoid the use of morphine sulfate extended-release capsules in patients with impaired consciousness or coma.

### **5.12 Risks of Gastrointestinal Complications**

Morphine sulfate extended-release capsules are contraindicated in patients with known or suspected gastrointestinal obstruction, including paralytic ileus.

The morphine in morphine sulfate extended-release capsules may cause spasm of the sphincter of Oddi. Opioids may cause increases in the serum amylase. Regularly evaluate patients with biliary tract disease, including acute pancreatitis, for worsening symptoms.

Cases of opioid-induced esophageal dysfunction (OIED) have been reported in patients taking opioids. The risk of OIED may increase as the dose and/or duration of opioids increases. Regularly evaluate patients for signs and symptoms of OIED (e.g., dysphagia, regurgitation, non-cardiac chest pain) and if necessary, adjust opioid therapy as clinically appropriate [see *Clinical Pharmacology (12.2)*].

### **5.13 Increased Risk of Seizures in Patients with Seizure Disorders**

The morphine in morphine sulfate extended-release capsules may increase the frequency of seizures in patients with seizure disorders, and may increase the risk of seizures occurring in other clinical settings associated with seizures. Regularly evaluate patients with a history of seizure disorders for worsened seizure control during morphine sulfate extended-release capsules therapy.

## 5.14 Withdrawal

Do not rapidly reduce or abruptly discontinue morphine sulfate extended-release capsules in a patient physically dependent on opioids. When discontinuing morphine sulfate extended-release capsules in a physically dependent patient, gradually taper the dosage. Rapid tapering of meperidine in a patient physically dependent on opioids may lead to a withdrawal syndrome and return of pain [see *Dosage and Administration (2.4)*, *Drug Abuse and Dependence (9.3)*].

Additionally, avoid the use of mixed agonist/antagonist (e.g., pentazocine, nalbuphine, and butorphanol) or partial agonist (e.g., buprenorphine) analgesics in patients who are receiving a full opioid agonist analgesic, including morphine sulfate extended-release capsules. In these patients, mixed agonist/antagonist and partial agonist analgesics may reduce the analgesic effect and/or may precipitate withdrawal symptoms [see *Drug Interactions (7)*].

## 5.15 Risks of Driving and Operating Machinery

Morphine sulfate extended-release capsules may impair the mental or physical abilities needed to perform potentially hazardous activities such as driving a car or operating machinery. Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of morphine sulfate extended-release capsules and know how they will react to the medication [see *Patient Counseling Information (17)*].

## 6 ADVERSE REACTIONS

The following serious adverse reactions are described, or described in greater detail, in other sections:

- Addiction, Abuse, and Misuse [see *Warnings and Precautions (5.1)*]
- Life Threatening Respiratory Depression [see *Warnings and Precautions (5.2)*]
- Interactions with Benzodiazepines or Other CNS Depressants [see *Warnings and Precautions (5.3)*]
- Neonatal Opioid Withdrawal Syndrome [see *Warnings and Precautions (5.4)*]
- Opioid-Induced Hyperalgesia and Allodynia [see *Warnings and Precautions (5.6)*]
- Adrenal Insufficiency [see *Warnings and Precautions (5.9)*]
- Severe Hypotension [see *Warnings and Precautions (5.10)*]
- Gastrointestinal Adverse Reactions [see *Warnings and Precautions (5.12)*]
- Seizures [see *Warnings and Precautions (5.13)*]
- Withdrawal [see *Warnings and Precautions (5.14)*]

### 6.1 Clinical Trial Experience

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

In controlled and open-label clinical studies, 560 patients with chronic malignant or non-malignant pain were treated with morphine sulfate extended-release capsules. The most common serious adverse events reported with administration of morphine sulfate extended-release capsules were vomiting, nausea, death, dehydration, dyspnea, and sepsis. (Deaths occurred in patients treated for pain due to underlying malignancy.) Serious adverse events caused by morphine include respiratory depression, apnea, and to a lesser degree, circulatory depression, respiratory arrest, shock and cardiac arrest.

The most common adverse events (seen in greater than 10%) reported by patients treated with morphine sulfate extended-release capsules during the clinical trials at least once during therapy were constipation, nausea, somnolence, vomiting, and headache. Adverse events occurring in 5 to 10% of study patients were peripheral edema,

diarrhea, abdominal pain, infection, urinary tract infection, accidental injury, flu syndrome, back pain, rash, sweating, fever, insomnia, depression, paresthesia, anorexia, dry mouth, asthenia and dyspnea. Other less common side effects expected from opioid analgesics, including morphine, or seen in fewer than 5% of patients taking morphine sulfate extended-release capsules in the clinical trials were:

*Body as a Whole:* malaise, withdrawal syndrome.

*Cardiovascular System:* bradycardia, hypertension, hypotension, palpitations, syncope, tachycardia.

*Digestive System:* biliary pain, dyspepsia, dysphagia, gastroenteritis, abnormal liver function tests, rectal disorder, thirst.

*Hemic and Lymphatic System:* anemia, thrombocytopenia.

*Metabolic and Nutritional Disorders:* edema, weight loss.

*Musculoskeletal:* skeletal muscle rigidity.

*Nervous System:* abnormal dreams, abnormal gait, agitation, amnesia, anxiety, ataxia, confusion, convulsions, coma, delirium, euphoria, hallucinations, lethargy, nervousness, abnormal thinking, tremor, vasodilation, vertigo.

*Respiratory System:* hiccup, hypoventilation, voice alteration.

*Skin and Appendages:* dry skin, urticaria.

*Special Senses:* amblyopia, eye pain, taste perversion.

*Urogenital System:* abnormal ejaculation, dysuria, impotence, decreased libido, oliguria, urinary retention.

Anaphylaxis has been reported with ingredients contained in morphine sulfate extended-release capsules. Advise patients how to recognize such a reaction and when to seek medical attention.

## **6.2 Postmarketing Experience**

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

Serotonin syndrome: Cases of serotonin syndrome, a potentially life-threatening condition, have been reported during concomitant use of opioids with serotonergic drugs.

Adrenal insufficiency: Cases of adrenal insufficiency have been reported with opioid use, more often following greater than one month of use.

Anaphylaxis: Anaphylaxis has been reported with ingredients contained in morphine sulfate extended-release capsules.

Androgen deficiency: Cases of androgen deficiency have occurred with use of opioids for an extended period of time [see *Clinical Pharmacology (12.2)*].

Hyperalgesia and Allodynia: Cases of hyperalgesia and allodynia have been reported with opioid therapy of any duration [see *Warnings and Precautions (5.6)*].

Hypoglycemia: Cases of hypoglycemia have been reported in patients taking opioids. Most reports were in patients with at least one predisposing risk factor (e.g., diabetes).

Opioid-induced esophageal dysfunction (OIED): Cases of OIED have been reported in patients taking opioids, and may occur more frequently in patients taking higher doses of opioids, and/or in patients taking opioids longer term [see *Warnings and Precautions (5.12)*].

#### Adverse Reactions from Observational Studies

A prospective, observational cohort study estimated the risks of addiction, abuse, and misuse in patients initiating long-term use of Schedule II opioid analgesics between 2017 and 2021. Study participants included in one or more analyses had been enrolled in selected insurance plans or health systems for at least one year, were free of at least one outcome at baseline, completed a minimum number of follow-up assessments, and either: 1) filled multiple extended-release/long-acting opioid analgesic prescriptions during a 90-day period (n=978); or 2) filled any Schedule II opioid analgesic prescriptions covering at least 70 of 90 days (n=1,244). Those included also had no dispensing of the qualifying opioids in the previous 6 months.

Over 12 months:

- approximately 1% to 6% of participants across the two cohorts newly met criteria for addiction, as assessed with two validated interview-based measures of moderate-to-severe opioid use disorder based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria, and
- approximately 9% and 22% of participants across the two cohorts newly met criteria for prescription opioid abuse and misuse [defined in *Drug Abuse and Dependence (9.2)*], respectively, as measured with a validated self-reported instrument.

A retrospective, observational cohort study estimated the risk of opioid-involved overdose or opioid overdose-related death in patients with new long-term use of Schedule II opioid analgesics from 2006 through 2016 (n=220,249). Included patients had been enrolled in either one of two commercial insurance programs, one managed care program, or one Medicaid program for at least 9 months. New long-term use was defined as having Schedule II opioid analgesic prescriptions covering at least 70 days' supply over the 3 months prior to study entry and none during the preceding 6 months. Patients were excluded if they had an opioid-involved overdose in the 9 months prior to study entry. Overdose was measured using a validated medical code-based algorithm with linkage to the National Death Index database. The 5-year cumulative incidence estimates for opioid-involved overdose or opioid overdose-related death ranged from approximately 1.5% to 4% across study sites, counting only the first event during follow-up. Approximately 17% of first opioid overdoses observed over the entire study period (5-11 years, depending on the study site) were fatal. Higher baseline opioid dose was the strongest and most consistent predictor of opioid-involved overdose or opioid overdose-related death. Study exclusion criteria may have selected patients at lower risk of overdose, and substantial loss to follow-up (approximately 80%) also may have biased estimates.

The risk estimates from the studies described above may not be generalizable to all patients receiving opioid analgesics, such as those with exposures shorter or longer than the duration evaluated in the studies.

## **7 DRUG INTERACTIONS**

Table 1 includes clinically significant drug interactions with morphine sulfate extended-release capsules.

**Table 1: Clinically Significant Drug Interactions with morphine sulfate extended-release capsules**

<b>Alcohol</b>
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<i>Clinical Impact:</i>	Concomitant use of alcohol with morphine sulfate extended-release capsules can result in an increase of morphine plasma levels and potentially fatal overdose of morphine.
<i>Intervention:</i>	Instruct patients not to consume alcoholic beverages or use prescription or non-prescription products containing alcohol while on morphine sulfate extended-release capsules therapy [see <i>Clinical Pharmacology (12.3)</i> ].
<b>Benzodiazepines and Other Central Nervous System (CNS) Depressants</b>	
<i>Clinical Impact:</i>	Due to additive pharmacologic effect, the concomitant use of benzodiazepine or other CNS depressants, including alcohol, can increase the risk of hypotension, respiratory depression, profound sedation, coma, and death.
<i>Intervention:</i>	Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Inform patients and caregivers of this potential interaction, educate them on the signs and symptoms of respiratory depression (including sedation). If concomitant use is warranted, consider recommending or prescribing an opioid overdose reversal agent [see <i>Dosage and Administration (2.2)</i> , <i>Warnings and Precautions (5.1, 5.2, 5.3)</i> ].
<i>Examples:</i>	Benzodiazepines and other sedatives/hypnotics, anxiolytics, tranquilizers and muscle relaxants, general anesthetics, antipsychotics, gabapentinoids (gabapentin or pregabalin), other opioids, alcohol.
<b>Serotonergic Drugs</b>	
<i>Clinical Impact:</i>	The concomitant use of opioids with other drugs that affect the serotonergic

