# SUMMARY OF PRODUCT CHARACTERISTICS

## 1 NAME OF THE MEDICINAL PRODUCT

Psyquet XL 300 mg prolonged-release tablets

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each prolonged-release tablet contains 300 mg of quetiapine (as quetiapine fumarate).

Excipient with known effect
Each prolonged-release tablet contains 85.3 mg of lactose (anhydrous).

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Prolonged-release tablet

300mg: White to off white, oblong biconvex tablet, 18.2 mm in length, 8.2 mm in width and 5.4 mm in thickness, engraved with “300” on one side.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Psyquet XL is indicated for:

- treatment of Schizophrenia.
- treatment of bipolar disorder:
    - For the treatment of moderate to severe manic episodes in bipolar disorder
    - For the treatment of major depressive episodes associated with bipolar disorder
    - For the prevention of recurrence of manic or depressed episodes in patients with bipolar disorder who previously responded to quetiapine treatment.

- add-on treatment of major depressive episodes in patients with Major Depressive Disorder (MDD) who have had sub-optimal response to antidepressant

monotherapy (see Section 5.1). Prior to initiating treatment, clinicians should consider the safety profile of quetiapine (see Section 4.4).

## 4.2 Posology and method of administration

Posology
Different dosing schedules exist for each indication. It must therefore be ensured that patients receive clear information on the appropriate dose for their condition.

**Adults:**
**For the treatment of schizophrenia and moderate to severe manic episodes in bipolar disorder**
Psyquet XL should be administered at least one hour before a meal. The daily dose at the start of therapy is 300 mg on Day 1 and 600 mg on Day 2. The recommended daily dose is 600 mg, however if clinically justified the dose may be increased to 800 mg daily. The dose should be adjusted within the effective dose range of 400 mg to 800 mg per day, depending on the clinical response and tolerability of the patient. For maintenance therapy in schizophrenia no dosage adjustment is necessary.

**For the treatment of major depressive episodes in bipolar disorder**
Psyquet XL should be administered at bedtime. The total daily dose for the first four days of therapy is 50 mg (Day 1), 100 mg (Day 2), 200 mg (Day 3) and 300 mg (Day 4). The recommended daily dose is 300 mg. In clinical trials, no additional benefit was seen in the 600 mg group compared to the 300 mg group (see section 5.1). Individual patients may benefit from a 600 mg dose. Doses greater than 300 mg should be initiated by physicians experienced in treating bipolar disorder. In individual patients, in the event of tolerance concerns, clinical trials have indicated that dose reduction to a minimum of 200 mg could be considered.

**For preventing recurrence in bipolar disorder**
For preventing recurrence of manic, mixed or depressive episodes in bipolar disorder, patients who have responded to Psyquet XL for acute treatment of bipolar disorder should continue on Psyquet XL at the same dose administered at bedtime. Psyquet XL dose can be adjusted depending on clinical response and tolerability of the individual patient within the dose range of 300 mg to 800 mg/day. It is important that the lowest effective dose is used for maintenance therapy.

**For add-on treatment of major depressive episodes in MDD:**
Psyquet XL should be administered prior to bedtime. The daily dose at the start of therapy is 50 mg on Day 1 and 2, and 150 mg on Day 3 and 4. Antidepressant effect was seen at 150 and 300 mg/day in short-term trials as add-on therapy (with amitriptyline, bupropion, citalopram, duloxetine, escitalopram, fluoxetine, paroxetine, sertraline and venlafaxine - see Section 5.1) and at 50 mg/day in short-term monotherapy trials.
There is an increased risk of adverse events at higher doses. Clinicians should therefore ensure that the lowest effective dose, starting with 50 mg/day, is used for treatment. The need to increase the dose from 150 to 300 mg/day should be based on individual patient evaluation.

***Switching from Quetiapine immediate-release tablets:***
For more convenient dosing, patients who are currently being treated with divided doses of immediate release Quetiapine tablets may be switched to Psyquet XL at the equivalent total daily dose taken once daily.
Individual dosage adjustments may be necessary.

