

**MORPHINE SULFATE- morphine sulfate tablet, film coated, extended release**  
**Lake Erie Medical DBA Quality Care Products LLC**

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**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use morphine sulfate extended-release tablets safely and effectively. See full prescribing information for morphine sulfate extended-release tablets.

**MORPHINE sulfate extended-release tablets, for oral use CII**

**Initial U.S. Approval: 1941**

**WARNING: ADDICTION, ABUSE, and MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; and NEONATAL OPIOID WITHDRAWAL SYNDROME**

*See full prescribing information for complete boxed warning.*

- Morphine sulfate extended-release exposes users to risks of addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk before prescribing, and monitor regularly for development of these behaviors and conditions. (5.1)
- Serious, life-threatening or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase. Instruct patients to swallow morphine sulfate extended-release tablets whole to avoid exposure to a potentially fatal dose of morphine. (5.2)
- Accidental ingestion of morphine sulfate extended-release tablets, especially in children, can result in fatal overdose of morphine. (5.2)
- Prolonged use of morphine sulfate extended-release during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available. (5.3)

----- **RECENT MAJOR CHANGES** -----

Boxed Warning	4/2014
Indications and Usage (1)	4/2014
Dosage and Administration (2)	4/2014
Warnings and Precautions (5)	4/2014

----- **INDICATIONS AND USAGE** -----

Morphine sulfate extended-release is an opioid agonist product indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (1)

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve morphine sulfate extended-release for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. (1)
- Morphine sulfate extended-release tablets are not indicated as an as-needed (prn) analgesic. (1)

----- **DOSAGE AND ADMINISTRATION** -----

- For opioid-naïve and opioid non-tolerant patients, initiate with 15 mg tablets orally every 8 to 12 hours. (2.1)
- Do not abruptly discontinue morphine sulfate extended-release in a physically dependent patient. (2.3)
- Instruct patients to swallow morphine sulfate extended-release tablets intact. (2.4)

----- **DOSAGE FORMS AND STRENGTHS** -----

Extended-release tablets: 15 mg, 30 mg, 60 mg, 100 mg, 200 mg (3)

----- **CONTRAINDICATIONS** -----

- Significant respiratory depression (4)
- Acute or severe bronchial asthma (4)
- Known or suspected paralytic ileus (4)
- Hypersensitivity to morphine (4)

----- **WARNINGS AND PRECAUTIONS** -----

- Interaction with CNS depressants: Concomitant use may cause profound sedation, respiratory depression, and death. If coadministration is required, consider dose reduction of one or both drugs because of additive pharmacologic effects. (5.4)

- Elderly, cachectic, debilitated patients, and those with chronic pulmonary disease: Monitor closely because of increased risk for life-threatening respiratory depression. (5.5, 5.6)
- Hypotensive effect: Monitor during dose initiation and titration. (5.7)
- Patients with head injury or increased intracranial pressure: Monitor for sedation and respiratory depression. Avoid use of morphine sulfate extended-release in patients with impaired consciousness or coma susceptible to intracranial effects of CO<sub>2</sub> retention. (5.8)

#### ----- ADVERSE REACTIONS -----

Most common adverse reactions: constipation, nausea, and sedation. (6.1)

**To report SUSPECTED ADVERSE REACTIONS, contact Actavis at 1-800-432-8534 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

#### ----- DRUG INTERACTIONS -----

- Mixed agonist/antagonist and partial agonist opioid analgesics: Avoid use with morphine sulfate extended-release because they may reduce analgesic effect of morphine sulfate extended-release or precipitate withdrawal symptoms. (5.11, 7.2)
- Monoamine oxidase inhibitors (MAOIs): Avoid morphine sulfate extended-release in patients taking MAOIs or within 14 days of stopping such treatment. (7.4)

#### ----- USE IN SPECIFIC POPULATIONS -----

- Pregnancy: Based on animal data, may cause fetal harm. (8.1)
- Nursing mothers: Morphine has been detected in human milk. Closely monitor infants of nursing women receiving morphine sulfate extended-release. (8.3)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 3/2016

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## FULL PRESCRIBING INFORMATION

**WARNING ADDICTION, ABUSE, and MISUSE; LIFE-THREATENING  
RESPIRATORY DEPRESSION, ACCIDENTAL INGESTION; and NEONATAL OPIOID  
WITHDRAWAL SYNDROME**

**Addiction, Abuse, and Misuse**

Morphine sulfate extended-release 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 morphine sulfate extended-release, and monitor all patients regularly for the development of these behaviors or 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. Monitor for respiratory depression, especially during initiation of morphine sulfate extended-release or following a dose increase. Instruct patients to swallow morphine sulfate extended-release tablets whole; crushing, chewing, or dissolving morphine sulfate extended-release tablets 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 tablets, especially by children, can result in a fatal overdose of morphine [see Warnings and Precautions (5.2)].

**Neonatal Opioid Withdrawal Syndrome**

Prolonged use of morphine sulfate extended-release during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available [see Warnings and Precautions (5.3)].

## **1 INDICATIONS & USAGE**

Morphine sulfate extended-release tablets are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

**Limitations of Use**

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve morphine sulfate extended-release for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- Morphine sulfate extended-release is not indicated as an as-needed (prn) analgesic.

## **2 DOSAGE & ADMINISTRATION**

### **2.1 Initial Dosing**

Morphine sulfate extended-release should be prescribed only by healthcare professionals who are

knowledgeable in the use of potent opioids for the management of chronic pain.

Initiate the dosing regimen for each patient individually, taking into account the patient's prior analgesic treatment experience and risk factors for addiction, abuse, and misuse [see Warnings and Precautions (5.1)]. Monitor patients closely for respiratory depression, especially within the first 24 to 72 hours of initiating therapy with morphine sulfate extended-release [see Warnings and Precautions (5.2)].