<i>Clinical Impact:</i>	neurotransmitter system has resulted in serotonin syndrome.
<i>Intervention:</i>	If concomitant use is warranted, frequently evaluate the patient, particularly during treatment initiation and dose adjustment. Discontinue morphine sulfate extended-release capsules if serotonin syndrome is suspected.
<i>Examples:</i>	Selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), triptans, 5-HT <sub>3</sub> receptor antagonists, drugs that effect the serotonin neurotransmitter system (e.g., mirtazapine, trazodone, tramadol), certain muscle relaxants (i.e., cyclobenzaprine, metaxalone), monoamine oxidase (MAO) inhibitors (those intended to treat psychiatric disorders and also others, such as linezolid and intravenous methylene blue).
<b>Monoamine Oxidase Inhibitors (MAOIs)</b>	
<i>Clinical Impact:</i>	MAOI interactions with opioids may manifest as serotonin syndrome or opioid toxicity (e.g., respiratory depression, coma) [see <i>Warnings and Precautions (5.2)</i> ].
<i>Intervention:</i>	Do not use morphine sulfate extended-release capsules in patients taking MAOIs or within 14 days of stopping such treatment.
<b>Mixed Agonist/Antagonist and Partial Agonist Opioid Analgesics</b>	
<i>Clinical Impact:</i>	May reduce the analgesic effect of morphine sulfate extended-release capsules and/or precipitate withdrawal symptoms.
<i>Intervention:</i>	Avoid concomitant use.
<i>Examples:</i>	butorphanol, nalbuphine, pentazocine, buprenorphine
<b>Muscle Relaxants</b>	
<i>Clinical Impact:</i>	Morphine may enhance the neuromuscular blocking action of skeletal muscle relaxants and produce an increased

	degree of respiratory depression.
<i>Intervention:</i>	Because respiratory depression may be greater than otherwise expected, decrease the dosage of morphine sulfate extended-release capsules and/or the muscle relaxant as necessary. Due to the risk of respiratory depression with concomitant use of muscle relaxants and opioids, consider recommending or prescribing an opioid overdose reversal agent. [see Dosage and Administration (2.2), Warnings and Precautions (5.2, 5.3)]
<i>Examples:</i>	cyclobenzaprine, metaxalone
<b>Cimetidine</b>	
<i>Clinical Impact:</i>	The concomitant use of cimetidine can potentiate morphine effects and increase risk of hypotension, respiratory depression, profound sedation, coma, and death.
<i>Intervention:</i>	Evaluate patients for signs of respiratory depression that may be greater than otherwise expected and decrease the dosage of morphine sulfate extended-release capsules and/or cimetidine as necessary.
<b>Diuretics</b>	
<i>Clinical Impact:</i>	Opioids can reduce the efficacy of diuretics by inducing the release of antidiuretic hormone.
<i>Intervention:</i>	Evaluate patients for signs of diminished diuresis and/or effects on blood pressure and increase the dosage of the diuretic as needed.
<b>Anticholinergic Drugs</b>	
<i>Clinical Impact:</i>	The concomitant use of anticholinergic drugs may increase risk of urinary retention and/or severe constipation, which may lead to paralytic ileus.
<i>Intervention:</i>	Evaluate patients for signs of urinary retention or reduced gastric motility when morphine sulfate extended-release

	capsules are used concomitantly with anticholinergic drugs.
<b>P-Glycoprotein (PGP) Inhibitors</b>	
<i>Clinical Impact:</i>	The concomitant use of PGP-inhibitors can increase the exposure to morphine by about two-fold and can increase risk of hypotension, respiratory depression, profound sedation, coma, and death.
<i>Intervention:</i>	Evaluate patients for signs of respiratory depression that may be greater than otherwise expected and decrease the dosage of morphine sulfate extended-release capsules and/or the PGP-inhibitor as necessary.

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

#### Risk Summary

Use of opioid analgesics for an extended period of time during pregnancy may cause neonatal opioid withdrawal syndrome [see *Warnings and Precautions (5.4)*]. There are no available data with morphine sulfate extended-release capsules in pregnant women to inform a drug-associated risk for major birth defects and miscarriage. Published studies with morphine use during pregnancy have not reported a clear association with morphine and major birth defects [see *Human Data*].

In published animal reproduction studies, morphine administered subcutaneously during the early gestational period produced neural tube defects (i.e., exencephaly and cranioschisis) at 5 and 16 times the human daily dose of 60 mg based on body surface area (HDD) in hamsters and mice, respectively, lower fetal body weight and increased incidence of abortion at 0.4 times the HDD in the rabbit, growth retardation at 6 times the HDD in the rat, and axial skeletal fusion and cryptorchidism at 16 times the HDD in the mouse.

Administration of morphine sulfate to pregnant rats during organogenesis and through lactation resulted in cyanosis, hypothermia, decreased brain weights, pup mortality, decreased pup body weights, and adverse effects on reproductive tissues at 3 to 4 times the HDD; and long-term neurochemical changes in the brain of offspring which correlate with altered behavioral responses that persist through adulthood at exposures comparable to and less than the HDD [see *Animal Data*]. Based on animal data, advise pregnant women of the potential risk to a fetus.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

## Clinical Considerations

### *Fetal/neonatal adverse reactions*

Use of opioid analgesics for an extended period of time during pregnancy for medical or nonmedical purposes can result in physical dependence in the neonate and neonatal opioid withdrawal syndrome shortly after birth. Neonatal opioid withdrawal syndrome presents as irritability, hyperactivity and abnormal sleep pattern, high pitched cry, tremor, vomiting, diarrhea and failure to gain weight. The onset, duration, and severity of neonatal opioid withdrawal syndrome vary based on the specific opioid used, duration of use, timing and amount of last maternal use, and rate of elimination of the drug by the newborn. Observe newborns for symptoms of neonatal opioid withdrawal syndrome and manage accordingly [see *Warnings and Precautions (5.4)*].

### *Labor or Delivery*

Opioids cross the placenta and may produce respiratory depression and psychophysiological effects in neonates. An opioid overdose reversal agent, such as naloxone or nalmefene, must be available for reversal of opioid-induced respiratory depression in the neonate. Morphine sulfate extended-release capsules are not recommended for use in pregnant women during or immediately prior to labor, when use of shorter-acting analgesics or other analgesic techniques are more appropriate. Opioid analgesics, including morphine sulfate extended-release capsules, can prolong labor through actions which temporarily reduce the strength, duration, and frequency of uterine contractions. However, this effect is not consistent and may be offset by an increased rate of cervical dilation, which tends to shorten labor. Monitor neonates exposed to opioid analgesics during labor for signs of excess sedation and respiratory depression.

## Data

### *Human Data*

The results from a population-based prospective cohort, including 70 women exposed to morphine during the first trimester of pregnancy and 448 women exposed to morphine at any time during pregnancy, indicate no increased risk for congenital malformations. However, these studies cannot definitely establish the absence of any risk because of methodological limitations, including small sample size and non-randomized study design.

### *Animal Data*

Formal reproductive and developmental toxicology studies for morphine have not been conducted. Exposure margins for the following published study reports are based on human daily dose of 60 mg morphine using a body surface area comparison (HDD).

Neural tube defects (exencephaly and cranioschisis) were noted following subcutaneous administration of morphine sulfate (35 to 322 mg/kg) on Gestation Day 8 to pregnant hamsters (4.7 to 43.5 times the HDD). A no adverse effect level was not defined in this study and the findings cannot be clearly attributed to maternal toxicity. Neural tube defects (exencephaly), axial skeletal fusions, and cryptorchidism were reported following a single subcutaneous (SC) injection of morphine sulfate to pregnant mice (100 to 500 mg/kg) on Gestation Day 8 or 9 at 200 mg/kg or greater (16 times the HDD) and fetal resorption at 400 mg/kg or higher (32 times the HDD). No adverse effects were noted following 100 mg/kg morphine in this model (8 times the HDD). In one study, following continuous subcutaneous infusion of doses greater than or equal to 2.72 mg/kg to mice (0.2 times the HDD), exencephaly, hydronephrosis, intestinal hemorrhage, split supraoccipital, malformed sternbrae, and malformed xiphoid were noted. The effects were reduced with increasing daily dose; possibly due to rapid induction of tolerance under these infusion conditions. The clinical significance of this report is not clear.

Decreased fetal weights were observed in pregnant rats treated with 20 mg/kg/day morphine sulfate (3.2 times the HDD) from Gestation Day 7 to 9. There was no evidence

of malformations despite maternal toxicity (10% mortality). In a second rat study, decreased fetal weight and increased incidences of growth retardation were noted at 35 mg/kg/day (5.7 times the HDD) and there was a reduced number of fetuses at 70 mg/kg/day (11.4 times the HDD) when pregnant rats were treated with 10, 35, or 70 mg/kg/day morphine sulfate via continuous infusion from Gestation Day 5 to 20. There was no evidence of fetal malformations or maternal toxicity.

An increased incidence of abortion was noted in a study in which pregnant rabbits were treated with 2.5 (0.8 times the HDD) to 10 mg/kg morphine sulfate via subcutaneous injection from Gestation Day 6 to 10. In a second study, decreased fetal body weights were reported following treatment of pregnant rabbits with increasing doses of morphine (10 to 50 mg/kg/day) during the pre-mating period and 50 mg/kg/day (16 times the HDD) throughout the gestation period. No overt malformations were reported in either publication; although only limited endpoints were evaluated.

In published studies in rats, exposure to morphine during gestation and/or lactation periods is associated with: decreased pup viability at 12.5 mg/kg/day or greater (2 times the HDD); decreased pup body weights at 15 mg/kg/day or greater (2.4 times the HDD); decreased litter size, decreased absolute brain and cerebellar weights, cyanosis, and hypothermia at 20 mg/kg/day (3.2 times the HDD); alteration of behavioral responses (play, social-interaction) at 1 mg/kg/day or greater (0.2 times the HDD); alteration of maternal behaviors (e.g., decreased nursing and pup retrievals) in mice at 1 mg/kg or higher (0.08 times the HDD) and rats at 1.5 mg/kg/day or higher (0.2 times the HDD); and a host of behavioral abnormalities in the offspring of rats, including altered responsiveness to opioids at 4 mg/kg/day (0.7 times the HDD) or greater.

Fetal and/or postnatal exposure to morphine in mice and rats has been shown to result in morphological changes in fetal and neonatal brain and neuronal cell loss, alteration of a number of neurotransmitter and neuromodulator systems, including opioid and non-opioid systems, and impairment in various learning and memory tests that appear to persist into adulthood. These studies were conducted with morphine treatment usually in the range of 4 to 20 mg/kg/day (0.7 to 3.2 times the HDD). Additionally, delayed sexual maturation and decreased sexual behaviors in female offspring at 20 mg/kg/day (3.2 times the HDD), and decreased plasma and testicular levels of luteinizing hormone and testosterone, decreased testes weights, seminiferous tubule shrinkage, germinal cell aplasia, and decreased spermatogenesis in male offspring were also observed at 20 mg/kg/day (3.2 times the HDD). Decreased litter size and viability were observed in the offspring of male rats that were intraperitoneally administered morphine sulfate for 1 day prior to mating at 25 mg/kg/day (4.1 times the HDD) and mated to untreated females. Decreased viability and body weight and/or movement deficits in both first and second generation offspring were reported when male mice were treated for 5 days with escalating doses of 120 to 240 mg/kg/day morphine sulfate (9.7 to 19.5 times the HDD) or when female mice treated with escalating doses of 60 to 240 mg/kg/day (4.9 to 19.5 times the HDD) followed by a 5-day treatment-free recovery period prior to mating. Similar multigenerational findings were also seen in female rats pre-gestationally treated with escalating doses of 10 to 22 mg/kg/day morphine (1.6 to 3.6 times the HDD).