***Elderly:***
As with other antipsychotics and antidepressants, Psyquet XL should be used with caution in the elderly, especially during the initial dosing period. The rate of dose titration of Psyquet XL may need to be slower, and the daily therapeutic dose lower, than that used in younger patients. The mean plasma clearance of quetiapine was reduced by 30% to 50% in elderly patients when compared to younger patients. Elderly patients should be started on 50 mg/day. The dose can be increased in increments of 50 mg/day to an effective dose, depending on the clinical response and tolerability of the individual patient.
In elderly patients with major depressive episodes in MDD, dosing should begin with 50 mg/day on Days 1- 3, increasing to 100 mg/day on Day 4 and 150 mg/day on Day 8. The lowest effective dose, starting from 50 mg/day should be used. Based on individual patient evaluation, if dose increase to 300 mg/day is required this should not be prior to Day 22 of treatment.

Efficacy and safety has not been evaluated in patients over 65 years with depressive episodes in the framework of bipolar disorder.

***Paediatric Population***
Psyquet XL is not recommended for use in children and adolescents below 18 years of age, due to a lack of data to support use in this age group. The available evidence from placebo-controlled clinical trials is presented in sections 4.4, 4.8, 5.1 and 5.2.

***Renal impairment:***
Dose adjustment is not necessary in patients with renal impairment.

***Hepatic impairment:***
Quetiapine is extensively metabolized by the liver. Therefore, Psyquet XL should be used with caution in patients with known hepatic impairment, especially during the initial dosing period. Patients with hepatic impairment should be started on 50 mg/day. The dose can be increased in increments of 50 mg/day to an effective dose, depending on the clinical response and tolerability of the individual patient.

Method of administration
Psyquet XL should be administered once daily, without food. The tablets should be swallowed whole and not split, chewed or crushed.

## 4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

Concomitant administration of cytochrome P450 3A4 inhibitors, such as HIV-protease inhibitors, azole-antifungal agents, erythromycin, clarithromycin and nefazodone, is contraindicated. (See section 4.5).

## 4.4 Special warnings and precautions for use

As Psyquet XL has several indications, the safety profile should be considered with respect to the individual patient's diagnosis and the dose being administered.
Long-term efficacy and safety in patients with MDD has not been evaluated as add-on therapy, however long-term efficacy and safety has been evaluated in adult patients as monotherapy (see Section 5.1).

**Paediatric population**
Quetiapine is not recommended for use in children and adolescents below 18 years of age, due to a lack of data to support use in this age group. Clinical trials with quetiapine have shown that in addition to the known safety profile identified in adults (see section 4.8), certain adverse events occurred at a higher frequency in children and adolescents compared to adults (increased appetite, elevations in serum prolactin, vomiting, rhinitis and syncope) or may have different implications for children and adolescents (extrapyramidal symptoms and irritability) and one was identified that has not been previously seen in adult studies (increases in blood pressure). Changes in thyroid function tests have also been observed in children and adolescents.

Furthermore, the long-term safety implications of treatment with quetiapine on growth and maturation have not been studied beyond 26 weeks. Long-term implications for cognitive and behavioural development are not known.

In placebo-controlled clinical trials with children and adolescent patients, quetiapine was associated with an increased incidence of extrapyramidal symptoms (EPS) compared to placebo in patients treated for schizophrenia, bipolar mania and bipolar depression (see section 4.8).

**Suicide/suicidal thoughts or clinical worsening**:
Depression is associated with an increased risk of suicidal thoughts, self-harm and suicide (suicide-related events). This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery.

In addition, physicians should consider the potential risk of suicide-related events after abrupt cessation of quetiapine treatment, due to the known risk factors for the disease being treated.

Other psychiatric conditions for which quetiapine is prescribed can also be associated with an increased risk of suicide related events. In addition, these conditions may be co-morbid with major depressive episodes.

The same precautions observed when treating patients with major depressive episodes should therefore be observed when treating patients with other psychiatric disorders.

Patients with a history of suicide related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment. A meta analysis of placebo controlled clinical trials of antidepressant drugs in adult patients with psychiatric disorders showed an increased risk of suicidal behaviour with antidepressants compared to placebo in patients less than 25 years old.

Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present.

In shorter-term placebo controlled clinical studies of patients with major depressive episodes in bipolar disorder an increased risk of suicide-related events was observed in young adults patients (younger than 25 years of age) who were treated with quetiapine as compared to those treated with placebo (3.0% vs. 0%, respectively). In clinical studies of patients with MDD the incidence of suicide-related events observed in young adult patients (younger than 25 years of age) was 2.1% (3/144) for quetiapine and 1.3% (1/75) for placebo. A population-based retrospective study of quetiapine for the treatment of patients with major depressive disorder showed an increased risk of self-harm and suicide in patients aged 25 to 64 years without a history of self-harm during use of quetiapine with other antidepressants.