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

#### *Use of Morphine Sulfate Extended-Release as the First Opioid Analgesic*

Initiate treatment with morphine sulfate extended-release with 15 mg tablets orally every 8 or 12 hours.

#### *Use of Morphine Sulfate Extended-Release in Patients who are not Opioid Tolerant*

The starting dose for patients who are not opioid tolerant is morphine sulfate extended-release 15 mg orally every 12 hours. Patients who are opioid tolerant are those receiving, 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, or an equianalgesic dose of another opioid.

Use of higher starting doses in patients who are not opioid tolerant may cause fatal respiratory depression.

#### *Conversion from Other Oral Morphine to Morphine Sulfate Extended-Release*

Patients receiving other oral morphine formulations may be converted to morphine sulfate extended-release by administering one-half of the patient's 24-hour requirement as morphine sulfate extended-release on an every-12-hour schedule or by administering one-third of the patient's daily requirement as morphine sulfate extended-release on an every-8-hour schedule.

#### *Conversion from Other Opioids to Morphine Sulfate Extended-Release*

There are no established conversion ratios for conversion from other opioids to morphine sulfate extended-release defined by clinical trials. Discontinue all other around-the-clock opioid drugs when morphine sulfate extended-release therapy is initiated and initiate dosing using morphine sulfate extended-release 15 mg orally every 8 to 12 hours.

It is safer to underestimate a patient's 24-hour oral morphine requirements and provide rescue medication (e.g., immediate-release morphine) than to overestimate the 24-hour oral morphine requirements and manage an adverse reaction. While useful tables of opioid equivalents are readily available, there is substantial inter-patient variability in the relative potency of different opioid drugs and products.

#### *Conversion from Parenteral Morphine or Other Opioids (Parenteral or Oral) to Morphine Sulfate Extended-Release*

When converting from parenteral morphine or other non-morphine opioids (parenteral or oral) to morphine sulfate extended-release, 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 or oral non-morphine opioids 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*

Close monitoring is of particular importance when converting 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.

## **2.2 Titration and Maintenance of Therapy**

Individually titrate morphine sulfate extended-release to a dose that provides adequate analgesia and minimizes adverse reactions. Continually reevaluate patients receiving morphine sulfate extended-release to assess the maintenance of pain control and the relative incidence of adverse reactions, as well as monitoring for the development of addiction, abuse, or misuse. 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 chronic therapy periodically reassess the continued need for the use of opioid analgesics.

Patients who experience breakthrough pain may require a dose increase of morphine sulfate extended-release, 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 dose. Because steady-state plasma concentrations are approximated in 1 day, morphine sulfate extended-release dosage adjustments may be done every 1 to 2 days.

If unacceptable opioid-related adverse reactions are observed, the subsequent doses may be reduced. Adjust the dose to obtain an appropriate balance between management of pain and opioid-related adverse reactions.

## **2.3 Discontinuation of Morphine Sulfate Extended-Release**


When the patient no longer requires therapy with morphine sulfate extended-release, use a gradual downward titration of the dose to prevent signs and symptoms of withdrawal in the physically-dependent patient. Do not abruptly discontinue morphine sulfate extended-release.


## **2.4 Administration of Morphine Sulfate Extended-Release Tablets**


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


## **3 DOSAGE FORMS & STRENGTHS**


Morphine sulfate extended-release tablets are available as follows:

15 mg – Each round, white to off white, film-coated tablet is debossed with  on one side and 270 on the other side contain 15 mg of morphine sulfate, USP.

30 mg – Each round, yellow, film-coated tablet is debossed with  on one side and 271 on the other side contain 30 mg of morphine sulfate, USP.

60 mg – Each round, pink, film-coated tablet is debossed with  on one side and 311 on the other side contain 60 mg of morphine sulfate, USP.

\*100 mg – Each round, red, film-coated tablet is debossed with  on one side and 323 on the other side contain 100 mg of morphine sulfate, USP.

\*200 mg – Each capsule-shaped, red, film-coated tablet is debossed with  on one side and 347 on the other side contain 200 mg of morphine sulfate, USP.

**\*100 mg and 200 mg tablets are for use in opioid-tolerant patients only**

## 4 CONTRAINDICATIONS

Morphine sulfate extended-release is contraindicated in patients with:

- Significant respiratory depression
- Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment
- Known or suspected paralytic ileus
- 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 contains morphine, a Schedule II controlled substance. As an opioid, morphine sulfate extended-release exposes its users to the risks of addiction, abuse, and misuse. As modified-release products such as morphine sulfate extended-release deliver the opioid over an extended period of time, there is a greater risk for overdose and death due to the larger amount of morphine present [see Drug Abuse and Dependence (9)].

Although the risk of addiction in any individual is unknown, it can occur in patients appropriately prescribed morphine sulfate extended-release and in those who obtain the drug illicitly. Addiction can occur at recommended doses and if the drug is misused or abused.

Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing morphine sulfate extended-release, and monitor all patients receiving opioids for development of these behaviors or 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 the proper management of pain in any given patient. Patients at increased risk may be prescribed modified-release opioid formulations such as morphine sulfate extended-release, but use in such patients necessitates intensive counseling about the risks of proper use of morphine sulfate extended-release along with intensive monitoring for signs of addiction, abuse, and misuse.

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

Opioid agonists such as morphine sulfate extended-release are sought by drug abusers and people with addiction disorders and are subject to criminal diversion. Consider these risks when prescribing or dispensing morphine sulfate extended-release. Strategies to reduce these risks include prescribing the drug in the smallest appropriate quantity and advising the patient on the proper disposal of unused drug [see Patient Counseling Information (17)]. 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 modified-release opioids, even when used as recommended. Respiratory depression from opioid use, 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 antagonists, 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, the risk is greatest during the initiation of therapy or following a dose increase. Closely monitor patients for respiratory depression when initiating therapy with

morphine sulfate extended-release and following dose increases.