## **8.2 Lactation**

### Risk Summary

Morphine is present in breast milk. Published lactation studies report variable concentrations of morphine in breast milk with administration of immediate-release morphine to nursing mothers in the early postpartum period with a milk-to-plasma morphine AUC ratio of 2.5:1 measured in one lactation study. However, there is insufficient information to determine the effects of morphine on the breastfed infant and the effects of morphine on milk production. Lactation studies have not been conducted with extended-release morphine, including morphine sulfate extended-release capsules. Because of the potential for serious adverse reactions, including excess sedation and

respiratory depression in a breastfed infant, advise patients that breastfeeding is not recommended during treatment with morphine sulfate extended-release capsules.

### Clinical Considerations

Monitor infants exposed to morphine through breast milk for excess sedation and respiratory depression. Withdrawal symptoms can occur in breastfed infants when maternal administration of morphine is stopped, or when breastfeeding is stopped.

## **8.3 Females and Males of Reproductive Potential**

### Infertility

Use of opioids for an extended period of time may cause reduced fertility in females and males of reproductive potential. It is not known whether these effects on fertility are reversible [see *Adverse Reactions (6.2)*, *Clinical Pharmacology (12.2)*].

In published animal studies, morphine administration adversely effected fertility and reproductive endpoints in male rats and prolonged estrus cycle in female rats [see *Carcinogenesis, Mutagenesis, Impairment of Fertility (13.1)*].

## **8.4 Pediatric Use**

The safety and effectiveness of morphine sulfate extended-release capsules in pediatric patients below the age of 18 have not been established. The range of dose strengths available may not be appropriate for treatment of very young pediatric patients. Sprinkling on applesauce is **NOT** a suitable alternative for these patients.

## **8.5 Geriatric Use**

The pharmacokinetics of morphine sulfate extended-release capsules have not been studied in elderly patients. In clinical studies of morphine sulfate extended-release capsules, 100 patients who received morphine sulfate extended-release capsules were age 65 and over, including 37 patients were age 75 and over. No overall differences in safety were observed between these subjects and younger subjects [see *Clinical Pharmacology (12.3)*].

Elderly patients (aged 65 years or older) may have increased sensitivity to morphine. In general, use caution when selecting a dosage for an elderly patient, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function and of concomitant disease or other drug therapy.

Respiratory depression is the chief risk for elderly patients treated with opioids, and has occurred after large initial doses were administered to patients who were not opioid-tolerant or when opioids were coadministered with other agents that depress respiration. Titrate the dosage of morphine sulfate extended-release capsules slowly in geriatric patients and frequently reevaluate the patient for signs of central nervous system and respiratory depression [see *Warnings and Precautions (5.7)*].

This drug is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to regularly evaluate renal function.

## **8.6 Hepatic Impairment**

Morphine pharmacokinetics have been reported to be significantly altered in patients with cirrhosis. Start these patients with a lower than normal dosage of morphine sulfate extended-release capsules and titrate slowly while regularly evaluating for signs of respiratory depression, sedation, and hypotension [see *Clinical Pharmacology (12.3)*].

## **8.7 Renal Impairment**

Morphine pharmacokinetics are altered in patients with renal failure. Start these patients with a lower than normal dosage of morphine sulfate extended-release capsules and titrate slowly while regularly evaluating for signs of respiratory depression, sedation, and hypotension [see *Clinical Pharmacology (12.3)*].

## **9 DRUG ABUSE AND DEPENDENCE**

### **9.1 Controlled Substance**

Morphine sulfate extended-release capsules contain morphine, a Schedule II controlled substance.

### **9.2 Abuse**

Morphine sulfate extended-release capsules contains morphine, a substance with high potential for misuse and abuse, which can lead to the development of substance use disorder, including addiction [see *Warnings and Precautions (5.1)*].

Misuse is the intentional use, for therapeutic purposes, of a drug by an individual in a way other than prescribed by a healthcare provider or for whom it was not prescribed.

Abuse is the intentional, non-therapeutic use of a drug, even once, for its desirable psychological or physiological effects.

Drug addiction is a cluster of behavioral, cognitive, and physiological phenomena that may include a strong desire to take the drug, difficulties in controlling drug use (e.g., continuing drug use despite harmful consequences, giving a higher priority to drug use than other activities and obligations), and possible tolerance or physical dependence.

Misuse and abuse of morphine sulfate extended-release capsules increases risk of overdose, which may lead to central nervous system and respiratory depression, hypotension, seizures, and death. The risk is increased with concurrent abuse of morphine sulfate extended-release capsules with alcohol and other CNS depressants. Abuse of and addiction to opioids in some individuals may not be accompanied by concurrent tolerance and symptoms of physical dependence. In addition, abuse of opioids can occur in the absence of addiction.

All patients treated with opioids require careful and frequent reevaluation for signs of misuse, abuse, and addiction, because use of opioid analgesic products carries the risk of addiction even under appropriate medical use. Patients at high risk of morphine sulfate extended-release capsules abuse include those with a history of prolonged use of any opioid, including products containing morphine, those with a history of drug or alcohol abuse, or those who use morphine sulfate extended-release capsules in combination with other abused drugs.

“Drug-seeking” behavior is very common in persons with substance use disorders. Drug-seeking tactics include emergency calls or visits near the end of office hours, refusal to undergo appropriate examination, testing, or referral, repeated “loss” of prescriptions, tampering with prescriptions, and reluctance to provide prior medical records or contact information for other treating healthcare provider(s). “Doctor shopping” (visiting multiple prescribers to obtain additional prescriptions) is common among people who abuse drugs and people with substance use disorder. Preoccupation with achieving adequate pain relief can be appropriate behavior in a patient with inadequate pain control.

Morphine sulfate extended-release capsules, like other opioids, can be diverted for nonmedical use into illicit channels of distribution. Careful record-keeping of prescribing information, including quantity, frequency, and renewal requests, as required by state and federal law, is strongly advised.

Proper assessment of the patient, proper prescribing practices, periodic reevaluation of therapy, and proper dispensing and storage are appropriate measures that help to limit abuse of opioid drugs.

#### Risks Specific to Abuse of morphine sulfate extended-release capsules

Abuse of morphine sulfate extended-release capsules poses a risk of overdose and death. The risk is increased with concurrent use of morphine sulfate extended-release capsules with alcohol and/or other CNS depressants.

Morphine sulfate extended-release capsules is approved for oral use only.

Inappropriate intravenous, intramuscular, or subcutaneous use of morphine sulfate extended-release capsules can result in death, local tissue necrosis, infection, pulmonary granulomas, increased risk of endocarditis, and valvular heart injury, and embolism.

Parenteral drug abuse is commonly associated with transmission of infectious diseases such as hepatitis and HIV.

### **9.3 Dependence**

Both tolerance and physical dependence can develop during use of opioid therapy.

Tolerance is a physiological state characterized by a reduced response to a drug after repeated administration (i.e., a higher dose of a drug is required to produce the same effect that was once obtained at a lower dose).

Physical dependence is a state that develops as a result of a physiological adaptation in response to repeated drug use, manifested by withdrawal signs and symptoms after abrupt discontinuation or a significant dose reduction of a drug.

Withdrawal may be precipitated through the administration of drugs with opioid antagonist activity (e.g., naloxone, nalmefene), mixed agonist/antagonist analgesics (e.g., pentazocine, butorphanol, nalbuphine), or partial agonists (e.g., buprenorphine). Physical dependence may not occur to a clinically significant degree until after several days to weeks of continued use.

Do not rapidly reduce or abruptly discontinue morphine sulfate extended-release capsules in a patient physically dependent on opioids. Rapid reduction or abrupt discontinuation of morphine sulfate extended-release capsules in a patient physically dependent on opioids may lead to serious withdrawal symptoms, uncontrolled pain, and suicide. Rapid reduction or abrupt discontinuation has also been associated with attempts to find other sources of opioid analgesics, which may be confused with drug-seeking for abuse.

When discontinuing morphine sulfate extended-release capsules, gradually taper the dosage using a patient-specific plan that considers the following: the dose of morphine sulfate extended-release capsules the patient has been taking, the duration of treatment, and the physical and psychological attributes of the patient. To improve the likelihood of a successful taper and minimize withdrawal symptoms, it is important that the opioid tapering schedule is agreed upon by the patient. In patients taking opioids for an extended period of time at high doses, ensure that a multimodal approach to pain management, including mental health support (if needed), is in place prior to initiating an opioid analgesic taper [*see Dosage and Administration (2.5), and Warnings and Precautions (5.14)*].

Infants born to mothers physically dependent on opioids will also be physically dependent and may exhibit respiratory difficulties and withdrawal signs [*see Use in Specific Populations (8.1)*].

## **10 OVERDOSAGE**

### Clinical Presentation

Acute overdose with morphine sulfate extended-release capsules can be manifested by respiratory depression, somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, constricted pupils, and, in some cases, pulmonary edema, bradycardia, hypotension, hypoglycemia, partial or complete airway obstruction, atypical snoring, and death. Marked mydriasis rather than miosis may be seen with hypoxia in overdose situations [see *Clinical Pharmacology (12.2)*]. Toxic leukoencephalopathy has been reported after opioid overdose and can present hours, days, or weeks after apparent recovery from the initial intoxication.

### Treatment of Overdose

In cases of overdose, priorities are the re-establishment of a patent and protected airway and institution of assisted or controlled ventilation, if needed. Employ other supportive measures (including oxygen, vasopressors) in the management of circulatory shock and pulmonary edema as indicated. Cardiac arrest or arrhythmias will require advanced life-support measures.

For clinically significant respiratory or circulatory depression secondary to opioid overdose, administer an opioid overdose reversal agent such as naloxone or nalmefene.

Because the duration of reversal would be expected to be less than the duration of action of morphine in morphine sulfate extended-release capsules, carefully monitor the patient until spontaneous respiration is reliably re-established. Morphine sulfate extended-release capsules will continue to release morphine and add to the morphine load for 36 to 48 hours or longer following ingestion necessitating prolonged monitoring. If the response to an opioid overdose reversal agent is suboptimal or only brief in nature, administer additional reversal agent as directed by the product's prescribing information.

In an individual physically dependent on opioids, administration of the recommended usual dosage of the opioid overdose reversal agent will precipitate an acute withdrawal syndrome. The severity of the withdrawal symptoms experienced will depend on the degree of physical dependence and the dose of the reversal agent administered. If a decision is made to treat serious respiratory depression in the physically dependent patient, administration of the reversal agent should be begun with care and by titration with smaller than usual doses of the reversal agent.

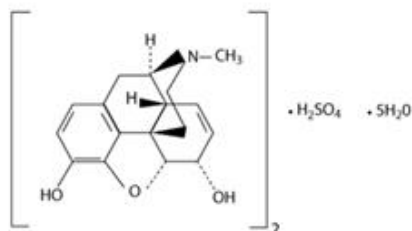
## **11 DESCRIPTION**

Morphine sulfate extended-release capsules, USP (once daily) are for oral use and contain pellets of morphine sulfate, an opioid agonist.