***Metabolic risk***
Given the observed risk for worsening of their metabolic profile, including changes in weight, blood glucose (see hyperglycemia) and lipids, which was seen in clinical studies, patient's metabolic parameters should be assessed at the time of treatment initiation and changes in these parameters should be regularly controlled for during the course of treatment. Worsening in these parameters should be managed as clinically appropriate (see also section 4.8).

***Extrapyramidal symptoms:***
In placebo controlled clinical trials of adult patients quetiapine was associated with an increased incidence of extrapyramidal symptoms (EPS) compared to placebo in patients treated for major depressive episodes in bipolar disorder and major depressive disorder (see sections 4.8 and 5.1).

The use of quetiapine has been associated with the development of akathisia, characterised by a subjectively unpleasant or distressing restlessness and need to move often accompanied by an inability to sit or stand still. This is most likely to occur within the first few weeks of treatment. In patients who develop these symptoms, increasing the dose may be detrimental.

***Tardive dyskinesia:***

If signs and symptoms of tardive dyskinesia appear, dose reduction or discontinuation of quetiapine should be considered. The symptoms of tardive dyskinesia can worsen or even arise after discontinuation of treatment (see Section 4.8).

***Somnolence and dizziness:***
Quetiapine treatment has been associated with somnolence and related symptoms, such as sedation (see Section 4.8). In clinical trials for treatment of patients with bipolar depression and major depressive disorder, onset was usually within the first 3 days of treatment and was predominantly of mild to moderate intensity. Patients experiencing somnolence of severe intensity may require more frequent contact for a minimum of 2 weeks from onset of somnolence, or until symptoms improve and treatment discontinuation may need to be considered.

***Orthostatic hypotension***
Quetiapine treatment has been associated with orthostatic hypotension and related dizziness (see Section 4.8) which, like somnolence has onset usually during the initial dose-titration period. This could increase the occurrence of accidental injury (fall), especially in the elderly population. Therefore, patients should be advised to exercise caution until they are familiar with the potential effects of the medication.

Quetiapine should be used with caution in patients with known cardiovascular disease, cerebrovascular disease, or other conditions predisposing to hypotension. Dose reduction or more gradual titration should be considered if orthostatic hypotension occurs, especially in patients with underlying cardiovascular disease.

***Sleep apnoea syndrome:***
Sleep apnoea syndrome has been reported in patients using quetiapine. In patients receiving concomitant central nervous system depressants and who have a history of or are at risk for sleep apnoea, such as those who are overweight/obese or are male, quetiapine should be used with caution.

***Seizures:***
In controlled clinical trials there was no difference in the incidence of seizures in patients treated with quetiapine or placebo. No data is available about the incidence of seizures in patients with a history of seizure disorder. As with other antipsychotics, caution is recommended when treating patients with a history of seizures (see Section 4.8).

***Neuroleptic malignant syndrome:***
Neuroleptic malignant syndrome has been associated with antipsychotic treatment, including quetiapine (see section 4.8). Clinical manifestations include hyperthermia, altered mental status, muscular rigidity, autonomic instability, and increased creatine phosphokinase. In such an event, quetiapine should be discontinued and appropriate medical treatment given.

***Serotonin syndrome:***
Concomitant administration of Psyquet XL and other serotonergic agents, such as MAO inhibitors, selective serotonin re-uptake inhibitors (SSRIs), serotonin norepinephrine re-uptake inhibitors (SNRIs) or tricyclic antidepressants may result in serotonin syndrome, a potentially life-threatening condition (see section 4.5).

If concomitant treatment with other serotonergic agents is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases. Symptoms of serotonin syndrome may include mental-status changes, autonomic instability, neuromuscular abnormalities, and/or gastrointestinal symptoms.

If serotonin syndrome is suspected, a dose reduction or discontinuation of therapy should be
considered depending on the severity of the symptoms.