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

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

### **5.3 Neonatal Opioid Withdrawal Syndrome**

Prolonged use of morphine sulfate extended-release 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. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

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.

### **5.4 Interactions with Central Nervous System Depressants**

Hypotension, and profound sedation, coma or respiratory depression may result if morphine sulfate extended-release is used concomitantly with other central nervous system (CNS) depressants (e.g., sedatives, anxiolytics, hypnotics, neuroleptics, other opioids).

When considering the use of morphine sulfate extended-release in a patient taking a CNS depressant, assess the duration of use of the CNS depressant and the patient's response, including the degree of tolerance that has developed to CNS depression. Additionally, evaluate the patient's use of alcohol and/or illicit drugs that cause CNS depression. If the decision to begin morphine sulfate extended-release is made, start with the lowest possible dose, 15 mg every 12 hours, monitor patients for signs of sedation and respiratory depression, and consider using a lower dose of the concomitant CNS depressant [see Drug Interactions (7.1)].

### **5.5 Use in Elderly, Cachectic, and 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. Monitor such patients closely, particularly when initiating and titrating morphine sulfate extended-release and when morphine sulfate extended-release is given concomitantly with other drugs that depress respiration [see Warnings and Precautions (5.2)].

### **5.6 Use in Patients with Chronic Pulmonary Disease**

Monitor patients with significant chronic obstructive pulmonary disease or cor pulmonale, and patients having a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression for respiratory depression, particularly when initiating therapy and titrating with morphine sulfate extended-release, as in these patients, even usual therapeutic doses of morphine sulfate extended-release may decrease respiratory drive to the point of apnea [see Warnings and Precautions (5.2)]. Consider the use of alternative non-opioid analgesics in these patients if possible.

### **5.7 Hypotensive Effects**

Morphine sulfate extended-release 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 (7.1)]. Monitor these patients for signs of hypotension after initiating or titrating the dose of morphine sulfate extended-release. In patients with circulatory shock, morphine sulfate extended-release may cause vasodilation that can further reduce cardiac output and blood pressure. Avoid the use of morphine sulfate extended-release in patients with circulatory shock.

### **5.8 Use in Patients with Head Injury or Increased Intracranial Pressure**

Monitor patients taking morphine sulfate extended-release 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) for signs of sedation and respiratory depression, particularly when initiating therapy with morphine sulfate extended-release. Morphine sulfate extended-release may reduce respiratory drive, and the resultant CO<sub>2</sub> retention can further increase intracranial pressure. Opioids may also obscure the clinical course in a patient with a head injury.

Avoid the use of morphine sulfate extended-release in patients with impaired consciousness or coma.

### **5.9 Use in Patients with Gastrointestinal Conditions**

Morphine sulfate extended-release is contraindicated in patients with paralytic ileus. Avoid the use of morphine sulfate extended-release in patients with other GI obstruction.

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

### **5.10 Use in Patients with Convulsive or Seizure Disorders**

The morphine in morphine sulfate extended-release may aggravate convulsions in patients with convulsive disorders, and may induce or aggravate seizures in some clinical settings. Monitor patients with a history of seizure disorders for worsened seizure control during morphine sulfate extended-release therapy.

### **5.11 Avoidance of Withdrawal**

Avoid the use of mixed agonist/antagonist (i.e., pentazocine, nalbuphine, and butorphanol) or partial agonist (buprenorphine) analgesics in patients who have received or are receiving a course of therapy with a full opioid agonist analgesic, including morphine sulfate extended-release. In these patients, mixed agonists/antagonist and partial agonist analgesics may reduce the analgesic effect and/or may precipitate withdrawal symptoms.

When discontinuing morphine sulfate extended-release, gradually taper the dose [see Dosage and Administration (2.3)]. Do not abruptly discontinue morphine sulfate extended-release.

### **5.12 Driving and Operating Machinery**

Morphine sulfate extended-release 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 and know how they will react to the medication.

## **6 ADVERSE REACTIONS**

The following serious adverse reactions are described elsewhere in the labeling:

- Addiction, Abuse, and Misuse [see Warnings and Precautions (5.1)]
- Life-Threatening Respiratory Depression [see Warnings and Precautions (5.2)]
- Neonatal Opioid Withdrawal Syndrome [see Warnings and Precautions (5.3)]

- Interactions with Other CNS Depressants [see Warnings and Precautions (5.4)]
- Hypotensive Effect [see Warnings and Precautions (5.7)]
- Gastrointestinal Effects [see Warnings and Precautions (5.9)]
- Seizures [see Warnings and Precautions (5.10)]

## 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 to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Morphine sulfate extended-release may increase the risk of serious adverse reactions such as those observed with other opioid analgesics, including respiratory depression, apnea, respiratory arrest, circulatory depression, hypotension, or shock [see Overdosage (10)].

### Most Frequently Observed Reactions

In clinical trials, the most common adverse reactions with morphine sulfate extended-release were constipation, dizziness, sedation, nausea, vomiting, sweating, dysphoria, and euphoric mood.

Some of these effects seem to be more prominent in ambulatory patients and in those not experiencing severe pain.

### Less Frequently Observed Reactions

**Cardiovascular disorders:** tachycardia, bradycardia, palpitations

**Eye disorders:** visual impairment, vision blurred, diplopia, miosis

**Gastrointestinal disorders:** dry mouth, diarrhea, abdominal pain, constipation, dyspepsia

**General disorders and administration site conditions:** chills, feeling abnormal, edema, edema peripheral, weakness

**Hepatobiliary disorders:** biliary colic

**Metabolism and nutrition disorders:** anorexia

**Musculoskeletal and connective tissue disorders:** muscle rigidity, muscle twitching

**Nervous system disorders:** presyncope, syncope, headache, tremor, uncoordinated muscle movements, convulsion, intracranial pressure increased, taste alteration, paresthesia, nystagmus

**Psychiatric disorders:** agitation, mood altered, anxiety, depression, abnormal dreams, hallucination, disorientation, insomnia

**Renal and urinary disorders:** urinary retention, urinary hesitation, antidiuretic effects

**Reproductive system and breast disorders:** reduced libido and/or potency

**Respiratory, thoracic and mediastinal disorders:** laryngospasm

**Skin and subcutaneous tissue disorders:** pruritus, urticaria, rash

**Vascular disorders:** flushing, hypotension, hypertension

## 6.2 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of morphine sulfate extended-release: amenorrhea, asthenia, bronchospasm, confusional state, drug hypersensitivity, fatigue, hyperalgesia, hypertonia, ileus, increased hepatic enzymes, intestinal obstruction, lethargy, malaise, pulmonary edema, thinking disturbances, somnolence, and vertigo.

