

**ANAPROX- naproxen sodium tablet**  
**DIRECT RX**

-----  
**NAPROXEN SODIUM**

**WARNING: RISK OF SERIOUS CARDIOVASCULAR AND GASTROINTESTINAL EVENTS**

**Cardiovascular Thrombotic Events**

- Nonsteroidal anti-inflammatory drugs (NSAIDs) cause an increased risk of serious cardiovascular thrombotic events, including myocardial infarction and stroke, which can be fatal. This risk may occur early in treatment and may increase with duration of use. (see WARNINGS).

- Naproxen tablets and naproxen sodium tablets are contraindicated in the setting of coronary artery bypass graft (CABG) surgery (see CONTRAINDICATIONS, WARNINGS).  
**Gastrointestinal Bleeding, Ulceration, and Perforation**

- NSAIDs cause an increased risk of serious gastrointestinal (GI) adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients and patients with a prior history of peptic ulcer disease and/or GI bleeding are at greater risk for serious GI events (see WARNINGS).

Naproxen USP is a propionic acid derivative related to the arylacetic acid group of nonsteroidal anti-inflammatory drugs.

The chemical names for naproxen USP and naproxen sodium USP are (S)-6-methoxy- $\alpha$ -methyl-2-naphthaleneacetic acid and (S)-6-methoxy- $\alpha$ -methyl-2-naphthaleneacetic acid, sodium salt, respectively. Naproxen USP and naproxen sodium USP have the following structures, respectively:

chemical-structure

Naproxen USP has a molecular weight of 230.26 and a molecular formula of C<sub>14</sub>H<sub>14</sub>O<sub>3</sub>. Naproxen sodium USP has a molecular weight of 252.23 and a molecular formula of C<sub>14</sub>H<sub>13</sub>NaO<sub>3</sub>.

Naproxen USP is an odorless, white to off-white crystalline substance. It is lipid-soluble, practically insoluble in water at low pH and freely soluble in water at high pH. The octanol/water partition coefficient of naproxen at pH 7.4 is 1.6 to 1.8. Naproxen sodium USP is a white to creamy white, crystalline solid, freely soluble in water at neutral pH.

Naproxen tablets USP are available as light orange colored tablets containing 250 mg of naproxen USP, light orange colored tablets containing 375 mg of naproxen USP and light orange colored tablets containing 500 mg of naproxen USP for oral administration. The inactive ingredients are microcrystalline cellulose, croscarmellose sodium, iron oxide red, iron oxide yellow, povidone and magnesium stearate.

Naproxen sodium tablets USP are available as blue tablets containing 275 mg of naproxen sodium USP and as blue tablets containing 550 mg of naproxen sodium USP for oral administration. The inactive ingredients are croscarmellose sodium, colloidal silicon dioxide, povidone, magnesium stearate, microcrystalline cellulose and talc. The coating suspension for the naproxen sodium 275 mg and 550 mg tablet contains hypromellose, titanium dioxide, polyethylene glycol, FD&C blue#2, and iron oxide red.

**Mechanism of Action**

Naproxen has analgesic, anti-inflammatory, and antipyretic properties. The sodium salt of naproxen has been developed as a more rapidly absorbed formulation of naproxen for use as an analgesic.

The mechanism of action of the naproxen, like that of other NSAIDs, is not completely understood but involves inhibition of cyclooxygenase (COX-1 and COX-2).

Naproxen is a potent inhibitor of prostaglandin synthesis *in vitro*. Naproxen concentrations reached during therapy have produced *in vivo* effects. Prostaglandins sensitize afferent nerves and potentiate the action of bradykinin in inducing pain in animal models. Prostaglandins are mediators of inflammation. Because naproxen is an inhibitor of prostaglandin synthesis, its mode of action may be due to a decrease of prostaglandins in peripheral tissues.

#### Pharmacokinetics

Naproxen and naproxen sodium are rapidly and completely absorbed from the gastrointestinal tract with an *in vivo* bioavailability of 95%. The different dosage forms of naproxen are bioequivalent in terms of extent of absorption (AUC) and peak concentration (C<sub>max</sub>); however, the products do differ in their pattern of absorption. These differences between naproxen products are related to both the chemical form of naproxen used and its formulation. Even with the observed differences in pattern of absorption, the elimination half-life of naproxen is unchanged across products ranging from 12 to 17 hours. Steady-state levels of naproxen are reached in 4 to 5 days, and the degree of naproxen accumulation is consistent with this half-life. This suggests that the differences in pattern of release play only a negligible role in the attainment of steady-state plasma levels.

#### Absorption

##### Naproxen Tablets

After administration of naproxen tablets, peak plasma levels are attained in 2 to 4 hours. After oral administration of naproxen sodium, peak plasma levels are attained in 1 to 2 hours. The difference in rates between the two products is due to the increased aqueous solubility of the sodium salt of naproxen used in naproxen sodium. Peak plasma levels of naproxen given as naproxen suspension are attained in 1 to 4 hours.

#### Distribution

Naproxen has a volume of distribution of 0.16 L/kg. At therapeutic levels naproxen is greater than 99% albumin-bound. At doses of naproxen greater than 500 mg/day there is less than proportional increase in plasma levels due to an increase in clearance caused by saturation of plasma protein binding at higher doses (average trough C<sub>ss</sub> 36.5, 49.2 and 56.4 mg/L with 500, 1000 and 1500 mg daily doses of naproxen, respectively). The naproxen anion has been found in the milk of lactating women at a concentration equivalent to approximately 1% of maximum naproxen concentration in plasma (see PRECAUTIONS; NURSING MOTHERS).

#### Elimination

##### Metabolism

Naproxen is extensively metabolized in the liver to 6-O-desmethyl naproxen, and both parent and metabolites do not induce metabolizing enzymes. Both naproxen and 6-O-desmethyl naproxen are further metabolized to their respective acylglucuronide conjugated metabolites.