Each morphine sulfate extended-release capsule contains either 30 mg, 45 mg, 60 mg, 75 mg, 90 mg, or 120 mg of morphine sulfate, USP and the following inactive ingredients: diethyl phthalate, ethylcellulose, gelatin, hydroxypropyl cellulose, methacrylic acid copolymer, polyethylene glycol, sugar spheres, talc, and titanium dioxide. The 30 mg capsules also contain FD&C blue No. 1. The 45 mg capsules also contain FD&C blue No. 1 and FD&C red No. 3. The 60 mg capsules also contain D&C yellow No. 10 and FD&C green No. 3. The 75 mg capsules also contain black iron oxide, red iron oxide, and yellow iron oxide. The 90 mg capsules also contain D&C Red No. 33, D&C yellow No. 10 and FD&C blue No. 1. The 120 mg capsules also contain FD&C blue No. 1. The ink ingredients are common for all strengths: black iron oxide, butyl alcohol, dehydrated alcohol, isopropyl alcohol, potassium hydroxide, propylene glycol, purified water, shellac, and strong ammonium solution.

The chemical name of morphine sulfate is 7,8-didehydro-4,5 alpha-epoxy-17-methylmorphinan-3,6 alpha-diol sulfate (2:1) (salt) pentahydrate with a molecular weight of 758.83. The molecular formula is  $(C_{17}H_{19}NO_3)_2 \cdot H_2SO_4 \cdot 5H_2O$ .

Morphine sulfate is an odorless, white, crystalline powder. It is soluble in water and slightly soluble in alcohol, but is practically insoluble in chloroform or ether. The octanol: water partition coefficient of morphine is 1.42 at physiologic pH and the pKa is 7.9 for the tertiary nitrogen (the majority is ionized at pH 7.4). Its structural formula is:



FDA approved dissolution test specifications differ from USP.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Morphine is a full opioid agonist with relative selectivity for the mu-opioid receptor, although it can interact with other opioid receptors at higher doses. The principal therapeutic action of morphine is analgesia. Like all full opioid agonists, there is no ceiling effect for analgesia with morphine. Clinically, dosage is titrated to provide adequate analgesia and may be limited by adverse reactions, including respiratory and CNS depression.

The precise mechanism of the analgesic action is unknown. However, specific CNS opioid receptors for endogenous compounds with opioid-like activity have been identified throughout the brain and spinal cord and are thought to play a role in the analgesic effects of this drug.

### 12.2 Pharmacodynamics

#### CNS Depressant/Alcohol Interaction

Additive pharmacodynamic effects may be expected when morphine sulfate extended-release capsules are used in conjunction with alcohol, other opioids, or illicit drugs that cause central nervous system depression.

#### Effects on the Central Nervous System

Morphine produces respiratory depression by direct action on brainstem respiratory centers. The respiratory depression involves a reduction in the responsiveness of the brainstem respiratory centers to both increases in carbon dioxide tension and to electrical stimulation.

Morphine causes miosis, even in total darkness. Pinpoint pupils are a sign of opioid overdose but are not pathognomonic (e.g., pontine lesions of hemorrhagic or ischemic origins may produce similar findings). Marked mydriasis rather than miosis may be seen with hypoxia in overdose situations.

#### Effects on the Gastrointestinal Tract and Other Smooth Muscle

Morphine causes a reduction in motility and is associated with an increase in smooth muscle tone in the antrum of the stomach and duodenum. Digestion of food in the small intestine is delayed and propulsive contractions are decreased. Propulsive peristaltic waves in the colon are decreased, while tone is increased to the point of spasm, resulting in constipation. Other opioid-induced effects may include a reduction in biliary and pancreatic secretions, spasm of sphincter of Oddi, transient elevations in serum amylase, and opioid-induced esophageal dysfunction (OIED).

Morphine may also cause spasm of the sphincter of the urinary bladder.

#### Effects on the Cardiovascular System

Morphine produces peripheral vasodilation which may result in orthostatic hypotension or syncope. Manifestations of histamine release and/or peripheral vasodilation may include pruritus, flushing, red eyes, sweating, and/or orthostatic hypotension.

#### Effects on the Endocrine System

Opioids inhibit the secretion of adrenocorticotrophic hormone (ACTH), cortisol, and luteinizing hormone (LH) in humans [see *Adverse Reactions (6.2)*]. They also stimulate prolactin, growth hormone (GH) secretion, and pancreatic secretion of insulin and glucagon.

Use of opioids for an extended period of time may influence the hypothalamic-pituitary-gonadal axis, leading to androgen deficiency that may manifest as low libido, impotence, erectile dysfunction, amenorrhea, or infertility. The causal role of opioids in the clinical syndrome of hypogonadism is unknown because the various medical, physical, lifestyle, and psychological stressors that may influence gonadal hormone levels have not been adequately controlled for in studies conducted to date [see *Adverse Reactions (6.2)*].

#### Effects on the Immune System

Opioids have been shown to have a variety of effects on components of the immune system. The clinical significance of these findings is unknown. Overall, the effects of opioids appear to be modestly immunosuppressive.

#### Concentration-Efficacy Relationships

The minimum effective analgesic concentration will vary widely among patients, especially among patients who have been previously treated with opioid agonists. The minimum effective analgesic concentration of morphine for any individual patient may increase over time due to an increase in pain, the development of a new pain syndrome, and/or the development of analgesic tolerance [see *Dosage and Administration (2.1, 2.2)*].

#### Concentration-Adverse Reaction Relationships

There is a relationship between increasing morphine plasma concentration and increasing frequency of dose-related opioid adverse reactions such as nausea, vomiting, CNS effects, and respiratory depression. In opioid-tolerant patients, the situation may be altered by the development of tolerance to opioid-related adverse reactions [see *Dosage and Administration (2.1, 2.3)*].

### **12.3 Pharmacokinetics**

#### Absorption

Morphine sulfate extended-release capsules consist of two components, an immediate-release component and an extended-release component.

The oral bioavailability of morphine is less than 40% and shows large inter-individual variability due to extensive pre-systemic metabolism.

Following single-dose oral administration of a 60 mg dose of morphine sulfate extended-release capsules under fasting conditions, morphine concentrations of approximately 3

to 6 ng/mL were achieved within 30 minutes after dosing and maintained for the 24-hour dosing interval. The pharmacokinetics of morphine sulfate extended-release capsules were shown to be dose-proportional over a single oral dose range of 30 to 120 mg in healthy volunteers and a multiple oral dose range of at least 30 to 180 mg in patients with chronic moderate to severe pain.

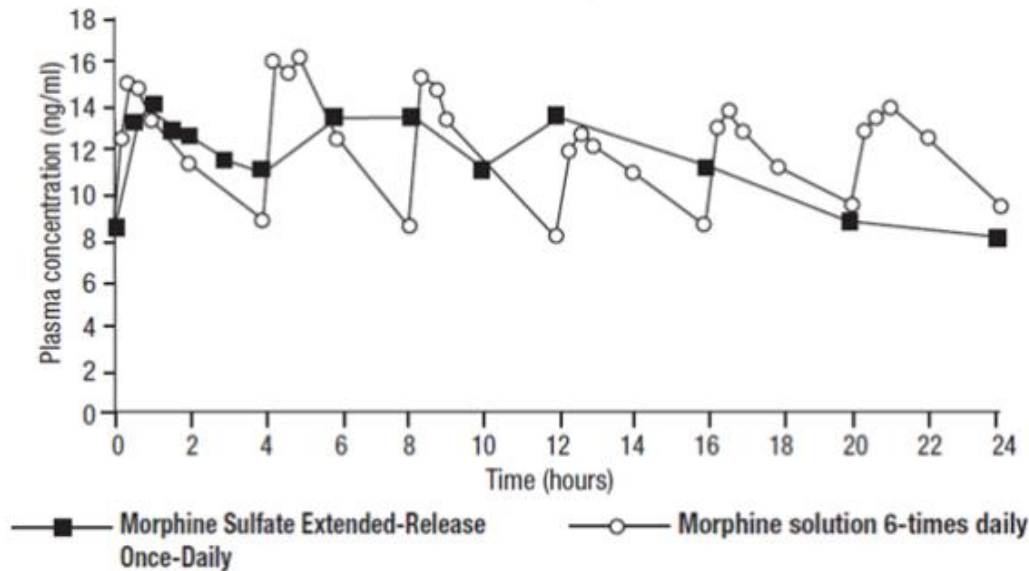
**Food Effect:** When a 60 mg dose of morphine sulfate extended-release capsules was administered immediately following a high fat meal, peak morphine concentrations and AUC values were similar to those observed when the dose of morphine sulfate extended-release capsules was administered in a fasting state, although achievement of initial concentrations was delayed by approximately 1 hour under fed conditions. Therefore, morphine sulfate extended-release capsules can be administered without regard to food. When the contents of morphine sulfate extended-release capsules were administered by sprinkling on applesauce, the rate and extent of morphine absorption were found to be bioequivalent to the same dose when administered as an intact capsule.

**Steady State:** Steady-state plasma concentrations of morphine are achieved 2 to 3 days after initiation of once-daily administration of morphine sulfate extended-release capsules.

Morphine sulfate extended-release 60 mg capsules (once-daily) and 10 mg morphine oral solution (6 times daily) were equally bioavailable.

**Graph 1**

**Mean Steady-State Plasma Morphine Concentrations Following Once-Daily Administration of morphine sulfate extended-release capsules or 6-Times Daily Administration of Morphine Solution**



A once-daily dose of morphine sulfate extended-release capsules provided similar  $C_{max}$ ,  $C_{min}$ , and AUC values and peak-trough fluctuations (% FL,  $C_{max}-C_{min}/C_{av}$ ) compared to 6-times daily administration of the same total daily dose of morphine oral solution (Table 2).

**Table 2 Pharmacokinetic Data Mean ± SD**

Parameter	Morphine Sulfate Extended Release	Morphine Oral Solution
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<b>Parameter</b>	<b>Capsules Once-Daily</b>	<b>Solution 6-Times Daily</b>
AUC (ng/mL.h)	273.25 ± 81.24	279.11 ± 63.00
C <sub>max</sub> (ng/mL)	18.65 ± 7.13	19.96 ± 4.82
C <sub>min</sub> (ng/mL)	6.98 ± 2.44	6.61 ± 2.15
% FL	106.38 ± 78.14	116.22 ± 26.67

### Distribution

Once absorbed, morphine is distributed to skeletal muscle, kidneys, liver, intestinal tract, lungs, spleen and brain. Although the primary site of action is the CNS, only small quantities cross the blood-brain barrier. Morphine also crosses the placental membranes and has been found in breast milk [see *Use in Specific Populations (8.1, 8.3)*]. The volume of distribution of morphine is approximately 1 to 6 L/kg, and morphine is 20 to 35% reversibly bound to plasma proteins.

### Elimination

#### *Metabolism*

The major pathways of morphine metabolism include glucuronidation to produce metabolites including morphine-3-glucuronide, M3G (about 50%) and morphine-6-glucuronide, M6G (about 5 to 15%) and sulfation in the liver to produce morphine-3-etheral sulfate. A small fraction (less than 5%) of morphine is demethylated. M6G has been shown to have analgesic activity but crosses the blood-brain barrier poorly, while M3G has no significant analgesic activity.