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

## **7 DRUG INTERACTIONS**

### **7.1 CNS Depressants**

The concomitant use of morphine sulfate extended-release with other CNS depressants including sedatives, hypnotics, tranquilizers, general anesthetics, phenothiazines, other opioids, and alcohol can increase the risk of respiratory depression, profound sedation, coma, and death. Monitor patients receiving CNS depressants and morphine sulfate extended-release for signs of respiratory depression, sedation, and hypotension.

When combined therapy with any of the above medications is considered, the dose of one or both agents should be reduced [see Dosage and Administration (2.2) and Warnings and Precautions (5.4)].

### **7.2 Interactions with Mixed Agonist/Antagonist and Partial Agonist Opioid Analgesics**

Mixed agonist/antagonist (i.e., pentazocine, nalbuphine, and butorphanol) and partial agonist (buprenorphine) analgesics may reduce the analgesic effect of morphine sulfate extended-release or precipitate withdrawal symptoms. Avoid the use of agonist/antagonist and partial agonist analgesics in patients receiving morphine sulfate extended-release.

### **7.3 Muscle Relaxants**

Morphine may enhance the neuromuscular blocking action of skeletal muscle relaxants and produce an increased degree of respiratory depression. Monitor patients receiving muscle relaxants and morphine sulfate extended-release for signs of respiratory depression that may be greater than otherwise expected.

### **7.4 Monoamine Oxidase Inhibitors (MAOIs)**

The effects of morphine may be potentiated by MAOIs. Monitor patients on concurrent therapy with an MAOI and morphine sulfate extended-release for increased respiratory and central nervous system depression. MAOIs have been reported to potentiate the effects of morphine anxiety, confusion, and significant depression of respiration or coma. Morphine sulfate extended-release should not be used in patients taking MAOIs or within 14 days of stopping such treatment.

### **7.5 Cimetidine**

Cimetidine can potentiate morphine-induced respiratory depression. There is a report of confusion and severe respiratory depression when a patient undergoing hemodialysis was concurrently administered morphine and cimetidine. Monitor patients for respiratory depression when morphine sulfate extended-release and cimetidine are used concurrently.

### **7.6 Diuretics**

Morphine can reduce the efficacy of diuretics by inducing the release of antidiuretic hormone. Morphine may also lead to acute retention of urine by causing spasm of the sphincter of the bladder, particularly in men with enlarged prostates.

### **7.7 Anticholinergics**

Anticholinergics or other medications with anticholinergic activity when used concurrently with opioid analgesics may result in increased risk of urinary retention and/or severe constipation, which may lead to paralytic ileus. Monitor patients for signs of urinary retention or reduced gastric motility when morphine sulfate extended-release is used concurrently with anticholinergic drugs.

### **7.8 P-Glycoprotein (PGP) Inhibitors**

PGP-inhibitors (e.g., quinidine) may increase the absorption/exposure of morphine sulfate by about two-

fold. Therefore, monitor patients for signs of respiratory and central nervous system depression when morphine sulfate extended-release is used concurrently with PGP inhibitors.

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

#### Clinical Considerations

##### Fetal/neonatal adverse reactions

Prolonged use of opioid analgesics during pregnancy for medical or nonmedical purposes can result in physical dependence in the neonate and neonatal opioid withdrawal syndrome shortly after birth. Observe newborns for symptoms of neonatal opioid withdrawal syndrome, such as poor feeding, diarrhea, irritability, tremor, rigidity, and seizures, and manage accordingly [see Warnings and Precautions (5.3)].

##### Teratogenic Effects -Pregnancy Category C

There are no adequate and well-controlled studies in pregnant women. Morphine sulfate extended-release should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

In humans, the frequency of congenital anomalies has been reported to be no greater than expected among the children of 70 women who were treated with morphine during the first four months of pregnancy or in 448 women treated with morphine anytime during pregnancy. Furthermore, no malformations were observed in the infant of a woman who attempted suicide by taking an overdose of morphine and other medication during the first trimester of pregnancy.

Several literature reports indicate that morphine administered subcutaneously during the early gestational period in mice and hamsters produced neurological, soft tissue and skeletal abnormalities. With one exception, the effects that have been reported were following doses that were maternally toxic and the abnormalities noted were characteristic of those observed when maternal toxicity is present. In one study, following subcutaneous infusion of doses greater than or equal to 0.15 mg/kg to mice, exencephaly, hydronephrosis, intestinal hemorrhage, split supraoccipital, malformed sternebrae, and malformed xiphoid were noted in the absence of maternal toxicity. In the hamster, morphine sulfate given subcutaneously on gestation day 8 produced exencephaly and cranioschisis. In rats treated with subcutaneous infusions of morphine during the period of organogenesis, no teratogenicity was observed. No maternal toxicity was observed in this study, however, increased mortality and growth retardation were seen in the offspring. In two studies performed in the rabbit, no evidence of teratogenicity was reported at subcutaneous doses up to 100 mg/kg.