##### Excretion

The clearance of naproxen is 0.13 mL/min/kg. Approximately 95% of the naproxen from any dose is excreted in the urine, primarily as naproxen (<1%), 6-O-desmethyl naproxen (<1%) or their conjugates (66% to 92%). The plasma half-life of the naproxen anion in humans ranges from 12 to 17 hours. The corresponding half-lives of both naproxen's metabolites and conjugates are shorter than 12 hours, and their rates of excretion have been found to coincide closely with the rate of naproxen disappearance from the plasma. Small amounts, 3% or less of the administered dose, are excreted in the feces. In patients with renal failure metabolites may accumulate (see WARNINGS; RENAL TOXICITY AND

## HYPERKALEMIA).

### Special Populations

#### Pediatric Patients

In pediatric patients aged 5 to 16 years with arthritis, plasma naproxen levels following a 5 mg/kg single dose of naproxen suspension (see DOSAGE AND ADMINISTRATION) were found to be similar to those found in normal adults following a 500 mg dose. The terminal half-life appears to be similar in pediatric and adult patients. Pharmacokinetic studies of naproxen were not performed in pediatric patients younger than 5 years of age. Pharmacokinetic parameters appear to be similar following administration of naproxen suspension or tablets in pediatric patients.

#### Geriatric Patients

Studies indicate that although total plasma concentration of naproxen is unchanged, the unbound plasma fraction of naproxen is increased in the elderly, although the unbound fraction is <1% of the total naproxen concentration. Unbound trough naproxen concentrations in elderly subjects have been reported to range from 0.12% to 0.19% of total naproxen concentration, compared with 0.05% to 0.075% in younger subjects. The clinical significance of this finding is unclear, although it is possible that the increase in free naproxen concentration could be associated with an increase in the rate of adverse events per a given dosage in some elderly patients.

#### Race

Pharmacokinetic differences due to race have not been studied.

#### Hepatic Impairment

Naproxen pharmacokinetics has not been determined in subjects with hepatic insufficiency.

Chronic alcoholic liver disease and probably other diseases with decreased or abnormal plasma proteins (albumin) reduce the total plasma concentration of naproxen, but the plasma concentration of unbound naproxen is increased. Caution is advised when high doses are required and some adjustment of dosage may be required in these patients. It is prudent to use the lowest effective dose.

#### Renal Impairment

Naproxen pharmacokinetics has not been determined in subjects with renal insufficiency. Given that naproxen, its metabolites and conjugates are primarily excreted by the kidney, the potential exists for naproxen metabolites to accumulate in the presence of renal insufficiency. Elimination of naproxen is decreased in patients with severe renal impairment. Naproxen-containing products are not recommended for use in patients with moderate to severe and severe renal impairment (creatinine clearance <30 mL/min) (see WARNINGS; RENAL TOXICITY AND HYPERKALEMIA).

#### Drug Interaction Studies

Aspirin: When NSAIDs were administered with aspirin, the protein binding of NSAIDs were reduced, although the clearance of free NSAID was not altered. The clinical significance of this interaction is not known. See Table 1 for clinically significant drug interactions of NSAIDs with aspirin (see PRECAUTIONS; DRUG INTERACTIONS).

#### General Information

Naproxen has been studied in patients with rheumatoid arthritis, osteoarthritis, juvenile arthritis, ankylosing spondylitis, tendonitis and bursitis, and acute gout. Improvement in patients treated for rheumatoid arthritis was demonstrated by a reduction in joint swelling, a reduction in duration of morning stiffness, a reduction in disease activity as assessed by both the investigator and patient, and by increased mobility as demonstrated by a reduction in walking time. Generally, response to naproxen has not been found to be dependent on age, sex, severity or duration of rheumatoid arthritis.

In patients with osteoarthritis, the therapeutic action of naproxen has been shown by a reduction in joint

pain or tenderness, an increase in range of motion in knee joints, increased mobility as demonstrated by a reduction in walking time, and improvement in capacity to perform activities of daily living impaired by the disease.

In a clinical trial comparing standard formulations of naproxen 375 mg twice a day (750 mg a day) vs 750 mg twice a day (1500 mg/day), 9 patients in the 750 mg group terminated prematurely because of adverse events. Nineteen patients in the 1500 mg group terminated prematurely because of adverse events. Most of these adverse events were gastrointestinal events.

In clinical studies in patients with rheumatoid arthritis, osteoarthritis, and juvenile arthritis, naproxen has been shown to be comparable to aspirin and indomethacin in controlling the aforementioned measures of disease activity, but the frequency and severity of the milder gastrointestinal adverse effects (nausea, dyspepsia, heartburn) and nervous system adverse effects (tinnitus, dizziness, lightheadedness) were less in naproxen-treated patients than in those treated with aspirin or indomethacin.

In patients with ankylosing spondylitis, naproxen has been shown to decrease night pain, morning stiffness and pain at rest. In double-blind studies the drug was shown to be as effective as aspirin, but with fewer side effects.

In patients with acute gout, a favorable response to naproxen was shown by significant clearing of inflammatory changes (e.g., decrease in swelling, heat) within 24 to 48 hours, as well as by relief of pain and tenderness.

Naproxen has been studied in patients with mild to moderate pain secondary to postoperative, orthopedic, postpartum episiotomy and uterine contraction pain and dysmenorrhea. Onset of pain relief can begin within 1 hour in patients taking naproxen and within 30 minutes in patients taking naproxen sodium. Analgesic effect was shown by such measures as reduction of pain intensity scores, increase in pain relief scores, decrease in numbers of patients requiring additional analgesic medication, and delay in time to remedication. The analgesic effect has been found to last for up to 12 hours.

Naproxen may be used safely in combination with gold salts and/or corticosteroids; however, in controlled clinical trials, when added to the regimen of patients receiving corticosteroids, it did not appear to cause greater improvement over that seen with corticosteroids alone. Whether naproxen has a "steroid-sparing" effect has not been adequately studied. When added to the regimen of patients receiving gold salts, naproxen did result in greater improvement. Its use in combination with salicylates is not recommended because there is evidence that aspirin increases the rate of excretion of naproxen and data are inadequate to demonstrate that naproxen and aspirin produce greater improvement over that achieved with aspirin alone. In addition, as with other NSAIDs, the combination may result in higher frequency of adverse events than demonstrated for either product alone.

In <sup>51</sup>Cr blood loss and gastroscopy studies with normal volunteers, daily administration of 1000 mg of naproxen as 1000 mg of naproxen tablets or 1100 mg of naproxen sodium tablets has been demonstrated to cause statistically significantly less gastric bleeding and erosion than 3250 mg of aspirin.