#### *Excretion*

Approximately 10% of a morphine dose is excreted unchanged in the urine. Elimination of morphine is primarily via hepatic metabolism to glucuronide metabolites M3G and M6G which are then renally excreted. A small amount of the glucuronide metabolites is excreted in the bile and there is some minor enterohepatic recycling. Seven to 10% of administered morphine is excreted in the feces. The mean adult plasma clearance of morphine is about 20 to 30 mL/minute/kg. The effective terminal half-life of morphine after IV administration is reported to be approximately 2 hours. The terminal elimination half-life of morphine following single dose of morphine sulfate extended-release capsules administration is approximately 24 hrs.

### Specific Populations

#### *Sex*

An analysis of pharmacokinetic data from healthy subjects taking morphine sulfate extended-release capsules indicated that morphine concentrations were similar in males and females.

#### *Race/Ethnicity*

Chinese subjects given intravenous morphine had a higher clearance when compared to Caucasian subjects (1852 +/- 116 mL/min compared to 1495 +/- 80 mL/min).

#### *Hepatic Impairment*

Morphine pharmacokinetics are altered in individuals with cirrhosis. Clearance was found to decrease with a corresponding increase in half-life. The M3G and M6G to morphine plasma AUC ratios also decreased in these subjects, indicating diminished metabolic activity. Adequate studies of the pharmacokinetics of morphine in patients with severe hepatic impairment have not been conducted.

#### *Renal Impairment*

Morphine pharmacokinetics are altered in patients with renal failure. The AUC is increased and clearance is decreased and the metabolites, M3G and M6G, may accumulate to much higher plasma levels in patients with renal failure as compared to patients with normal renal function. Adequate studies of the pharmacokinetics of morphine in patients with severe renal impairment have not been conducted.

#### *Drug Interaction/Alcohol Interaction*

In *in vitro* studies of the dissolution of morphine sulfate extended-release capsules 30 mg mixed with 900 mL of buffer solutions containing ethanol (20% and 40%), the amount of morphine released increased in an alcohol concentration-dependent manner. While the relevance of *in vitro* lab tests regarding morphine sulfate extended-release capsules to the clinical setting remains to be determined, this acceleration of release may correlate with *in vivo* rapid release of the total morphine dose, which could result in the absorption of a potentially fatal dose of morphine.

## **13 NONCLINICAL TOXICOLOGY**

### **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**

#### Carcinogenesis

Long-term animal studies have not been completed to evaluate the carcinogenic potential of morphine.

#### Mutagenesis

No formal studies to assess the mutagenic potential of morphine have been conducted. In the published literature, morphine was found to be mutagenic *in vitro* increasing DNA fragmentation in human T-cells. Morphine was reported to be mutagenic in the *in vivo* mouse micronucleus assay and positive for the induction of chromosomal aberrations in mouse spermatids and murine lymphocytes. Mechanistic studies suggest that the *in vivo* clastogenic effects reported with morphine in mice may be related to increases in glucocorticoid levels produced by morphine in this species. In contrast to the above positive findings, *in vitro* studies in the literature have also shown that morphine did not induce chromosomal aberrations in human leukocytes or translocations or lethal mutations in *Drosophila*.

#### Impairment of Fertility

No formal nonclinical studies to assess the potential of morphine to impair fertility have been conducted. Several nonclinical studies from the literature have demonstrated adverse effects on male fertility in the rat from exposure to morphine. One study in which male rats were administered morphine sulfate subcutaneously prior to mating (up to 30 mg/kg twice daily) and during mating (20 mg/kg twice daily) with untreated females, a number of adverse reproductive effects including reduction in total pregnancies and higher incidence of pseudopregnancies at 20 mg/kg/day (3.2 times the HDD) were reported. Studies from the literature have also reported changes in hormonal levels in male rats (i.e. testosterone, luteinizing hormone) following treatment with morphine at 10 mg/kg/day or greater (1.6 times the HDD).

Female rats that were administered morphine sulfate intraperitoneally prior to mating exhibited prolonged estrous cycles at 10 mg/kg/day (1.6 times the HDD).

Exposure of adolescent male rats to morphine has been associated with delayed sexual maturation, and following mating to untreated females, smaller litters, increased pup mortality, and/or changes in reproductive endocrine status in adult male offspring have been reported (estimated 5 times the plasma levels at the HDD).

## **14 CLINICAL STUDIES**

Morphine sulfate extended-release capsules were studied in a double-blind, placebo-controlled, fixed-dose, parallel group trial in 295 patients with moderate to severe pain due to osteoarthritis. These patients had either a prior sub-optimal response to acetaminophen, NSAID therapy, or previously received intermittent opioid analgesic therapy. Thirty-milligrams morphine sulfate extended-release capsules administered once-daily, either in the morning or the evening, were more effective than placebo in reducing pain.

**Table 3 Change from Baseline in WOMAC OA Index Pain VAS Subscale Score**


Overall	Placebo	Morphine Sulfate Extended-Release Capsules QAM	Morphine Sulfate Extended-Release Capsules QPM
LS Mean	-36.23	-75.26 <sup>a</sup>	-75.39 <sup>a</sup>
Std. Error	11.482	11.305	11.747


a) P<0.05; REPEATED MEASURES ANALYSIS


This study was not designed to assess the effects of morphine sulfate extended-release capsules on the course of the osteoarthritis.


## 16 HOW SUPPLIED/STORAGE AND HANDLING


Morphine sulfate extended-release capsules, USP (Once Daily) are available as follows:


30 mg – Size 3 capsule with dark blue opaque cap and body, printed with  and 3090 on both the cap and body in black ink. Capsules are supplied in bottles of 100 (NDC 0228-3090-11).

45 mg – Size 3 capsule with violet opaque cap and body, printed with  and 3116 on both the cap and body in black ink. Capsules are supplied in bottles of 100 (NDC 0228-3116-11).

60 mg – Size 2 capsule with light green opaque cap and body, printed with  and 3091 on both the cap and body in black ink. Capsules are supplied in bottles of 100 (NDC 0228-3091-11).

75 mg – Size 1 capsule with brown opaque cap and body, printed with  and 3117 on both the cap and body in black ink. Capsules are supplied in bottles of 100 (NDC 0228-3117-11).

90 mg – Size 1 capsule with green opaque cap and body, printed with  and 3092 on both the cap and body in black ink. Capsules are supplied in bottles of 100 (NDC 0228-3092-11).

120 mg – Size 0 capsule with light blue opaque cap and body, printed with  and 3093 on both the cap and body in black ink. Capsules are supplied in bottles of 100 (NDC 0228-3093-11).

Store at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [see USP Controlled Room Temperature].

Protect from light and moisture.

Dispense in a tight, light-resistant container as defined in USP.

Store morphine sulfate extended-release capsules securely and dispose of properly [see *Patient Counseling Information (17)*].

## 17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide and Instructions for Use).

### Storage and Disposal

Because of the risks associated with accidental ingestion, misuse, and abuse, advise patients to store morphine sulfate extended-release capsules securely, out of sight and reach of children, and in a location not accessible by others, including visitors to the home. Inform patients that leaving morphine sulfate extended-release capsules unsecured can pose a deadly risk to others in the home [see *Warnings and Precautions (5.1, 5.5), Drug Abuse and Dependence (9.2)*].

Advise patients and caregivers that when medicines are no longer needed, they should be disposed of promptly. Expired, unwanted, or unused morphine sulfate extended-release capsules should be disposed of by flushing the unused medication down the toilet if a drug take-back option is not readily available. Inform patients that they can visit [www.fda.gov/drugdisposal](http://www.fda.gov/drugdisposal) for a complete list of medicines recommended for disposal by flushing, as well as additional information on disposal of unused medicines.

### Addiction, Abuse, and Misuse

Inform patients that the use of morphine sulfate extended-release capsules, even when taken as recommended, can result in addiction, abuse, and misuse, which can lead to overdose and death [see *Warnings and Precautions (5.1)*]. Instruct patients not to share morphine sulfate extended-release capsules with others and to take steps to protect morphine sulfate extended-release capsules from theft or misuse.

### Life-Threatening Respiratory Depression

Inform patients of the risk of life-threatening respiratory depression, including information that the risk is greatest when starting morphine sulfate extended-release capsules or when the dose is increased, and that it can occur even at recommended doses.

Educate patients and caregivers on how to recognize respiratory depression and emphasize the importance of calling 911 or getting emergency medical help right away in the event of a known or suspected overdose [see *Warnings and Precautions (5.2)*].

### Accidental Ingestion

Inform patients that accidental ingestion, especially by children, may result in respiratory depression or death [see *Warnings and Precautions (5.2)*].

**Interactions with Alcohol** Instruct patients not to consume alcoholic beverages, as well as prescription and over-the-counter products that contain alcohol, during treatment with morphine sulfate extended-release capsules. The co-ingestion of alcohol with morphine sulfate extended-release capsules may result in increased plasma levels and a potentially fatal overdose of morphine [see *Warnings and Precautions (5.3) and Drug Interactions (7)*].

### Interactions with Benzodiazepines and Other CNS Depressants

Inform patients and caregivers that potentially fatal additive effects may occur if morphine sulfate extended-release capsules are used with benzodiazepines or other CNS depressants, including alcohol (e.g., non-benzodiazepine sedative/hypnotics, anxiolytics, tranquilizers, muscle relaxants, general anesthetics, antipsychotics, gabapentinoids [gabapentin or pregabalin], and other opioids), and not to use these concomitantly unless supervised by a health care provider [see *Warnings and Precautions (5.3), Drug Interactions (7)*].

## Patient Access to an Opioid Overdose Reversal Agent for the Emergency Treatment of Opioid Overdose

Inform patients and caregivers about opioid overdose reversal agents (e.g., naloxone, nalmefene). Discuss the importance of having access to an opioid overdose reversal agent, especially if the patient has risk factors for overdose (e.g., concomitant use of CNS depressants, a history of opioid use disorder, or prior opioid overdose) or if there are household members (including children) or other close contacts at risk for accidental ingestion or opioid overdose.

Discuss with the patient the options for obtaining an opioid overdose reversal agent (e.g., prescription, over-the-counter, or as part of a community-based program) [*see Dosage and Administration (2.2), Warnings and Precautions (5.3)*].

Educate patients and caregivers on how to recognize the signs and symptoms of an overdose.

Explain to patients and caregivers that effects of opioid overdose reversal agents like naloxone and nalmefene are temporary, and that they must call 911 or get emergency medical help right away in all cases of known or suspected opioid overdose, even if an opioid overdose reversal agent is administered [*see Overdosage (10)*].

Advise patients and caregivers:

- how to treat with the overdose reversal agent in the event of an opioid overdose.
- to tell family and friends about the opioid overdose reversal agent, and to keep it in a place where family and friends can access it in an emergency.
- to read the Patient Information (or other educational material) that will come with their opioid overdose reversal agent. Emphasize the importance of doing this before an opioid emergency happens, so the patient and caregiver will know what to do.

## Hyperalgesia and Allodynia

Inform patients and caregivers not to increase opioid dosage without first consulting a clinician. Advise patients to seek medical attention if they experience symptoms of hyperalgesia, including worsening pain, increased sensitivity to pain, or new pain [*see Warnings and Precautions (5.7); Adverse Reactions (6.2)*].

## Serotonin Syndrome

Inform patients that morphine sulfate extended-release capsules could cause a rare but potentially life-threatening condition resulting from concomitant administration of serotonergic drugs. Warn patients of the symptoms of serotonin syndrome and to seek medical attention right away if symptoms develop. Instruct patients to inform their physicians if they are taking, or plan to take serotonergic medications [*see Drug Interactions (7)*].