##### Non-Teratogenic Effects

Infants born to mothers who have taken opioids chronically may exhibit neonatal withdrawal syndrome [see Warnings and Precautions (5.3)], reversible reduction in brain volume, small size, decreased ventilatory response to CO<sub>2</sub> and increased risk of sudden infant death syndrome. Morphine sulfate should be used by a pregnant woman only if the need for opioid analgesia clearly outweighs the potential risks to the fetus.

Controlled studies of chronic *in utero* morphine exposure in pregnant women have not been conducted. Published literature has reported that exposure to morphine during pregnancy in animals is associated with reduction in growth and a host of behavioral abnormalities in the offspring. Morphine treatment during gestational periods of organogenesis in rats, hamsters, guinea pigs and rabbits resulted in the following treatment-related embryotoxicity and neonatal toxicity in one or more studies: decreased litter size, embryo-fetal viability, fetal and neonatal body weights, absolute brain and cerebellar weights, delayed motor and sexual maturation, and increased neonatal mortality, cyanosis and hypothermia. Decreased fertility in female offspring, 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. Decreased litter size and viability were observed in the offspring of male rats administered morphine (25 mg/kg, IP) for 1 day prior to mating. Behavioral abnormalities resulting from chronic morphine exposure of fetal animals included altered reflex and motor skill development, mild withdrawal, and altered responsiveness to morphine persisting into adulthood.

## **8.2 Labor and Delivery**

Opioids cross the placenta and may produce respiratory depression in neonates. Morphine sulfate extended-release is not for use in women during and immediately prior to labor, when shorter acting analgesics or other analgesic techniques are more appropriate. Opioid analgesics can prolong labor through actions that 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 dilatation, which tends to shorten labor.

## **8.3 Nursing Mothers**

Morphine is excreted in breast milk, with a milk to plasma morphine AUC ratio of approximately 2.5:1. The amount of morphine received by the infant varies depending on the maternal plasma concentration, the amount of milk ingested by the infant, and the extent of first pass metabolism.

Withdrawal signs can occur in breast-feeding infants when maternal administration of morphine is stopped.

Because of the potential for adverse reactions in nursing infants from morphine sulfate extended-release, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

## **8.4 Pediatric Use**

The safety and effectiveness in pediatric patients below the age of 18 have not been established.

## **8.5 Geriatric Use**

The pharmacokinetics of morphine sulfate extended-release have not been studied in elderly patients. Clinical studies of morphine sulfate extended-release did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. In general, dose selection for an elderly patient should be cautious, 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.

# **9 DRUG ABUSE AND DEPENDENCE**

## **9.1 Controlled Substance**

Morphine sulfate extended-release contains morphine, a Schedule II controlled substance with a high potential for abuse similar to other opioids including fentanyl, hydromorphone, methadone, oxycodone, and oxymorphone. Morphine sulfate extended-release can be abused and is subject to misuse, addiction, and criminal diversion [see Warnings and Precautions (5.1)].

The high drug content in extended-release formulations adds to the risk of adverse outcomes from abuse and misuse.

## **9.2 Abuse**

All patients treated with opioids require careful monitoring for signs of abuse and addiction, since use of opioid analgesic products carries the risk of addiction even under appropriate medical use. Drug

abuse is the intentional non-therapeutic use of an over-the-counter or prescription drug, even once, for its rewarding psychological or physiological effects. Drug abuse includes, but is not limited to the following examples: the use of a prescription or over-the-counter drug to get “high”, or the use of steroids for performance enhancement and muscle build up.

Drug addiction is a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and include: a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal.

"Drug seeking" behavior is very common to addicts and drug abusers. Drug-seeking tactics include emergency calls or visits near the end of office hours, refusal to undergo appropriate examination, testing or referral, repeated claims of loss of prescriptions, tampering with prescriptions and reluctance to provide prior medical records or contact information for other treating physician(s). “Doctor shopping” (visiting multiple prescribers) to obtain additional prescriptions is common among drug abusers and people suffering from untreated addiction.

Preoccupation with achieving adequate pain relief can be appropriate behavior in a patient with poor pain control.

Abuse and addiction are separate and distinct from physical dependence and tolerance. Physicians should be aware that addiction may not be accompanied by concurrent tolerance and symptoms of physical dependence in all addicts. In addition, abuse of opioids can occur in the absence of true addiction.

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

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

#### *Risks Specific to Abuse of Morphine Sulfate Extended-Release*

Morphine sulfate extended-release is for oral use only. Abuse of morphine sulfate extended-release poses a risk of overdose and death. This risk is increased with concurrent abuse of morphine sulfate extended-release with alcohol and other substances. Taking cut, broken, chewed, crushed, or dissolved morphine sulfate extended-release enhances drug release and increases the risk of overdose and death.

Due to the presence of talc as one of the excipients in morphine sulfate extended-release, parenteral abuse can be expected to result in local tissue necrosis, infection, pulmonary granulomas, and increased risk of endocarditis and valvular heart injury. 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 chronic opioid therapy. Tolerance is the need for increasing doses of opioids to maintain a defined effect such as analgesia (in the absence of disease progression or other external factors). Tolerance may occur to both the desired and undesired effects of drugs, and may develop at different rates for different effects.

Physical dependence results in withdrawal symptoms after abrupt discontinuation or a significant dose reduction of a drug. Withdrawal also may be precipitated through the administration of drugs with opioid antagonist activity, e.g., naloxone, nalmefene, mixed agonist/antagonist analgesics (pentazocine, butorphanol, nalbuphine), or partial agonists (buprenorphine). Physical dependence may not occur to a clinically significant degree until after several days to weeks of continued opioid usage.

Morphine sulfate extended-release should not be abruptly discontinued [see Dosage and Administration (2.3)]. If morphine sulfate extended-release is abruptly discontinued in a physically-dependent patient, an abstinence syndrome may occur. Some or all of the following can characterize this syndrome:

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.

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 overdosage with morphine is 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, and death. Marked mydriasis rather than miosis may be seen due to severe hypoxia in overdose situations.

### ***Treatment of Overdose***

In case 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 techniques.