Three 6-week, double-blind, multicenter studies with naproxen delayed release (375 or 500 mg twice a day, n=385) and naproxen (375 or 500 mg twice a day, n=279) were conducted comparing naproxen delayed release with naproxen, including 355 rheumatoid arthritis and osteoarthritis patients who had a recent history of NSAID-related GI symptoms. These studies indicated that naproxen delayed release and naproxen showed no significant differences in efficacy or safety and had similar prevalence of minor GI complaints. Individual patients, however, may find one formulation preferable to the other.

#### Geriatric Patients

The hepatic and renal tolerability of long-term naproxen administration was studied in two double-blind clinical trials involving 586 patients. Of the patients studied, 98 patients were age 65 and older and 10 of the 98 patients were age 75 and older. Naproxen was administered at doses of 375 mg twice daily or 750 mg twice daily for up to 6 months. Transient abnormalities of laboratory tests assessing hepatic and renal function were noted in some patients, although there were no differences noted in the occurrence

of abnormal values among different age groups.

Carefully consider the potential benefits and risks of naproxen, naproxen sodium and other treatment options before deciding to use naproxen tablets or naproxen sodium tablets. Use the lowest effective dosage for the shortest duration consistent with individual patient treatment goals (see WARNINGS: GASTROINTESTINAL BLEEDING, ULCERATION, AND PERFORATION).

Naproxen as naproxen tablets or naproxen sodium tablets are indicated:

- For the relief of the signs and symptoms of rheumatoid arthritis
- For the relief of the signs and symptoms of osteoarthritis
- For the relief of the signs and symptoms of ankylosing spondylitis
- For the relief of the signs and symptoms of juvenile arthritis

Naproxen as naproxen tablets or naproxen sodium tablets are also indicated:

- For relief of the signs and symptoms of tendonitis
- For relief of the signs and symptoms of bursitis
- For relief of the signs and symptoms of acute gout
- For the management of pain
- For the management of primary dysmenorrhea

Naproxen tablets and naproxen sodium tablets are contraindicated in the following patients:

- Known hypersensitivity (e.g., anaphylactic reactions and serious skin reactions) to naproxen, naproxen sodium, or any components of the drug product (see WARNINGS; ANAPHYLACTIC REACTIONS, SERIOUS SKIN REACTIONS).
- History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, sometimes fatal, anaphylactic reactions to NSAIDs have been reported in such patients (see WARNINGS; ANAPHYLACTIC REACTIONS, EXACERBATION OF ASTHMA RELATED TO ASPIRIN SENSITIVITY).
- In the setting of coronary artery bypass graft (CABG) surgery (see WARNINGS; CARDIOVASCULAR THROMBOTIC EVENTS).

#### Cardiovascular Thrombotic Events

Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious cardiovascular (CV) thrombotic events, including myocardial infarction (MI) and stroke, which can be fatal. Based on available data, it is unclear that the risk for CV thrombotic events is similar for all NSAIDs. The relative increase in serious CV thrombotic events over baseline conferred by NSAID use appears to be similar in those with and without known CV disease or risk factors for CV disease. However, patients with known CV disease or risk factors had a higher absolute incidence of excess serious CV thrombotic events, due to their increased baseline rate.

Some observational studies found that this increased risk of serious CV thrombotic events began as early as the first weeks of treatment. The increase in CV thrombotic risk has been observed most consistently at higher doses.

To minimize the potential risk for an adverse CV event in NSAID-treated patients, use the lowest effective dose for the shortest duration possible. Physicians and patients should remain alert for the development of such events, throughout the entire treatment course, even in the absence of previous CV symptoms. Patients should be informed about the symptoms of serious CV events and the steps to take if they occur.

There is no consistent evidence that concurrent use of aspirin mitigates the increased risk of serious CV thrombotic events associated with NSAID use. The concurrent use of aspirin and an NSAID, such as naproxen, increases the risk of serious gastrointestinal (GI) events (see WARNINGS; GASTROINTESTINAL BLEEDING, ULCERATION, AND PERFORATION).

#### Status Post Coronary Artery Bypass Graft (CABG) Surgery

Two large, controlled, clinical trials of a COX-2 selective NSAID for the treatment of pain in the first 10 to 14 days following CABG surgery found an increased incidence of myocardial infarction and stroke. NSAIDs are contraindicated in the setting of CABG (see CONTRAINDICATIONS).

#### Post-MI Patients

Observational studies conducted in the Danish National Registry have demonstrated that patients treated with NSAIDs in the post-MI period were at increased risk of reinfarction, CV-related death, and all-cause mortality beginning in the first week of treatment. In this same cohort, the incidence of death in the first year post-MI was 20 per 100 person years in NSAID-treated patients compared to 12 per 100 person years in non-NSAID exposed patients. Although the absolute rate of death declined somewhat after the first year post-MI, the increased relative risk of death in NSAID users persisted over at least the next four years of follow-up.

Avoid the use of naproxen and naproxen sodium in patients with a recent MI unless the benefits are expected to outweigh the risk of recurrent CV thrombotic events. If naproxen or naproxen sodium are used in patients with a recent MI, monitor patients for signs of cardiac ischemia.

#### Gastrointestinal Bleeding, Ulceration, and Perforation

NSAIDs, including naproxen cause serious gastrointestinal (GI) adverse events including inflammation, bleeding, ulceration, and perforation of the esophagus, stomach, small intestine, or large intestine, which can be fatal. These serious adverse events can occur at any time, with or without warning symptoms, in patients treated with NSAIDs. Only one in five patients who develop a serious upper GI adverse event on NSAID therapy is symptomatic. Upper GI ulcers, gross bleeding, or perforation caused by NSAIDs occurred in approximately 1% of patients treated for 3 to 6 months, and in about 2% to 4% of patients treated for one year. However, even short-term NSAID therapy is not without risk.

#### Risk Factors for GI Bleeding, Ulceration, and Perforation

Patients with a prior history of peptic ulcer disease and/or GI bleeding who used NSAIDs had a greater than 10-fold increased risk for developing a GI bleed compared to patients without these risk factors. Other factors that increase the risk of GI bleeding in patients treated with NSAIDs include longer duration of NSAID therapy; concomitant use of oral corticosteroids, aspirin, anticoagulants, or selective serotonin reuptake inhibitors (SSRIs); smoking; use of alcohol; older age; and poor general health status. Most postmarketing reports of fatal GI events occurred in elderly or debilitated patients. Additionally, patients with advanced liver disease and/or coagulopathy are at increased risk for GI bleeding.