## MAOI Interaction

Inform patients not to take morphine sulfate extended-release capsules while using any drugs that inhibit monoamine oxidase. Patients should not start MAOIs while taking morphine sulfate extended-release capsules [*see Warnings and Precautions (5.8)*].

## Important Administration Instructions

Instruct patients how to properly take morphine sulfate extended-release capsules, including the following:

- Swallowing morphine sulfate extended-release capsules whole or sprinkling the capsule contents on applesauce and then swallowing immediately without chewing [*see Dosage and Administration (2.1, 2.5)*]
- Not crushing, chewing, or dissolving the pellets in the capsules [*see Dosage and Administration (2.1)*]

- Using morphine sulfate extended-release capsules exactly as prescribed to reduce the risk of life-threatening adverse reactions (e.g., respiratory depression) [*see Warnings and Precautions (5.2)*]
- Not discontinuing morphine sulfate extended-release capsules without first discussing the need for a tapering regimen with the prescriber [*see Dosage and Administration (2.4)*]

#### Important Discontinuation Instructions

In order to avoid developing withdrawal symptoms, instruct patients not to discontinue morphine sulfate extended-release capsules without first discussing a tapering plan with the prescriber [*see Dosage and Administration (2.4)*]

#### Driving or Operating Heavy Machinery

Inform patients that morphine sulfate extended-release capsules may impair the ability to perform potentially hazardous activities such as driving a car or operating heavy machinery. Advise patients not to perform such tasks until they know how they will react to the medication [*see Warnings and Precautions (5.15)*].

#### Constipation

Advise patients of the potential for severe constipation, including management instructions and when to seek medical attention [*see Adverse Reactions (6)*].

#### Adrenal Insufficiency

Inform patients that morphine sulfate extended-release capsules could cause adrenal insufficiency, a potentially life-threatening condition. Adrenal insufficiency may present with non-specific symptoms and signs such as nausea, vomiting, anorexia, fatigue, weakness, dizziness, and low blood pressure. Advise patients to seek medical attention if they experience a constellation of these symptoms [*see Warnings and Precautions (5.9)*].

#### Hypotension

Inform patients that morphine sulfate extended-release capsules may cause orthostatic hypotension and syncope. Instruct patients how to recognize symptoms of low blood pressure and how to reduce the risk of serious consequences should hypotension occur (e.g., sit or lie down, carefully rise from a sitting or lying position) [*see Warnings and Precautions (5.10)*].

#### Anaphylaxis

Inform patients that anaphylaxis has been reported with ingredients contained in morphine sulfate extended-release capsules. Advise patients how to recognize such a reaction and when to seek medical attention [*see Contraindications (4), Adverse Reactions (6)*].

#### Pregnancy

##### Neonatal Opioid Withdrawal Syndrome

Inform female patients of reproductive potential that use of morphine sulfate extended-release capsules for an extended period of time during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated [*see Warnings and Precautions (5.4), Use in Specific Populations (8.1)*].

#### Embryo-Fetal Toxicity

Inform female patients of reproductive potential that morphine sulfate extended-release capsules can cause fetal harm and to inform their healthcare provider of a known or suspected pregnancy [*see Use in Specific Populations (8.1)*].

#### Lactation

Advise patients that breastfeeding is not recommended during treatment with morphine sulfate extended-release capsules [see *Use in Specific Populations (8.2)*]

#### Infertility

Inform patients that use of opioids for an extended period of time may cause reduced fertility. It is not known whether these effects on fertility are reversible [see *Adverse Reactions (6.2)*].

#### **DEA Order Form Required.**

Manufactured For:

**Teva Pharmaceuticals**

Parsippany, NJ 07054

Rev. B 3/2026

#### **MEDICATION GUIDE**

#### **Morphine Sulfate (mor' feen sul' fate) Extended-Release Capsules, USP (Once Daily), CII**

##### **Morphine sulfate extended-release capsules are:**

- A strong prescription pain medicine that contains an opioid (narcotic) that is used to manage severe and persistent pain that requires an extended treatment period with a daily opioid pain medicine when other pain medicines do not treat your pain well enough or you cannot tolerate them.
- A long-acting (extended-release) opioid pain medicine that can put you at risk for overdose and death. Even if you take your dose correctly as prescribed you are at risk for opioid addiction, abuse, and misuse that can lead to death.
- Not to be taken on an “as needed” basis.

##### **Important information about Morphine sulfate extended-release capsules:**

- **Get emergency help or call 911 right away if you take too many morphine sulfate extended-release capsules (overdose).** When you first start taking morphine sulfate extended-release capsules, when your dose is changed, or if you take too much (overdose), serious or life-threatening breathing problems that can lead to death may occur. Ask your healthcare provider about medicines like naloxone or nalmefene that can be used in an emergency to reverse an opioid overdose.
- Taking morphine sulfate extended-release capsules with other opioid medicines, benzodiazepines, gabapentinoids (gabapentin or pregabalin), alcohol, or other central nervous system depressants (including street drugs) can cause severe drowsiness, decreased awareness, breathing problems, coma, and death.
- Never give anyone else your morphine sulfate extended-release capsules. They could die from taking it. Selling or giving away morphine sulfate extended-release capsules is against the law.
- Store morphine sulfate extended-release capsules securely, out of sight and reach of children, and in a location not accessible by others, including visitors to the home.

##### **Do not take morphine sulfate extended-release capsules if you have:**

- severe asthma, trouble breathing, or other lung problems.
- a bowel blockage or have narrowing of the stomach or intestines.

##### **Before taking morphine sulfate extended-release capsules, tell your healthcare provider if you have a history of:**

- head injury, seizures
- liver, kidney, thyroid problems
- problems urinating
- pancreas or gallbladder problems

- abuse of street or prescription drugs, alcohol addiction, opioid overdose, or mental health problems.

**Tell your healthcare provider if you are:**

- noticing your pain getting worse. If your pain gets worse after you take morphine sulfate extended-release capsules, do not take more of morphine sulfate extended-release capsules without first talking to your healthcare provider. Talk to your healthcare provider if the pain that you have increases, if you feel more sensitive to pain, or if you have new pain after taking morphine sulfate extended-release capsules.
- **Are pregnant or planning to become pregnant.** Use of morphine sulfate extended-release capsules for an extended period of time during pregnancy can cause withdrawal symptoms in your newborn baby that could be life-threatening if not recognized and treated.
- **breastfeeding.** Not recommended during treatment with morphine sulfate extended-release capsules. It may harm your baby.
- living in a household where there are small children or someone who has abused street or prescription drugs.
- taking prescription or over-the-counter medicines, vitamins, or herbal supplements. Taking morphine sulfate extended-release capsules with certain other medicines can cause serious side effects.

**When taking morphine sulfate extended-release capsules:**

- Do not change your dose. Take morphine sulfate extended-release capsules exactly as prescribed by your healthcare provider. Use the lowest dose possible for the shortest time needed.
- Take your prescribed dose every 24 hours, at the same time every day. Do not take more than your prescribed dose in 24 hours. If you miss a dose, take your next dose at your usual time the next day.
- Swallow morphine sulfate extended-release capsules whole. Do not cut, break, chew, crush, dissolve, snort, or inject morphine sulfate extended-release capsules because this may cause you to overdose and die.
- If you cannot swallow morphine sulfate extended-release capsules, see the detailed Instructions for Use.
- **Call your healthcare provider if the dose you are taking does not control your pain.**
- **Do not stop taking morphine sulfate extended-release capsules without talking to your healthcare provider.**
- Dispose of expired, unwanted, or unused morphine sulfate extended-release capsules by promptly flushing down the toilet, if a drug take-back option is not readily available. Visit [www.fda.gov/drugdisposal](http://www.fda.gov/drugdisposal) for additional information on disposal of unused medicines.

**While taking morphine sulfate extended-release capsules DO NOT:**

- Drive or operate heavy machinery, until you know how morphine sulfate extended-release capsules affect you. Morphine sulfate extended-release capsules can make you sleepy, dizzy, or lightheaded.
- Drink alcohol, or use prescription or over-the-counter medicines containing alcohol. Using products containing alcohol during treatment with morphine sulfate extended-release capsules may cause you to overdose and die.

**The possible side effects of morphine sulfate extended-release capsules are:**

- constipation, nausea, sleepiness, vomiting, tiredness, headache, dizziness, abdominal pain. Call your healthcare provider if you have any of these symptoms and they are severe.

**Get emergency medical help or call 911 right away if you have:**

- trouble breathing, shortness of breath, fast heartbeat, chest pain, swelling of your face, tongue, or throat, extreme drowsiness, light-headedness when changing positions, feeling faint, agitation, high body temperature, trouble walking, stiff muscles, or mental changes such as confusion.

These are not all the possible side effects of morphine sulfate extended-release capsules. Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088. **For more information go to [dailymed.nlm.nih.gov](http://dailymed.nlm.nih.gov).**

Manufactured For: **Teva Pharmaceuticals**, Parsippany, NJ 07054

For additional product information about morphine sulfate extended-release capsules, contact Teva at 1-888-838-2872.

This Medication Guide has been approved by the U.S. Food and Drug Administration.  
Rev. B 3/2026

## INSTRUCTIONS FOR USE

### **Morphine Sulfate (mor' feen sul' fate) Extended-Release Capsules, USP (Once Daily) CII**

- If you cannot swallow morphine sulfate extended-release capsules, tell your healthcare provider. There may be another way to take morphine sulfate extended-release capsules that may be right for you. If your healthcare provider tells you that you can take morphine sulfate extended-release capsules using this other way, follow these steps:

Morphine sulfate extended-release capsules can be opened and the pellets inside the capsule can be sprinkled over applesauce, as follows:

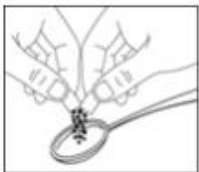


Figure 1

Open the morphine sulfate extended-release capsule and sprinkle the pellets over approximately one tablespoon of applesauce (See Figure 1).

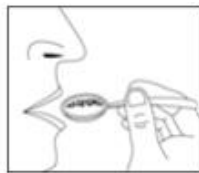


Figure 2

Swallow all of the applesauce and pellets right away. Do not save any of the applesauce and pellets for another dose (See Figure 2).



Figure 3

Rinse your mouth to make sure you have swallowed all of the pellets. Do not chew the pellets (See Figure 3).



Figure 4

Flush the empty capsule down the toilet right away (See Figure 4).

You should not receive morphine sulfate extended-release capsules through a nasogastric tube or gastric tube (stomach tube).

This Instructions for Use has been approved by the U.S. Food and Drug Administration.

Manufactured For:  
**Teva Pharmaceuticals**  
Parsippany, NJ 07054

Rev. B 3/2026

### PRINCIPAL DISPLAY PANEL

NDC 0228-3090-11

CII

(Once Daily)  
Morphine Sulfate Extended-Release Capsules, USP

30 mg

PHARMACIST: Dispense the accompanying Medication Guide to each patient.