The opioid antagonists, naloxone or nalmefene, are specific antidotes to respiratory depression resulting from opioid overdose. Opioid antagonists should not be administered in the absence of clinically significant respiratory or circulatory depression secondary to morphine overdose. Such agents should be administered cautiously to persons who are known, or suspected to be physically dependent on morphine sulfate extended-release. In such cases, an abrupt or complete reversal of opioid effects may precipitate an acute withdrawal syndrome.

Because the duration of reversal would be expected to be less than the duration of action of morphine in morphine sulfate extended-release, carefully monitor the patient until spontaneous respiration is reliably re-established. Morphine sulfate extended-release will continue to release morphine and add to the morphine load for 24 to 48 hours or longer following ingestion necessitating prolonged monitoring. If the response to opioid antagonists is suboptimal or not sustained, additional antagonist should be administered as directed in the product's prescribing information.

In an individual physically dependent on opioids, administration of the usual dose of the antagonist 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 antagonist administered. If a decision is made to treat serious respiratory depression in the physically dependent patient, administration of the antagonist should be begun with care and by titration with smaller than usual doses of the antagonist.

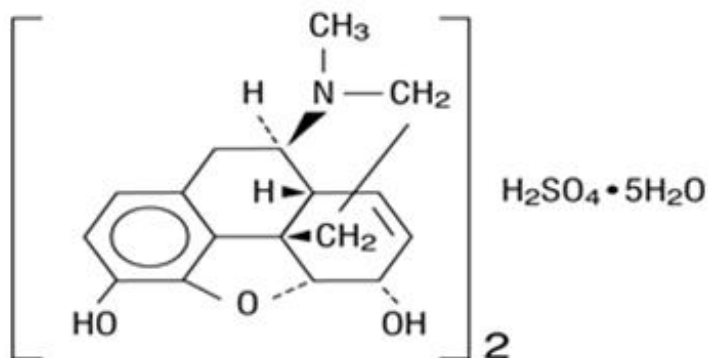
## **11 DESCRIPTION**

Morphine sulfate extended-release tablets are for oral use and contain morphine sulfate, USP, an agonist at the  $\mu$ -opioid receptor.

Each tablet contains the following inactive ingredients common to all strengths: anhydrous lactose, cetostearyl alcohol, hydroxyethyl cellulose, magnesium stearate, polyethylene glycol, polyvinyl alcohol, talc and titanium dioxide. The 30 mg tablets also contain yellow iron oxide. The 60 mg tablets also contain red iron oxide. The 100 mg and 200 mg tablets also contain red iron oxide and yellow iron oxide.

The tablet strengths describe the amount of morphine per tablet as the pentahydrated sulfate salt (morphine sulfate).

Morphine sulfate, USP is an odorless, white, crystalline powder with a bitter taste. It has a solubility of 1 in 21 parts of water and 1 in 1000 parts of alcohol, but is practically insoluble in chloroform or ether. The octanol: water partition coefficient of morphine is 1.42 at physiologic pH and the  $pK_b$  is 7.9 for the tertiary nitrogen (mostly ionized at pH 7.4). Its structural formula is:



## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Morphine sulfate, an opioid agonist, is relatively selective for the mu receptor, although it can interact with other opioid receptors at higher doses. In addition to analgesia, the widely diverse effects of morphine sulfate include analgesia, dysphoria, euphoria, somnolence, respiratory depression, diminished gastrointestinal motility, altered circulatory dynamics, histamine release, physical dependence, and alterations of the endocrine and autonomic nervous systems.

Morphine produces both its therapeutic and its adverse effects by interaction with one or more classes of specific opioid receptors located throughout the body. Morphine acts as a full agonist, binding with and activating opioid receptors at sites in the peri-aqueductal and peri-ventricular grey matter, the ventro-medial medulla and the spinal cord to produce analgesia.

### 12.2 Pharmacodynamics

#### Plasma Level-Analgesia Relationships

While plasma morphine-efficacy relationships can be demonstrated in non-tolerant individuals, they are influenced by a wide variety of factors and are not generally useful as a guide to the clinical use of morphine. Dosages of morphine should be chosen and must be titrated on the basis of clinical evaluation of the patient and the balance between therapeutic and adverse effects.

#### CNS Depressant/Alcohol Interaction

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

#### Effects on the Central Nervous System

The principal actions of therapeutic value of morphine are analgesia and sedation. Specific CNS opiate receptors for endogenous compounds with opioid-like activity have been identified throughout the brain and spinal cord and are likely to play a role in the expression of analgesic effects.

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

Morphine depresses the cough reflex by direct effect on the cough center in the medulla. Morphine causes miosis, even in total darkness. Pinpoint pupils are a sign of narcotic 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 worsening hypoxia.

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

Morphine causes a reduction in motility associated with an increase in smooth muscle tone in the antrum of the stomach and in the duodenum. Digestion of food is delayed in the small intestine and propulsive contractions are decreased. Propulsive peristaltic waves in the colon are decreased, while tone may be increased to the point of spasm. The end result is constipation. Morphine can cause a marked reduction in gastric, biliary and pancreatic secretions, spasm of the sphincter of Oddi, and transient elevations in serum amylase.

#### Effects on the Cardiovascular System

Morphine produces peripheral vasodilation which may result in orthostatic hypotension. Release of histamine can occur and may contribute to opioid-induced hypotension. Manifestations of histamine release and/or peripheral vasodilation may include pruritus, flushing, red eyes, and sweating.

#### Effects on the Endocrine System

Opioids inhibit the secretion of ACTH, cortisol, testosterone, and luteinizing hormone (LH) in humans. They also stimulate prolactin, growth hormone (GH) secretion, and pancreatic secretion of insulin and glucagon.