#### Strategies to Minimize the GI Risks in NSAID-treated patients:

- Use the lowest effective dosage for the shortest possible duration.
- Avoid administration of more than one NSAID at a time.
- Avoid use in patients at higher risk unless benefits are expected to outweigh the increased risk of bleeding. For such patients, as well as those with active GI bleeding, consider alternate therapies other than NSAIDs.

- Remain alert for signs and symptoms of GI ulceration and bleeding during NSAID therapy.

- If a serious GI adverse event is suspected, promptly initiate evaluation and treatment, and discontinue naproxen or naproxen sodium until a serious GI adverse event is ruled out.

- In the setting of concomitant use of low-dose aspirin for cardiac prophylaxis, monitor patients more closely for evidence of GI bleeding (see PRECAUTIONS; DRUG INTERACTIONS).

#### Hepatotoxicity

Elevations of ALT or AST (three or more times the upper limit of normal [ULN]) have been reported in approximately 1% of patients in clinical trials. In addition, rare, sometimes fatal, cases of severe hepatic injury, including fulminant hepatitis, liver necrosis and hepatic failure have been reported.

Elevations of ALT or AST (less than three times ULN) may occur in up to 15% of patients taking NSAIDs including naproxen.

Inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, diarrhea, pruritus, jaundice, right upper quadrant tenderness, and “flu-like” symptoms). If clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), discontinue naproxen or naproxen sodium immediately, and perform a clinical evaluation of the patient.

#### Hypertension

NSAIDs, including naproxen and naproxen sodium, can lead to new onset of hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of CV events. Patients taking angiotensin converting enzyme (ACE) inhibitors, thiazide diuretics, or loop diuretics may have impaired response to these therapies when taking NSAIDs (see PRECAUTIONS; DRUG INTERACTIONS).

Monitor blood pressure (BP) during the initiation of NSAID treatment and throughout the course of therapy.

#### Heart Failure and Edema

The Coxib and traditional NSAID Trialists’ Collaboration meta-analysis of randomized controlled trials demonstrated an approximately two-fold increase in hospitalization for heart failure in COX-2 selective-treated patients and nonselective NSAID-treated patients compared to placebo-treated patients. In a Danish National Registry study of patients with heart failure, NSAID use increased the risk of MI, hospitalization for heart failure, and death.

Additionally, fluid retention and edema have been observed in some patients treated with NSAIDs. Use of naproxen may blunt the CV effects of several therapeutic agents used to treat these medical conditions (e.g., diuretics, ACE inhibitors, or angiotensin receptor blockers [ARBs]) (see PRECAUTIONS; DRUG INTERACTIONS).

Avoid the use of naproxen and naproxen sodium in patients with severe heart failure unless the benefits are expected to outweigh the risk of worsening heart failure. If naproxen or naproxen sodium is used in patients with severe heart failure, monitor patients for signs of worsening heart failure.

Since each naproxen sodium tablet contains 25 mg or 50 mg of sodium (about 1 mEq per each 250 mg of naproxen), this should be considered in patients whose overall intake of sodium must be severely restricted.

#### Renal Toxicity and Hyperkalemia

##### Renal Toxicity

Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury. Renal toxicity has also been seen in patients in whom renal prostaglandins have a compensatory role in the maintenance of renal perfusion. In these patients, administration of an NSAID may cause a dose-dependent reduction in prostaglandin formation and, secondarily, in renal blood flow, which may precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, dehydration, hypovolemia, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors or ARBs, and the elderly. Discontinuation of NSAID therapy is usually followed by recovery to the pretreatment state

No information is available from controlled clinical studies regarding the use of naproxen or naproxen sodium in patients with advanced renal disease. The renal effects of naproxen or naproxen sodium may hasten the progression of renal dysfunction in patients with preexisting renal disease.

Correct volume status in dehydrated or hypovolemic patients prior to initiating naproxen or naproxen sodium. Monitor renal function in patients with renal or hepatic impairment, heart failure, dehydration, or hypovolemia during use of naproxen or naproxen sodium (see PRECAUTIONS; DRUG INTERACTIONS). Avoid the use of naproxen or naproxen sodium in patients with advanced renal disease unless the benefits are expected to outweigh the risk of worsening renal function. If naproxen or naproxen sodium is used in patients with advanced renal disease, monitor patients for signs of worsening renal function.

#### Hyperkalemia

Increases in serum potassium concentration, including hyperkalemia, have been reported with use of NSAIDs, even in some patients without renal impairment. In patients with normal renal function, these effects have been attributed to a hyporeninemic-hypoaldosteronism state.

#### Anaphylactic Reactions

Naproxen has been associated with anaphylactic reactions in patients with and without known hypersensitivity to naproxen and in patients with aspirin-sensitive asthma (see CONTRAINDICATIONS, WARNINGS; EXACERBATION OF ASTHMA RELATED TO ASPIRIN SENSITIVITY).

#### Exacerbation of Asthma Related to Aspirin Sensitivity

A subpopulation of patients with asthma may have aspirin-sensitive asthma which may include chronic rhinosinusitis complicated by nasal polyps; severe, potentially fatal bronchospasm; and/or intolerance to aspirin and other NSAIDs. Because cross-reactivity between aspirin and other NSAIDs has been reported in such aspirin-sensitive patients, naproxen and naproxen sodium are contraindicated in patients with this form of aspirin sensitivity (see CONTRAINDICATIONS). When naproxen and naproxen sodium are used in patients with preexisting asthma (without known aspirin sensitivity), monitor patients for changes in the signs and symptoms of asthma.

#### Serious Skin Reactions

NSAIDs, including naproxen, can cause serious skin adverse reactions such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. These serious events may occur without warning. Inform patients about the signs and symptoms of serious skin reactions and to discontinue the use of naproxen or naproxen sodium at the first appearance of skin rash or any other sign of hypersensitivity. Naproxen and naproxen sodium are contraindicated in patients with previous serious skin reactions to NSAIDs (see CONTRAINDICATIONS).

#### Premature Closure of Fetal Ductus Arteriosus

Naproxen may cause premature closure of the fetal ductus arteriosus. Avoid use of NSAIDs, including naproxen or naproxen sodium, in pregnant women starting at 30 weeks of gestation (third trimester) (see PRECAUTIONS; PREGNANCY).

#### Hematologic Toxicity

Anemia has occurred in NSAID-treated patients. This may be due to occult or gross blood loss, fluid retention, or an incompletely described effect on erythropoiesis. If a patient treated with naproxen or naproxen sodium has any signs or symptoms of anemia, monitor hemoglobin or hematocrit.