Rx only

100 Capsules

NDC 0228-3090-11  
(Once Daily)  
**Morphine Sulfate Extended-Release Capsules, USP**

**30 mg**

PHARMACIST: Dispense the accompanying Medication Guide to each patient.  
Rx only  
100 Capsules

teva

Print Medication Guides at:  
[www.tevausea.com/medguides](http://www.tevausea.com/medguides)  
**Each Extended-Release Capsule Contains:**  
Morphine Sulfate, USP .....30 mg  
**Usual Dosage: ONCE DAILY.** See package literature.  
**DO NOT CRUSH, CHEW, OR DISSOLVE.**  
PROTECT FROM LIGHT AND MOISTURE.  
**KEEP OUT OF REACH OF CHILDREN.**  
**Store** at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].  
**Dispense** in a tight, light-resistant container as defined in the USP.  
Manufactured For:  
Teva Pharmaceuticals  
Parsippany, NJ 07054  
Rev. A 9/2024

GTIN 00302283090113

3 0228-3090-11 3

52-0767

Lot/Exp/Serialization Coding Area

### PRINCIPAL DISPLAY PANEL

NDC 0228-3116-11

CII


(Once Daily)  
Morphine Sulfate Extended-Release Capsules, USP

45 mg

PHARMACIST: Dispense the accompanying Medication Guide to each patient.


Rx only

100 Capsules

NDC 0228-3116-11  
(Once Daily)  
**Morphine Sulfate  
Extended-Release  
Capsules, USP** 

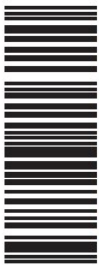
**45 mg**

PHARMACIST: Dispense the accompanying Medication Guide to each patient.  
Rx only  
100 Capsules



GTIN 00302283116110

Print Medication Guides at:  
[www.tevausa.com/medguides](http://www.tevausa.com/medguides)  
**Each Extended-Release Capsule Contains:**  
Morphine Sulfate, USP .....45 mg  
**Usual Dosage: ONCE DAILY.** See package literature.  
**DO NOT CRUSH, CHEW, OR DISSOLVE.**  
PROTECT FROM LIGHT AND MOISTURE.  
**KEEP OUT OF REACH OF CHILDREN.**  
**Store** at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].  
**Dispense** in a tight, light-resistant container as defined in the USP.  
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Rev. A 9/2024

  
N 0228-3116-11 0

52-0768

Lot/Exp/Serialization Coding Area

### PRINCIPAL DISPLAY PANEL

NDC 0228-3091-11

CII

(Once Daily)


Morphine Sulfate Extended-Release Capsules, USP

60 mg

PHARMACIST: Dispense the accompanying Medication Guide to each patient.


Rx only

100 Capsules

NDC 0228-3091-11  
(Once Daily)  
**Morphine Sulfate  
Extended-Release  
Capsules, USP** 

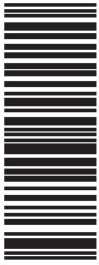
**60 mg**

PHARMACIST: Dispense the accompanying Medication Guide to each patient.  
Rx only  
100 Capsules



GTIN 00302283091110

Print Medication Guides at:  
[www.tevausa.com/medguides](http://www.tevausa.com/medguides)  
**Each Extended-Release Capsule Contains:**  
Morphine Sulfate, USP .....60 mg  
**Usual Dosage: ONCE DAILY.** See package literature.  
**DO NOT CRUSH, CHEW, OR DISSOLVE.**  
PROTECT FROM LIGHT AND MOISTURE.  
**KEEP OUT OF REACH OF CHILDREN.**  
**Store** at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].  
**Dispense** in a tight, light-resistant container as defined in the USP.  
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N 0228-3091-11 0

52-0769

Lot/Exp/Serialization Coding Area

**PRINCIPAL DISPLAY PANEL**

NDC 0228-3117-11

CII

(Once Daily)

Morphine Sulfate Extended-Release Capsules, USP

75 mg

PHARMACIST: Dispense the accompanying Medication Guide to each patient.

Rx only

100 Capsules

NDC 0228-3117-11  
 (Once Daily)  
**Morphine Sulfate Extended-Release Capsules, USP**  
**75 mg**  
 PHARMACIST: Dispense the accompanying Medication Guide to each patient.  
 Rx only  
 100 Capsules

teva

Print Medication Guides at:  
[www.tevausea.com/medguides](http://www.tevausea.com/medguides)  
**Each Extended-Release Capsule Contains:**  
 Morphine Sulfate, USP .....75 mg  
**Usual Dosage: ONCE DAILY.** See package literature.  
**DO NOT CRUSH, CHEW, OR DISSOLVE.**  
 PROTECT FROM LIGHT AND MOISTURE.  
**KEEP OUT OF REACH OF CHILDREN.**  
**Store** at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].  
**Dispense** in a tight, light-resistant container as defined in the USP.  
 Manufactured For:  
 Teva Pharmaceuticals  
 Parsippany, NJ 07054  
 Rev. A 9/2024

GTIN 00302283117117

52-0770

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Lot/Exp/Serialization Coding Area

**PRINCIPAL DISPLAY PANEL**

NDC 0228-3092-11

Rx only

CII

(Once Daily)

Morphine Sulfate Extended-Release Capsules, USP

90 mg

PHARMACIST: Dispense the accompanying Medication Guide to each patient.

FOR USE IN OPIOID-TOLERANT PATIENTS ONLY

100 Capsules

NDC 0228-3092-11    Rx only    GTIN 00302283092117

Print Medication Guides at:  
www.tevause.com/medguides

**Each Extended-Release Capsule Contains:**  
Morphine Sulfate, USP . . . . . 90 mg

**Usual Dosage: ONCE DAILY.** See package literature.  
**DO NOT CRUSH, CHEW, OR DISSOLVE.**  
PROTECT FROM LIGHT AND MOISTURE.  
**KEEP OUT OF REACH OF CHILDREN.**

**Store** at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].

**Dispense** in a tight, light-resistant container as defined in the USP.


Manufactured For:  
Teva Pharmaceuticals  
Parsippany, NJ 07054  
Rev. A 9/2024


**90 mg**

PHARMACIST: Dispense the accompanying Medication Guide to each patient.

FOR USE IN OPIOID-TOLERANT PATIENTS ONLY

100 Capsules



  
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52-0771

**Lot/Exp/Serialization Coding Area**

**PRINCIPAL DISPLAY PANEL**

NDC 0228-3093-11

Rx only

CII

(Once Daily)

Morphine Sulfate Extended-Release Capsules, USP

120 mg

PHARMACIST: Dispense the accompanying Medication Guide to each patient.

FOR USE IN OPIOID-TOLERANT PATIENTS ONLY

100 Capsules

NDC 0228-3093-11    Rx only    GTIN 00302283093114

Print Medication Guides at:  
www.tevause.com/medguides

**Each Extended-Release Capsule Contains:**  
Morphine Sulfate, USP . . . . . 120 mg

**Usual Dosage: ONCE DAILY.** See package literature.  
**DO NOT CRUSH, CHEW, OR DISSOLVE.**  
PROTECT FROM LIGHT AND MOISTURE.  
**KEEP OUT OF REACH OF CHILDREN.**

**Store** at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].

**Dispense** in a tight, light-resistant container as defined in the USP.


Manufactured For:  
Teva Pharmaceuticals  
Parsippany, NJ 07054  
Rev. A 9/2024

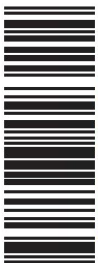
**120 mg**

PHARMACIST: Dispense the accompanying Medication Guide to each patient.

FOR USE IN OPIOID-TOLERANT PATIENTS ONLY

100 Capsules



  
N 3 0228-3093-11 4

52-0772

**Lot/Exp/Serialization Coding Area**

**MORPHINE SULFATE**

morphine sulfate capsule, extended release

Product Information			
<b>Product Type</b>	HUMAN PRESCRIPTION DRUG	<b>Item Code (Source)</b>	NDC:0228-3090
<b>Route of Administration</b>	ORAL	<b>DEA Schedule</b>	CII

Active Ingredient/Active Moiety				
Ingredient Name		Basis of Strength	Strength	
MORPHINE SULFATE (UNII: X3P646A2J0) (MORPHINE - UNII:76I7G6D29C)		MORPHINE SULFATE	30 mg	
Inactive Ingredients				
Ingredient Name			Strength	
DIETHYL PHTHALATE (UNII: UF064M00AF)				
ETHYLCELLULOSES (UNII: 7Z8S9VYZ4B)				
GELATIN (UNII: 2G86QN327L)				
HYDROXYPROPYL CELLULOSE, UNSPECIFIED (UNII: 9XZ8H6N6OH)				
METHACRYLIC ACID - METHYL METHACRYLATE COPOLYMER (1:1) (UNII: 74G4R6TH13)				
POLYETHYLENE GLYCOL, UNSPECIFIED (UNII: 3WJQ0SDW1A)				
SUCROSE (UNII: C151H8M554)				
TALC (UNII: 7SEV7J4R1U)				
TITANIUM DIOXIDE (UNII: 15FIX9V2JP)				
FD&C BLUE NO. 1 (UNII: H3R47K3TBD)				
FERROSFERRIC OXIDE (UNII: XM0M87F357)				
BUTYL ALCOHOL (UNII: 8PJ61P6TS3)				
ALCOHOL (UNII: 3K9958V90M)				
ISOPROPYL ALCOHOL (UNII: ND2M416302)				
POTASSIUM HYDROXIDE (UNII: WZH3C48M4T)				
PROPYLENE GLYCOL (UNII: 6DC9Q167V3)				
WATER (UNII: 059QF0K00R)				
SHELLAC (UNII: 46N107B71O)				
AMMONIA (UNII: 5138Q19F1X)				
Product Characteristics				
Color	blue (dark blue)	Score	no score	
Shape	CAPSULE	Size	16mm	
Flavor		Imprint Code	3090	
Contains				
Packaging				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:0228-3090-11	100 in 1 BOTTLE; Type 0: Not a Combination Product	02/04/2014	
Marketing Information				
Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date	
ANDA	ANDA079040	02/04/2014		

MORPHINE SULFATE			
morphine sulfate capsule, extended release			
Product Information			
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:0228-3116

<b>Route of Administration</b>	ORAL	<b>DEA Schedule</b>	CII
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**Active Ingredient/Active Moiety**

Ingredient Name	Basis of Strength	Strength
<b>MORPHINE SULFATE</b> (UNII: X3P646A2J0) (MORPHINE - UNII:76I7G6D29C)	MORPHINE SULFATE	45 mg

**Inactive Ingredients**

Ingredient Name	Strength
<b>DIETHYL PHTHALATE</b> (UNII: UF064M00AF)	
<b>ETHYLCELLULOSES</b> (UNII: 7Z8S9VYZ4B)	
<b>GELATIN</b> (UNII: 2G86QN327L)	
<b>HYDROXYPROPYL CELLULOSE, UNSPECIFIED</b> (UNII: 9XZ8H6N6OH)	
<b>METHACRYLIC ACID - METHYL METHACRYLATE COPOLYMER (1:1)</b> (UNII: 74G4R6TH13)	
<b>POLYETHYLENE GLYCOL, UNSPECIFIED</b> (UNII: 3WJQ0SDW1A)	
<b>SUCROSE</b> (UNII: C151H8M554)	
<b>TALC</b> (UNII: 7SEV7J4R1U)	
<b>TITANIUM DIOXIDE</b> (UNII: 15FIX9V2JP)	
<b>FD&amp;C BLUE NO. 1</b> (UNII: H3R47K3TBD)	
<b>FD&amp;C RED NO. 3</b> (UNII: PN2ZH5LOQY)	
<b>FERROSO FERRIC OXIDE</b> (UNII: XM0M87F357)	
<b>BUTYL ALCOHOL</b> (UNII: 8PJ61P6TS3)	
<b>ALCOHOL</b> (UNII: 3K9958V90M)	
<b>ISOPROPYL ALCOHOL</b> (UNII: ND2M416302)	
<b>POTASSIUM HYDROXIDE</b> (UNII: WZH3C48M4T)	
<b>PROPYLENE GLYCOL</b> (UNII: 6DC9Q167V3)	
<b>WATER</b> (UNII: 059QF0K00R)	
<b>SHELLAC</b> (UNII: 46N107B71O)	
<b>AMMONIA</b> (UNII: 5138Q19F1X)	