#### Effects on the Immune System

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

### **12.3 Pharmacokinetics**

Morphine sulfate extended-release tablets contain morphine sulfate. Morphine is released from morphine sulfate extended-release somewhat more slowly than from immediate-release oral preparations. Following oral administration of a given dose of morphine, the amount ultimately absorbed is essentially the same whether the source is morphine sulfate extended-release or an immediate-release formulation. Because of pre-systemic elimination (i.e., metabolism in the gut wall and liver) only about 40% of the administered dose reaches the central compartment.

#### Absorption

The oral bioavailability of morphine is approximately 20 to 40%. When morphine sulfate extended-release is given on a fixed dosing regimen, steady-state is achieved in about a day.

#### Food Effect

The effect of food upon the systemic bioavailability of morphine sulfate extended-release has not been systematically evaluated for all strengths. One study, conducted with the 30 mg morphine sulfate extended-release tablets, showed no significant differences in  $C_{max}$  and AUC (0-24h) values, whether the tablet was taken while fasting or with a high-fat breakfast.

#### Distribution

Once absorbed, morphine is distributed to skeletal muscle, kidneys, liver, intestinal tract, lungs, spleen, and brain. Morphine also crosses placental membranes and has been found in breast milk. The volume of distribution ( $V_d$ ) for morphine is approximately 3 to 4 liters per kilogram and morphine is 30 to 35% reversibly bound to plasma proteins.

#### 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

The elimination of morphine occurs primarily as renal excretion of M3G and its effective half-life after intravenous administration is normally 2 to 4 hours. Approximately 10% of the dose is excreted unchanged in urine. In some studies involving longer periods of plasma sampling, a longer terminal half-life of about 15 hours was reported. A small amount of the glucuronide conjugate is excreted in the bile, and there is some minor enterohepatic recycling.

#### Specific Populations

##### *Geriatric Patients*

The pharmacokinetics of morphine sulfate extended-release has not been studied in elderly patients.

##### *Pediatric Patients*

The pharmacokinetics of morphine sulfate extended-release has not been studied in pediatric patients below the age of 18.

##### *Gender*

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

##### *Race*

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.

## **13 NONCLINICAL TOXICOLOGY**

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


Carcinogenesis: Studies in animals to evaluate the carcinogenic potential of morphine have not been conducted.


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, higher incidence of pseudopregnancies, and reduction in implantation sites were seen. Studies from the literature have also reported changes in hormonal levels (i.e., testosterone, luteinizing hormone, serum corticosterone) following treatment with morphine. These changes may be associated with the reported effects on fertility in the rat.

## **16 HOW SUPPLIED/STORAGE AND HANDLING**

Morphine sulfate extended-release tablets are available as follows:

15 mg – Each round, white to off white, film-coated tablet is debossed with  on one side and 270 on the other side contain 15 mg of morphine sulfate, USP.


30 mg – Each round, yellow, film-coated tablet is debossed with  on one side and 271 on the other side contain 30 mg of morphine sulfate, USP.


55700-367-30


55700-367-60

55700-367-90

55700-367-01

60 mg – Each round, pink, film-coated tablet is debossed with  on one side and 311 on the other side contain 60 mg of morphine sulfate, USP.

100 mg – Each round, red, film-coated tablet is debossed with  on one side and 323 on the other side contain 100 mg of morphine sulfate, USP.

200 mg – Each capsule-shaped, red, film-coated tablet is debossed with  on one side and 347 on the other side contain 200 mg of morphine sulfate, USP.

Store at 25°C (77°F); excursions permitted between 15° to 30°C (59° to 86°F).

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

### **CAUTION**

### **DEA FORM REQUIRED**

## **17 PATIENT COUNSELING INFORMATION**

Advise the patient to read the FDA-approved patient labeling (Medication Guide).

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

Inform patients that the use of morphine sulfate extended-release, even when taken as recommended, can result in addiction, abuse, and misuse, which can lead to overdose or death [see Warnings and Precautions (5.1)]. Instruct patients not to share morphine sulfate extended-release with others and to take steps to protect morphine sulfate extended-release 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 or when the dose is increased, and that it can occur even at recommended doses [see Warnings and Precautions (5.2)]. Advise patients how to

recognize respiratory depression and to seek medical attention if breathing difficulties develop.

#### Accidental Ingestion

Inform patients that accidental ingestion, especially in children, may result in respiratory depression or death [see Warnings and Precautions (5.2)]. Instruct patients to take steps to store morphine sulfate extended-release securely and to dispose of unused morphine sulfate extended-release by flushing the tablets down the toilet.

#### Neonatal Opioid Withdrawal Syndrome

Inform female patients of reproductive potential that prolonged use of morphine sulfate extended-release during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated [see Warnings and Precautions (5.3)].

#### Interactions with Alcohol and other CNS Depressants

Inform patients that potentially serious additive effects may occur if morphine sulfate extended-release is used with alcohol or other CNS depressants, and not to use such drugs unless supervised by a health care provider.

#### Important Administration Instructions

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

- Swallowing morphine sulfate extended-release tablets whole
- Not crushing, chewing, or dissolving the tablets
- Using morphine sulfate extended-release exactly as prescribed to reduce the risk of life-threatening adverse reactions (e.g., respiratory depression)
- Not discontinuing morphine sulfate extended-release without first discussing the need for a tapering regimen with the prescriber

#### Hypotension

Inform patients that morphine sulfate extended-release 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).

#### Driving or Operating Heavy Machinery

Inform patients that morphine sulfate extended-release 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.

#### Constipation

Advise patients of the potential for severe constipation, including management instructions and when to seek medical attention.

#### Anaphylaxis

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

#### Pregnancy

Advise female patients that morphine sulfate extended-release can cause fetal harm and to inform the prescriber if they are pregnant or plan to become pregnant.

Healthcare professionals can telephone Actavis' Medical Affairs Department (1-800-432-8534) for information on this product.

#### Disposal of Unused Morphine Sulfate Extended-Release Tablets

Advise patients to flush the unused tablets down the toilet when morphine sulfate extended-release is no longer needed.