NSAIDs, including naproxen or naproxen sodium, may increase the risk of bleeding events. Co-morbid conditions such as coagulation disorders, or concomitant use of warfarin and other anticoagulants, antiplatelet agents (e.g., aspirin), serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) may increase this risk. Monitor these patients for signs of bleeding (see PRECAUTIONS; DRUG INTERACTIONS).

#### General

Naproxen-containing products such as naproxen and naproxen sodium, and other naproxen products should not be used concomitantly since they all circulate in the plasma as the naproxen anion.

Naproxen and naproxen sodium cannot be expected to substitute for corticosteroids or to treat corticosteroid insufficiency. Abrupt discontinuation of corticosteroids may lead to disease

exacerbation. Patients on prolonged corticosteroid therapy should have their therapy tapered slowly if a decision is made to discontinue corticosteroids and the patient should be observed closely for any evidence of adverse effects, including adrenal insufficiency and exacerbation of symptoms of arthritis.

Patients with initial hemoglobin values of 10g or less who are to receive long-term therapy should have hemoglobin values determined periodically.

Because of adverse eye findings in animal studies with drugs of this class, it is recommended that ophthalmic studies be carried out if any change or disturbance in vision occurs.

#### Information for Patients

Advise the patient to read the FDA-approved patient labeling (Medication Guide) that accompanies each prescription dispensed. Inform patients, families, or their caregivers of the following information before initiating therapy with naproxen or naproxen sodium and periodically during the course of ongoing therapy.

#### Cardiovascular Thrombotic Events

Advise patients to be alert for the symptoms of cardiovascular thrombotic events, including chest pain, shortness of breath, weakness, or slurring of speech, and to report any of these symptoms to their health care provider immediately (see WARNINGS; CARDIOVASCULAR THROMBOTIC EVENTS).

#### Gastrointestinal Bleeding, Ulceration, and Perforation

Advise patients to report symptoms of ulcerations and bleeding, including epigastric pain, dyspepsia, melena, and hematemesis to their health care provider. In the setting of concomitant use of low-dose aspirin for cardiac prophylaxis, inform patients of the increased risk for the signs and symptoms of GI bleeding (see WARNINGS; GASTROINTESTINAL BLEEDING, ULCERATION, AND PERFORATION).

#### Hepatotoxicity

Inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and “flu-like” symptoms). If these occur, instruct patients to stop naproxen or naproxen sodium and seek immediate medical therapy (see WARNINGS; HEPATOTOXICITY).

#### Heart Failure and Edema

Advise patients to be alert for the symptoms of congestive heart failure including shortness of breath, unexplained weight gain, or edema and to contact their healthcare provider if such symptoms occur (see WARNINGS; HEART FAILURE AND EDEMA).

#### Anaphylactic Reactions

Inform patients of the signs of an anaphylactic reaction (e.g., difficulty breathing, swelling of the face or throat). Instruct patients to seek immediate emergency help if these occur (see CONTRAINDICATION, WARNINGS; ANAPHYLACTIC REACTIONS).

#### Serious Skin Reactions

Advise patients to stop naproxen or naproxen sodium immediately if they develop any type of rash and to contact their healthcare provider as soon as possible (see WARNINGS; SERIOUS SKIN REACTIONS).

#### Female Fertility

Advise females of reproductive potential who desire pregnancy that NSAIDs, including VOLTAREN, may be associated with a reversible delay in ovulation (see PRECAUTIONS; CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY).

#### Fetal Toxicity

Inform pregnant women to avoid use of naproxen or naproxen sodium and other NSAIDs starting at 30 weeks gestation because of the risk of the premature closing of the fetal ductus arteriosus (see WARNINGS; PREMATURE CLOSURE OF FETAL DUCTUS ARTERIOSUS).

#### Avoid Concomitant Use of NSAIDs

Inform patients that the concomitant use of naproxen and naproxen sodium with other NSAIDs or salicylates (e.g., diflunisal, salsalate) is not recommended due to the increased risk of gastrointestinal toxicity, and little or no increase in efficacy (see WARNINGS; GASTROINTESTINAL BLEEDING, ULCERATION, AND PERFORATION, PRECAUTIONS; DRUG INTERACTIONS). Alert patients that NSAIDs may be present in “over the counter” medications for treatment of colds, fever, or insomnia.

#### Use of NSAIDs and Low-Dose Aspirin

Inform patients not to use low-dose aspirin concomitantly with naproxen and naproxen sodium until they talk to their healthcare provider (see PRECAUTIONS; DRUG INTERACTIONS).

#### Activities Requiring Alertness

Caution should be exercised by patients whose activities require alertness if they experience drowsiness, dizziness, vertigo or depression during therapy with naproxen.

#### Masking of Inflammation and Fever

The pharmacological activity of naproxen or naproxen sodium in reducing inflammation, and possibly fever, may diminish the utility of diagnostic signs in detecting infections.

#### Laboratory Monitoring

Because serious GI bleeding, hepatotoxicity, and renal injury can occur without warning symptoms or signs, consider monitoring patients on long-term NSAID treatment with a CBC and a chemistry profile periodically (see WARNINGS; GASTROINTESTINAL BLEEDING, ULCERATION AND PERFORATION, and HEPATOTOXICITY).

#### Drug Interactions

See Table 1 for clinically significant drug interactions with naproxen.

#### Table 1: Clinically Significant Drug Interactions with naproxen

##### Drugs That Interfere with Hemostasis

##### Clinical Impact:

- Naproxen and anticoagulants such as warfarin have a synergistic effect on bleeding. The concomitant use of naproxen and anticoagulants has an increased risk of serious bleeding compared to the use of either drug alone.
- Serotonin release by platelets plays an important role in hemostasis. Case-control and cohort epidemiological studies showed that concomitant use of drugs that interfere with serotonin reuptake and an NSAID may potentiate the risk of bleeding more than an NSAID alone.

##### Intervention:

Monitor patients with concomitant use of naproxen or naproxen sodium with anticoagulants (e.g., warfarin), antiplatelet agents (e.g., aspirin), selective serotonin reuptake inhibitors (SSRIs), and serotonin norepinephrine reuptake inhibitors (SNRIs) for signs of bleeding (see WARNINGS; HEMATOLOGIC TOXICITY).