***Severe neutropenia and agranulocytosis:***
Severe neutropenia (neutrophil count <0.5 x 109/L) has been reported in quetiapine clinical trials. Most cases of severe neutropenia have occurred within a couple of months of starting therapy with quetiapine. There was no apparent dose relationship. During post-marketing experience some cases were fatal. Possible risk factors for neutropenia include pre-existing low white blood cell count (WBC) and history of drug induced neutropenia.
However, some cases occurred in patients without pre-existing risk factors. Quetiapine should be discontinued in patients with a neutrophil count <1.0 x 109/L. Patients should be observed for signs and symptoms of infection and neutrophil counts followed (until they exceed 1.5 x 109/L) (see section 5.1).

Neutropenia should be considered in patients presenting with infection or fever, particularly in the absence of obvious predisposing factor(s), and should be managed as clinically appropriate.

Patients should be advised to immediately report the appearance of signs/symptoms consistent with agranulocytosis or infection (e.g., fever, weakness, lethargy, or sore throat) at any time during quetiapine therapy. Such patients should have a WBC count and an absolute neutrophil count (ANC) performed promptly, especially in the absence of predisposing factors.

***Anticholinergic (muscarinic) effects:***
Norquetiapine, an active metabolite of quetiapine, has moderate to strong affinity for several muscarinic receptor subtypes. This contributes to ADRs reflecting anticholinergic effects when quetiapine is used at recommended doses, when used concomitantly with other medications having anticholinergic effects, and in the setting of overdose.
Quetiapine should be used with caution in patients receiving medications having anticholinergic (muscarinic) effects. Quetiapine should be used with caution in patients with a current diagnosis or prior history of urinary retention, clinically significant prostatic hypertrophy, intestinal obstruction or related conditions, increased intraocular pressure or narrow angle glaucoma. (See sections 4.5, 4.8, 5.1 and 4.9.)

***Interactions:***
See also section 4.5.

Concomitant use of quetiapine with a strong hepatic enzyme inducer such as carbamazepine or phenytoin substantially decreases quetiapine plasma concentrations,

which could affect the efficacy of quetiapine therapy. In patients receiving a hepatic enzyme inducer, initiation of quetiapine treatment should only occur if the physician considers that the benefits of quetiapine outweigh the risks of removing the hepatic enzyme inducer. It is important that any change in the inducer is gradual, and if required, replaced with a non-inducer (e.g. sodium valproate).

***Weight***
Weight gain has been reported in patients who have been treated with quetiapine, and should be monitored and managed as clinically appropriate as in accordance with utilized antipsychotic guidelines (See Sections 4.8 and 5.1).

***Hyperglycaemia:***
Hyperglycaemia and/ or development or exacerbation of diabetes occasionally associated with ketoacidosis or coma has been reported rarely, including some fatal cases (see section 4.8). In some cases, a prior increase in body weight has been reported which may be a predisposing factor. Appropriate clinical monitoring is advisable in accordance with utilised antipsychotic guidelines. Patients treated with any antipsychotic agent including quetiapine, should be observed for signs and symptoms of hyperglycaemia, (such as polydipsia, polyuria, polyphagia and weakness) and patients with diabetes mellitus or with risk factors for diabetes mellitus should be monitored regularly for worsening of glucose control. Weight should be monitored regularly.

***Lipids:***
Increases in triglycerides, LDL and total cholesterol, and decreases in HDL cholesterol have been observed in clinical trials with quetiapine (see section 4.8). Lipid changes should be managed as clinically appropriate.

***QT prolongation:***
In clinical trials and use in accordance with the SPC, quetiapine was not associated with a persistent increase in absolute QT intervals. In post marketing, QT prolongation was reported with quetiapine at the therapeutic doses (see Section 4.8) and in overdose (see Section 4.9). As with other antipsychotics, caution should be exercised when quetiapine is prescribed in patients with cardiovascular disease or family history of QT prolongation. Also caution should be exercised when quetiapine is prescribed either with medicines known to increase QT interval, or with concomitant neuroleptics, especially in the elderly, in patients with congenital long QT syndrome, congestive heart failure, heart hypertrophy, hypokalaemia or hypomagnesaemia (see section 4.5).