Manufactured by:  
Actavis Elizabeth LLC  
Elizabeth, NJ 07207 USA

Distributed by:  
Actavis Pharma, Inc.  
Parsippany, NJ 07054 USA

40-9192

Revised: December 2014

## **MEDICATION GUIDE**

### **Morphine Sulfate (MOR-feen SUL-fate)**

#### **Extended-Release Tablets, CII**

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

- A strong prescription pain medicine that contains an opioid (narcotic) that is used to manage pain severe enough to require daily around-the-clock, long-term treatment with an opioid, when other pain treatments such as non-opioid pain medicines or immediate-release opioid 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 for use to treat pain that is not around-the-clock.

##### **Important information about morphine sulfate extended-release tablets:**

- **Get emergency help right away if you take too many morphine sulfate extended-release tablets (overdose).** When you first start taking morphine sulfate extended-release tablets, 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.
- Never give anyone else your morphine sulfate extended-release tablets. They could die from taking it. Store morphine sulfate extended-release tablets away from children and in a safe place to prevent stealing or abuse. Selling or giving away morphine sulfate extended-release tablets is against the law.

##### **Do not take morphine sulfate extended-release tablets 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 tablets, 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, or mental health problems.

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

- **pregnant or planning to become pregnant.** Prolonged use of morphine sulfate extended-release tablets during pregnancy can cause withdrawal symptoms in your newborn baby that could be life-

threatening if not recognized and treated.

- **breastfeeding.** Morphine sulfate passes into breast milk and may harm your baby.
- taking prescription or over-the-counter medicines, vitamins, or herbal supplements. Taking morphine sulfate extended-release tablets with certain other medicines can cause serious side effects.

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

- Do not change your dose. Take morphine sulfate extended-release tablets exactly as prescribed by your healthcare provider.
- Take your prescribed dose every 8 to 12 hours, as directed by your healthcare provider. Do not take more than your prescribed dose. If you miss a dose, take your next dose at the usual time.
- Swallow morphine sulfate extended-release tablets whole. Do not cut, break, chew, crush, dissolve, snort, or inject morphine sulfate extended-release tablets because this may cause you to overdose and die.
- **Call your healthcare provider if the dose you are taking does not control your pain.**
- **Do not stop taking morphine sulfate extended-release tablets without talking to your healthcare provider.**
- After you stop taking morphine sulfate extended-release tablets, flush any unused tablets down the toilet.

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

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

**The possible side effects of morphine sulfate extended-release tablets 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 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, or you are feeling faint.

These are not all the possible side effects of morphine sulfate extended-release tablets. Call your doctor 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).** For additional product information about morphine sulfate extended-release tablets contact Actavis at 1-800-432-8534.

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

Manufactured by:  
Actavis Elizabeth LLC  
Elizabeth, NJ 07207 USA

Distributed by:  
Actavis Pharma, Inc.  
Parsippany, NJ 07054 USA

40-9192

Revised: December 2014

(MG 41-1216/1214)



Holland, OH 43528

**MORPHINE SULFATE ER 30 MG**

Warning: Keep out of children's reach.  
Store at controlled temperature 59-86 degrees F.  
Consult with a physician or see insert for dosage.  
YELLOW, ROUND, LOGO;271



GTIN: 00355700367602

NDC: 55700-0367-60

Serial:

Lot:

EXP: //

REV. 04/17

Each tablet contains Morphine Sulfate

Mfr: Actavis Elizabeth LLC, Elizabeth, NJ 07207

#60 TABLETS

WARNING: MAY BE HABIT FORMING



Rx only

MORPHINE SULFATE ER 30 MG  
#60 TABLETS  
Lot: EXP: //  
NDC: 55700-0367-60

MORPHINE SULFATE ER 30 MG  
#60 TABLETS  
Lot: EXP: //  
NDC: 55700-0367-60

SOURCE CODE : 022842711

**MORPHINE SULFATE**

morphine sulfate tablet, film coated, extended release

**Product Information**

Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:55700-367(NDC:0228-4271)
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	30 mg

**Inactive Ingredients**

Ingredient Name	Strength
ANHYDROUS LACTOSE (UNII: 3SY5LH9PMK)	
HYDROXYETHYL CELLULOSE (280 MPAS AT 2%) (UNII: 12VCE9HR9E)	
MAGNESIUM STEARATE (UNII: 70097M6I30)	
TALC (UNII: 7SEV7J4R1U)	
TITANIUM DIOXIDE (UNII: 15FIX9V2JP)	
FERRIC OXIDE YELLOW (UNII: EX438O2MRT)	
POLYETHYLENE GLYCOL, UNSPECIFIED (UNII: 3WJQ0SDW1A)	
CETOSTEARYL ALCOHOL (UNII: 2DMT128MIS)	
POLYVINYL ALCOHOL, UNSPECIFIED (UNII: 532B59J990)	

**Product Characteristics**

Color	YELLOW	Score	no score
Shape	ROUND	Size	7mm
Flavor		Imprint Code	271
Contains			

**Packaging**

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:55700-367-30	30 in 1 BOTTLE; Type 0: Not a Combination Product	10/26/2015	
2	NDC:55700-367-60	60 in 1 BOTTLE; Type 0: Not a Combination Product	10/26/2015	
3	NDC:55700-367-90	90 in 1 BOTTLE; Type 0: Not a Combination Product	10/26/2015	
4	NDC:55700-367-01	120 in 1 BOTTLE; Type 0: Not a Combination Product	10/26/2015	

**Marketing Information**

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA203849	10/26/2015	

**Labeler** - Lake Erie Medical DBA Quality Care Products LLC (831276758)**Establishment**

Name	Address	ID/FEI	Business Operations
Lake Erie Medical DBA Quality Care Products LLC		831276758	repack(55700-367)

Revised: 4/2019

Lake Erie Medical DBA Quality Care Products LLC