##### Aspirin

##### Clinical Impact:

Controlled clinical studies showed that the concomitant use of NSAIDs and analgesic doses of aspirin does not produce any greater therapeutic effect than the use of NSAIDs alone. In a clinical study, the

concomitant use of an NSAID and aspirin was associated with a significantly increased incidence of GI adverse reactions as compared to use of the NSAID alone (see WARNINGS; GASTROINTESTINAL BLEEDING, ULCERATION AND PERFORATION).

Intervention:

Concomitant use of naproxen or naproxen sodium and analgesic doses of aspirin is not generally recommended because of the increased risk of bleeding (see WARNINGS; HEMATOLOGIC TOXICITY).

Naproxen or naproxen sodium is not a substitute for low dose aspirin for cardiovascular protection.

ACE Inhibitors, Angiotensin Receptor Blockers, and Beta-Blockers

Clinical Impact:

- NSAIDs may diminish the antihypertensive effect of angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), or beta-blockers (including propranolol).
- In patients who are elderly, volume-depleted (including those on diuretic therapy), or have renal impairment, co-administration of an NSAID with ACE-inhibitors or ARBs may result in deterioration of renal function, including possible acute renal failure. These effects are usually reversible.

Intervention:

- During concomitant use of naproxen or naproxen sodium and ACE inhibitors, ARBs, or beta-blockers, monitor blood pressure to ensure that the desired blood pressure is obtained.
- During concomitant use of naproxen or naproxen sodium and ACE-inhibitors or ARBs in patients who are elderly, volume-depleted, or have impaired renal function, monitor for signs of worsening renal function (see WARNINGS; RENAL TOXICITY AND HYPERKALEMIA).

When these drugs are administered concomitantly, patients should be adequately hydrated. Assess renal function at the beginning of the concomitant treatment and periodically thereafter.

Diuretics

Clinical Impact:

Clinical studies, as well as post-marketing observations, showed that NSAIDs reduced the natriuretic effect of loop diuretics (e.g., furosemide) and thiazide diuretics in some patients. This effect has been attributed to the NSAID inhibition of renal prostaglandin synthesis.

Intervention:

During concomitant use of naproxen or naproxen sodium with diuretics, observe patients for signs of worsening renal function, in addition to assuring diuretic efficacy including antihypertensive effects (see WARNINGS; RENAL TOXICITY AND HYPERKALEMIA).

Digoxin

Clinical Impact:

The concomitant use of naproxen with digoxin has been reported to increase the serum concentration and prolong the half-life of digoxin.

Intervention:

During concomitant use of naproxen or naproxen sodium and digoxin, monitor serum digoxin levels.

Lithium

Clinical Impact:

NSAIDs have produced elevations in plasma lithium levels and reductions in renal lithium clearance. The mean minimum lithium concentration increased 15%, and the renal clearance decreased by

approximately 20%. This effect has been attributed to NSAID inhibition of renal prostaglandin synthesis.

Intervention:

During concomitant use of naproxen or naproxen sodium and lithium, monitor patients for signs of lithium toxicity.

Methotrexate

Clinical Impact:

Concomitant use of NSAIDs and methotrexate may increase the risk for methotrexate toxicity (e.g., neutropenia, thrombocytopenia, renal dysfunction).

Intervention:

During concomitant use of naproxen or naproxen sodium and methotrexate, monitor patients for methotrexate toxicity.

Cyclosporine

Clinical Impact:

Concomitant use of naproxen or naproxen sodium and cyclosporine may increase cyclosporine's nephrotoxicity.

Intervention:

During concomitant use of naproxen or naproxen sodium and cyclosporine, monitor patients for signs of worsening renal function.

NSAIDs and Salicylates

Clinical Impact:

Concomitant use of naproxen with other NSAIDs or salicylates (e.g., diflunisal, salsalate) increases the risk of GI toxicity, with little or no increase in efficacy (see WARNINGS; GASTROINTESTINAL BLEEDING, ULCERATION AND PERFORATION).

Intervention:

The concomitant use of naproxen with other NSAIDs or salicylates is not recommended.

Pemetrexed

Clinical Impact:

Concomitant use of naproxen or naproxen sodium and pemetrexed may increase the risk of pemetrexed-associated myelosuppression, renal, and GI toxicity (see the pemetrexed prescribing information).

Intervention:

During concomitant use of naproxen or naproxen sodium and pemetrexed, in patients with renal impairment whose creatinine clearance ranges from 45 to 79 mL/min, monitor for myelosuppression, renal and GI toxicity.

NSAIDs with short elimination half-lives (e.g., diclofenac, indomethacin) should be avoided for a period of two days before, the day of, and two days following administration of pemetrexed.

In the absence of data regarding potential interaction between pemetrexed and NSAIDs with longer half-lives (e.g., meloxicam, nabumetone), patients taking these NSAIDs should interrupt dosing for at least five days before, the day of, and two days following pemetrexed administration.

Antacids and Sucralfate

Clinical Impact:

Concomitant administration of some antacids (magnesium oxide or aluminum hydroxide) and sucralfate can delay the absorption of naproxen.

Intervention:

Concomitant administration of antacids such as magnesium oxide or aluminum hydroxide, and sucralfate with naproxen or naproxen sodium is not recommended.

Due to the gastric pH elevating effects of H<sub>2</sub>-blockers, sucralfate and intensive antacid therapy, concomitant administration of naproxen delayed release tablets are not recommended.

Cholestyramine

Clinical Impact:

Concomitant administration of cholestyramine can delay the absorption of naproxen.

Intervention:

Concomitant administration of cholestyramine with naproxen or naproxen sodium is not recommended.

Probenecid

Clinical Impact:

Probenecid given concurrently increases naproxen anion plasma levels and extends its plasma half-life significantly.

Intervention:

Patients simultaneously receiving naproxen or naproxen sodium and probenecid should be observed for adjustment of dose if required.

Other albumin-bound drugs

Clinical Impact:

Naproxen is highly bound to plasma albumin; it thus has a theoretical potential for interaction with other albumin-bound drugs such as coumarin-type anticoagulants, sulphonylureas, hydantoins, other NSAIDs, and aspirin.

Intervention:

Patients simultaneously receiving naproxen or naproxen sodium and a hydantoin, sulphonamide or sulphonylurea should be observed for adjustment of dose if required.

Drug/Laboratory Test Interactions

Bleeding times

Clinical Impact:

Naproxen may decrease platelet aggregation and prolong bleeding time.