**Product Characteristics**

<b>Color</b>	purple (violet)	<b>Score</b>	no score
<b>Shape</b>	CAPSULE	<b>Size</b>	16mm
<b>Flavor</b>		<b>Imprint Code</b>	3116
<b>Contains</b>			

**Packaging**

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:0228-3116-11	100 in 1 BOTTLE; Type 0: Not a Combination Product	02/04/2014	

**Marketing Information**

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA079040	02/04/2014	

**MORPHINE SULFATE**  
morphine sulfate capsule, extended release

Product Information				
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:0228-3091	
Route of Administration	ORAL	DEA Schedule	CII	
Active Ingredient/Active Moiety				
Ingredient Name	Basis of Strength	Strength		
MORPHINE SULFATE (UNII: X3P646A2J0) (MORPHINE - UNII: 76I7G6D29C)	MORPHINE SULFATE	60 mg		
Inactive Ingredients				
Ingredient Name	Strength			
DIETHYL PHTHALATE (UNII: UF064M00AF)				
ETHYLCELLULOSES (UNII: 7Z8S9VYZ4B)				
GELATIN (UNII: 2G86QN327L)				
HYDROXYPROPYL CELLULOSE, UNSPECIFIED (UNII: 9XZ8H6N6OH)				
METHACRYLIC ACID - METHYL METHACRYLATE COPOLYMER (1:1) (UNII: 74G4R6TH13)				
POLYETHYLENE GLYCOL, UNSPECIFIED (UNII: 3WJQ0SDW1A)				
SUCROSE (UNII: C151H8M554)				
TALC (UNII: 7SEV7J4R1U)				
TITANIUM DIOXIDE (UNII: 15FIX9V2JP)				
D&C YELLOW NO. 10 (UNII: 35SW5USQ3G)				
FD&C GREEN NO. 3 (UNII: 3P3ONR6O1S)				
FERROSFERRIC OXIDE (UNII: XM0M87F357)				
BUTYL ALCOHOL (UNII: 8PJ61P6TS3)				
ALCOHOL (UNII: 3K9958V90M)				
ISOPROPYL ALCOHOL (UNII: ND2M416302)				
POTASSIUM HYDROXIDE (UNII: WZH3C48M4T)				
PROPYLENE GLYCOL (UNII: 6DC9Q167V3)				
WATER (UNII: 059QF0KO0R)				
SHELLAC (UNII: 46N107B71O)				
AMMONIA (UNII: 5138Q19F1X)				
Product Characteristics				
Color	green (light green)	Score	no score	
Shape	CAPSULE	Size	18mm	
Flavor		Imprint Code	3091	
Contains				
Packaging				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:0228-3091-11	100 in 1 BOTTLE; Type 0: Not a Combination Product	02/04/2014	
Marketing Information				
Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date	
ANDA	ANDA079040	02/04/2014		

# MORPHINE SULFATE

morphine sulfate capsule, extended release

## Product Information

<b>Product Type</b>	HUMAN PRESCRIPTION DRUG	<b>Item Code (Source)</b>	NDC:0228-3117
<b>Route of Administration</b>	ORAL	<b>DEA Schedule</b>	CII

## Active Ingredient/Active Moiety

<b>Ingredient Name</b>	<b>Basis of Strength</b>	<b>Strength</b>
<b>MORPHINE SULFATE</b> (UNII: X3P646A2J0) (MORPHINE - UNII:76I7G6D29C)	MORPHINE SULFATE	75 mg

## Inactive Ingredients

<b>Ingredient Name</b>	<b>Strength</b>
<b>DIETHYL PHTHALATE</b> (UNII: UF064M00AF)	
<b>ETHYLCELLULOSES</b> (UNII: 7Z8S9VYZ4B)	
<b>GELATIN</b> (UNII: 2G86QN327L)	
<b>HYDROXYPROPYL CELLULOSE, UNSPECIFIED</b> (UNII: 9XZ8H6N6OH)	
<b>METHACRYLIC ACID - METHYL METHACRYLATE COPOLYMER (1:1)</b> (UNII: 74G4R6TH13)	
<b>POLYETHYLENE GLYCOL, UNSPECIFIED</b> (UNII: 3WJQ0SDW1A)	
<b>SUCROSE</b> (UNII: C151H8M554)	
<b>TALC</b> (UNII: 7SEV7J4R1U)	
<b>TITANIUM DIOXIDE</b> (UNII: 15FIX9V2JP)	
<b>FERROSFERRIC OXIDE</b> (UNII: XM0M87F357)	
<b>FERRIC OXIDE RED</b> (UNII: 1K09F3G675)	
<b>FERRIC OXIDE YELLOW</b> (UNII: EX438O2MRT)	
<b>BUTYL ALCOHOL</b> (UNII: 8PJ61P6TS3)	
<b>ALCOHOL</b> (UNII: 3K9958V90M)	
<b>ISOPROPYL ALCOHOL</b> (UNII: ND2M416302)	
<b>POTASSIUM HYDROXIDE</b> (UNII: WZH3C48M4T)	
<b>PROPYLENE GLYCOL</b> (UNII: 6DC9Q167V3)	
<b>WATER</b> (UNII: 059QF0KO0R)	
<b>SHELLAC</b> (UNII: 46N107B71O)	
<b>AMMONIA</b> (UNII: 5138Q19F1X)	

## Product Characteristics

<b>Color</b>	brown	<b>Score</b>	no score
<b>Shape</b>	CAPSULE	<b>Size</b>	20mm
<b>Flavor</b>		<b>Imprint Code</b>	3117
<b>Contains</b>			

## Packaging

<b>#</b>	<b>Item Code</b>	<b>Package Description</b>	<b>Marketing Start Date</b>	<b>Marketing End Date</b>
1	NDC:0228-3117-11	100 in 1 BOTTLE; Type 0: Not a Combination Product	02/04/2014	

## Marketing Information

<b>Marketing Category</b>	<b>Application Number or Monograph Citation</b>	<b>Marketing Start Date</b>	<b>Marketing End Date</b>
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ANDA	ANDA079040	02/04/2014
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## MORPHINE SULFATE

morphine sulfate capsule, extended release

Product Information			
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:0228-3092
Route of Administration	ORAL	DEA Schedule	CII

Active Ingredient/Active Moiety		
Ingredient Name	Basis of Strength	Strength
MORPHINE SULFATE (UNII: X3P646A2J0) (MORPHINE - UNII:7617G6D29C)	MORPHINE SULFATE	90 mg

Inactive Ingredients	
Ingredient Name	Strength
DIETHYL PHTHALATE (UNII: UF064M00AF)	
ETHYLCELLULOSES (UNII: 7Z8S9VYZ4B)	
GELATIN (UNII: 2G86QN327L)	
HYDROXYPROPYL CELLULOSE, UNSPECIFIED (UNII: 9XZ8H6N6OH)	
METHACRYLIC ACID - METHYL METHACRYLATE COPOLYMER (1:1) (UNII: 74G4R6TH13)	
POLYETHYLENE GLYCOL, UNSPECIFIED (UNII: 3WJQ0SDW1A)	
SUCROSE (UNII: C151H8M554)	
TALC (UNII: 7SEV7J4R1U)	
TITANIUM DIOXIDE (UNII: 15FIX9V2JP)	
FD&C BLUE NO. 1 (UNII: H3R47K3TBD)	
FERROSFERRIC OXIDE (UNII: XM0M87F357)	
BUTYL ALCOHOL (UNII: 8PJ61P6TS3)	
ALCOHOL (UNII: 3K9958V90M)	
ISOPROPYL ALCOHOL (UNII: ND2M416302)	
POTASSIUM HYDROXIDE (UNII: WZH3C48M4T)	
PROPYLENE GLYCOL (UNII: 6DC9Q167V3)	
WATER (UNII: 059QF0KO0R)	
SHELLAC (UNII: 46N107B71O)	
AMMONIA (UNII: 5138Q19F1X)	
D&C RED NO. 33 (UNII: 9DBA0SBB0L)	
D&C YELLOW NO. 10 (UNII: 35SW5USQ3G)	

Product Characteristics			
Color	green	Score	no score
Shape	CAPSULE	Size	19mm
Flavor		Imprint Code	3092
Contains			

Packaging				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:0228-3092-11	100 in 1 BOTTLE; Type 0: Not a Combination Product	02/04/2014	

## Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA079040	02/04/2014	

## MORPHINE SULFATE

morphine sulfate capsule, extended release

### Product Information

Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:0228-3093
Route of Administration	ORAL	DEA Schedule	CII

### Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
MORPHINE SULFATE (UNII: X3P646A2J0) (MORPHINE - UNII:76I7G6D29C)	MORPHINE SULFATE	120 mg

### Inactive Ingredients

Ingredient Name	Strength
DIETHYL PHTHALATE (UNII: UF064M00AF)	
ETHYLCELLULOSES (UNII: 7Z8S9VYZ4B)	
GELATIN (UNII: 2G86QN327L)	
HYDROXYPROPYL CELLULOSE, UNSPECIFIED (UNII: 9XZ8H6N6OH)	
METHACRYLIC ACID - METHYL METHACRYLATE COPOLYMER (1:1) (UNII: 74G4R6TH13)	
POLYETHYLENE GLYCOL, UNSPECIFIED (UNII: 3WJQ0SDW1A)	
SUCROSE (UNII: C151H8M554)	
TALC (UNII: 7SEV7J4R1U)	
TITANIUM DIOXIDE (UNII: 15FIX9V2JP)	
FD&C BLUE NO. 1 (UNII: H3R47K3TBD)	
FERROSFERRIC OXIDE (UNII: XM0M87F357)	
BUTYL ALCOHOL (UNII: 8PJ61P6TS3)	
ALCOHOL (UNII: 3K9958V90M)	
ISOPROPYL ALCOHOL (UNII: ND2M416302)	
POTASSIUM HYDROXIDE (UNII: WZH3C48M4T)	
PROPYLENE GLYCOL (UNII: 6DC9Q167V3)	
WATER (UNII: 059QF0K00R)	
SHELLAC (UNII: 46N107B71O)	
AMMONIA (UNII: 5138Q19F1X)	

### Product Characteristics

Color	blue (light blue)	Score	no score
Shape	CAPSULE	Size	23mm
Flavor		Imprint Code	3093
Contains			

### Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:0228-3093-	100 in 1 BOTTLE; Type 0: Not a Combination	02/04/2014	

11	Product	02/04/2014	
<b>Marketing Information</b>			
Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA079040	02/04/2014	

**Labeler** - Actavis Pharma, Inc. (119723554)

Revised: 3/2026

Actavis Pharma, Inc.