Intervention:

This effect should be kept in mind when bleeding times are determined.

Porter-Silber test

Clinical Impact:

The administration of naproxen may result in increased urinary values for 17-ketogenic steroids because of an interaction between the drug and/or its metabolites with m-di-nitrobenzene used in this assay.

Intervention:

Although 17-hydroxy-corticosteroid measurements (Porter-Silber test) do not appear to be artifactually

altered, it is suggested that therapy with naproxen be temporarily discontinued 72 hours before adrenal function tests are performed if the Porter-Silber test is to be used.

Urinary assays of 5-hydroxy indoleacetic acid (5HIAA)

Clinical Impact:

Naproxen may interfere with some urinary assays of 5-hydroxy indoleacetic acid (5HIAA).

Intervention:

This effect should be kept in mind when urinary 5-hydroxy indoleacetic acid is determined.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

A 2-year study was performed in rats to evaluate the carcinogenic potential of naproxen at rat doses of 8, 16, and 24 mg/kg/day (0.05, 0.1, and 0.16 times the maximum recommended human daily dose [MRHD] of 1500 mg/day based on a body surface area comparison). No evidence of tumorigenicity was found.

Mutagenesis

Studies to evaluate the mutagenic potential of naproxen or naproxen sodium tablets have not been completed.

Impairment of fertility

Male rats were treated with 2, 5, 10, and 20 mg/kg naproxen by oral gavage for 60 days prior to mating and female rats were treated with the same doses for 14 days prior to mating and for the first 7 days of pregnancy. There were no adverse effects on fertility noted (up to 0.13 times the MRDH based on body surface area).

Pregnancy

Risk Summary

Use of NSAIDs, including naproxen and naproxen sodium tablets, during the third trimester of pregnancy increases the risk of premature closure of the fetal ductus arteriosus. Avoid use of NSAIDs, including naproxen, in pregnant women starting at 30 weeks of gestation (third trimester) (see WARNINGS; PREMATURE CLOSURE OF FETAL DUCTUS ARTERIOSUS).

There are no adequate and well-controlled studies of naproxen or naproxen sodium tablets in pregnant women.

Data from observational studies regarding potential embryofetal risks of NSAID use in women in the first or second trimesters of pregnancy are inconclusive. In the general U.S. population, all clinically recognized pregnancies, regardless of drug exposure, have a background rate of 2 to 4% for major malformations, and 15 to 20% for pregnancy loss. In animal reproduction studies in rats, rabbit, and mice no evidence of teratogenicity or fetal harm when naproxen was administered during the period of organogenesis at doses 0.13, 0.26, and 0.6 times the maximum recommended human daily dose of 1500 mg/day, respectively. Based on animal data, prostaglandins have been shown to have an important role in endometrial vascular permeability, blastocyst implantation, and decidualization. In animal studies, administration of prostaglandin synthesis inhibitors such as naproxen, resulted in increased pre- and post-implantation loss.

Data

Human Data

There is some evidence to suggest that when inhibitors of prostaglandin synthesis are used to delay preterm labor there is an increased risk of neonatal complications such as necrotizing enterocolitis, patent ductus arteriosus and intracranial hemorrhage. Naproxen treatment given in late pregnancy to delay parturition has been associated with persistent pulmonary hypertension, renal dysfunction and

abnormal prostaglandin E levels in preterm infants. Because of the known effects of nonsteroidal anti-inflammatory drugs on the fetal cardiovascular system (closure of ductus arteriosus), use during pregnancy (particularly starting at 30-weeks of gestation, or third trimester) should be avoided.

#### Animal Data

Reproduction studies have been performed in rats at 20 mg/kg/day (0.13 times the maximum recommended human daily dose of 1500 mg/day based on body surface area comparison), rabbits at 20 mg/kg/day (0.26 times the maximum recommended human daily dose, based on body surface area comparison), and mice at 170 mg/kg/day (0.6 times the maximum recommended human daily dose based on body surface area comparison) with no evidence of impaired fertility or harm to the fetus due to the drug. Based on animal data, prostaglandins have been shown to have an important role in endometrial vascular permeability, blastocyst implantation, and decidualization. In animal studies, administration of prostaglandin synthesis inhibitors such as naproxen, resulted in increased pre- and postimplantation loss.

#### Labor and Delivery

There are no studies on the effects of naproxen or naproxen sodium tablets during labor or delivery. In animal studies, NSAIDs, including naproxen, inhibit prostaglandin synthesis, cause delayed parturition, and increase the incidence of stillbirth.

#### Nursing Mothers

The naproxen anion has been found in the milk of lactating women at a concentration equivalent to approximately 1% of maximum naproxen concentration in plasma. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for naproxen or naproxen sodium tablets and any potential adverse effects on the breastfed infant from the naproxen or naproxen sodium tablets or from the underlying maternal condition.

#### Females and Males of Reproductive Potential

Based on the mechanism of action, the use of prostaglandin-mediated NSAIDs, including naproxen, may delay or prevent rupture of ovarian follicles, which has been associated with reversible infertility in some women. Published animal studies have shown that administration of prostaglandin synthesis inhibitors has the potential to disrupt prostaglandin-mediated follicular rupture required for ovulation. Small studies in women treated with NSAIDs have also shown a reversible delay in ovulation.

Consider withdrawal of NSAIDs, including naproxen and naproxen sodium tablets, in women who have difficulties conceiving or who are undergoing investigation of infertility.

#### Pediatric Use

Safety and effectiveness in pediatric patients below the age of 2 years have not been established. Pediatric dosing recommendations for juvenile arthritis are based on well-controlled studies (see DOSAGE AND ADMINISTRATION). There are no adequate effectiveness or dose-response data for other pediatric conditions, but the experience in juvenile arthritis and other use experience have established that single doses of 2.5 to 5 mg/kg (as naproxen suspension, see DOSAGE AND ADMINISTRATION), with total daily dose not exceeding 15 mg/kg/day, are well tolerated in pediatric patients over 2 years of age. Safety and effectiveness in pediatric patients below the age of 2 years have not been established.

#### Geriatric Use

Elderly patients, compared to younger patients, are at greater risk for NSAID-associated serious cardiovascular, gastrointestinal, and/or renal adverse reactions. If the anticipated benefit for the elderly patient outweighs these potential risks, start dosing at the low end of the dosing range, and monitor patients for adverse effects (see WARNINGS; CARDIOVASCULAR THROMBOTIC EVENTS, GASTROINTESTINAL BLEEDING, ULCERATION, AND PERFORATION, HEPATOTOXICITY, RENAL TOXICITY AND HYPERKALEMIA, PRECAUTIONS; LABORATORY MONITORING).

Studies indicate that although total plasma concentration of naproxen is unchanged, the unbound plasma fraction of naproxen is increased in the elderly. Caution is advised when high doses are required and

some adjustment of dosage may be required in elderly patients. As with other drugs used in the elderly, it is prudent to use the lowest effective dose.

Experience indicates that geriatric patients may be particularly sensitive to certain adverse effects of nonsteroidal anti-inflammatory drugs. Elderly or debilitated patients seem to tolerate peptic ulceration or bleeding less well when these events do occur. Most spontaneous reports of fatal GI events are in the geriatric population (see WARNINGS; GASTROINTESTINAL BLEEDING, ULCERATION, AND PERFORATION).

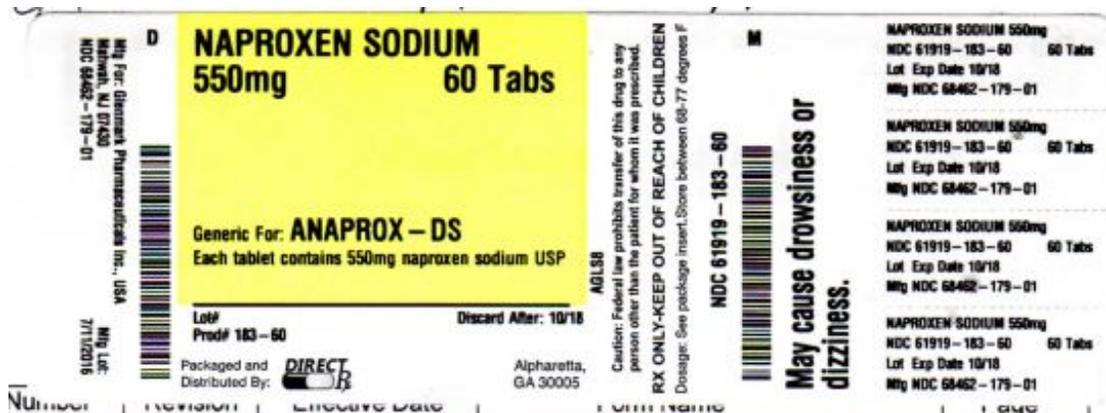
Naproxen is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function. Geriatric patients may be at a greater risk for the development of a form of renal toxicity precipitated by reduced prostaglandin formation during administration of nonsteroidal anti-inflammatory drugs (see WARNINGS: RENAL TOXICITY AND HYPERKALEMIA).

Symptoms following acute NSAID overdosages have been typically limited to lethargy, drowsiness, nausea, vomiting, and epigastric pain, which have been generally reversible with supportive care. Gastrointestinal bleeding has occurred. Hypertension, acute renal failure, respiratory depression, and coma have occurred, but were rare. Because naproxen sodium may be rapidly absorbed, high and early blood levels should be anticipated. A few patients have experienced convulsions, but it is not clear whether or not these were drug-related. It is not known what dose of the drug would be life threatening. (see WARNINGS; CARDIOVASCULAR THROMBOTIC EVENTS, GASTROINTESTINAL BLEEDING, ULCERATION, AND PERFORATION, HYPERTENSION, RENAL TOXICITY AND HYPERKALEMIA).

Manage patients with symptomatic and supportive care following an NSAID overdose. There are no specific antidotes. Hemodialysis does not decrease the plasma concentration of naproxen because of the high degree of its protein binding. Consider emesis and/or activated charcoal (60 to 100 g in adults, 1 to 2 g/kg of body weight in pediatric patients) and/or osmotic cathartic in symptomatic patients seen within four hours of ingestion or in patients with a large overdose (5 to 10 times the recommended dosage). Forced diuresis, alkalization of urine, hemodialysis, or hemoperfusion may not be useful due to high protein binding.

For additional information about overdose treatment contact a poison control center (1-800-222-1222).

Store at 20° to 25°C (68° to 77°F); excursions permitted between 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature]. Dispense in well-closed containers.



## ANAPROX

naproxen sodium tablet

**Product Information**

<b>Product Type</b>	HUMAN PRESCRIPTION DRUG	<b>Item Code (Source)</b>	NDC:6 19 19-183(NDC:68462-179)
<b>Route of Administration</b>	ORAL		

**Active Ingredient/Active Moiety**

<b>Ingredient Name</b>	<b>Basis of Strength</b>	<b>Strength</b>
NAPROXEN SODIUM (UNII: 9TN87S3A3C) (NAPROXEN - UNII:57Y76R9ATQ)	NAPROXEN SODIUM	550 mg

**Inactive Ingredients**

<b>Ingredient Name</b>	<b>Strength</b>
MAGNESIUM STEARATE (UNII: 70097M6I30)	
FD&C BLUE NO. 2 (UNII: L06K8R7DQK)	
POLYETHYLENE GLYCOL 400 (UNII: B697894SGQ)	
TITANIUM DIOXIDE (UNII: 15FIX9V2JP)	
POVIDONE (UNII: FZ989GH94E)	
CELLULOSE, MICROCRYSTALLINE (UNII: OP1R32D61U)	
CROSCARMELOSE SODIUM (UNII: M28OL1HH48)	
SILICON DIOXIDE (UNII: ETJ7Z6XBU4)	
TALC (UNII: 7SEV7J4R1U)	
HYPROMELLOSES (UNII: 3NXW29V3WO)	
FERRIC OXIDE RED (UNII: 1K09F3G675)	

**Product Characteristics**

<b>Color</b>	blue	<b>Score</b>	2 pieces
<b>Shape</b>	CAPSULE	<b>Size</b>	19mm
<b>Flavor</b>		<b>Imprint Code</b>	G;0
<b>Contains</b>			

**Packaging**

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:6 19 19-183-60	60 in 1 BOTTLE; Type 0: Not a Combination Product	07/11/2016	

**Marketing Information**

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA078314	07/11/2016	

**Labeler** - DIRECT RX (079254320)**Establishment**

Name	Address	ID/FEI	Business Operations
DIRECT RX		079254320	repack(6 19 19-183)