***Cardiomyopathy and myocarditis***
Cardiomyopathy and myocarditis have been reported in clinical trials and during the post-marketing experience (see section 4.8). In patients with suspected cardiomyopathy or myocarditis discontinuation of quetiapine should be considered.
***Severe Cutaneous Adverse Reactions***
Severe cutaneous adverse reactions (SCARs), including Stevens-Johnson Syndrome (SJS), Toxic epidermal Necrolysis (TEN), Acute Generalized Exanthematous Pustulosis (AGEP), Erythema Multiforme (EM) and Drug Reaction with Eosinophilia

and Systemic Symptoms (DRESS) which can be life-threatening or fatal have been reported very rarely with quetiapine treatment.
SCARs commonly present with one or more of the following symptoms: extensive cutaneous rash which may be pruritic or associated with pustules, exfoliative dermatitis, fever, lymphadenopathy and possible eosinophilia or neutrophilia. Most of these reactions occurred within 4 weeks after initiation of quetiapine therapy, some DRESS reactions occurred within 6 weeks after initiation of quetiapine therapy. If signs and symptoms suggestive of these severe skin reactions appear, quetiapine should be withdrawn immediately and alternative treatment should be considered.

***Withdrawal:***
Acute withdrawal symptoms such as insomnia, nausea, headache, diarrhoea, vomiting, dizziness, and irritability have been described after abrupt cessation of quetiapine. Gradual withdrawal over a period of at least one to two weeks is advisable.(see section 4.8)

***Elderly patients with dementia-related psychosis:***
Quetiapine is not approved for the treatment of dementia-related psychosis.

An approximately 3-fold increased risk of cerebrovascular adverse events has been seen in randomized placebo controlled trials in the dementia population with some atypical antipsychotics. The mechanism for this increased risk is not known. An increased risk cannot be excluded for other antipsychotics or other patient populations. Quetiapine should be used with caution in patients with risk factors for stroke.

In a meta-analysis of atypical antipsychotics, it has been reported that elderly patients with dementia-related psychosis are at an increased risk of death compared to placebo. In two 10-week placebo controlled quetiapine studies in the same patient population (n=710; mean age: 83 years; range: 56-99 years) the incidence of mortality in quetiapine treated patients was 5.5% versus 3.2% in the placebo group. The patients in these trials died from a variety of causes that were consistent with expectations for this population.

***Elderly patients with Parkinson's disease (PD)/parkinsonism***
A population-based retrospective study of quetiapine for the treatment of patients with MDD, showed an increased risk of death during use of quetiapine in patients aged >65 years. This association was not present when patients with PD were removed from the analysis. Caution should be exercised if quetiapine is prescribed to elderly patients with PD.

***Dysphagia***
Dysphagia (See section 4.8) has been reported with quetiapine. Quetiapine should be used with caution in patients at risk for aspiration pneumonia.

***Constipation and intestinal obstruction***
Constipation represents a risk factor for intestinal obstruction. Constipation and intestinal obstruction have been reported with quetiapine (see section 4.8 Undesirable effects). This includes fatal reports in patients who are at higher risk of intestinal

obstruction, including those that are receiving multiple concomitant medications that decrease intestinal motility and/or may not report symptoms of constipation. Patients with intestinal obstruction/ileus should be managed with close monitoring and urgent care.

***Venous thromboembolism (VTE)***
Cases of venous thromboembolism (VTE) have been reported with antipsychotic drugs. Since patients treated with antipsychotics often present with acquired risk factors for VTE, all possible risk factors for VTE should be identified before and during treatment with quetiapine and preventive measures undertaken.

**Pancreatitis**
Pancreatitis has been reported in clinical trials and during post marketing experience. Among post marketing reports, while not all cases were confounded by risk factors, many patients had factors which are known to be associated with pancreatitis such as increased triglycerides (see section 4.4), gallstones, and alcohol consumption.

***Additional information***
Quetiapine data in combination with divalproex or lithium in acute moderate to severe manic episodes is limited; however, combination therapy was well tolerated (see section 4.8 and 5.1). The data showed an additive effect at week 3.

***Lactose:***
Psyquet XL prolonged-release tablets contain lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product.

***Misuse and abuse:***
Cases of misuse and abuse have been reported. Caution may be needed when prescribing quetiapine to patients with a history of alcohol or drug abuse.

## 4.5 Interaction with other medicinal products and other forms of interaction

Given the primary central nervous system effects of quetiapine, quetiapine should be used with caution in combination with other centrally acting medicinal products and alcohol.

Quetiapine should be used with caution in combination with serotonergic medicinal products, such as MAO inhibitors, selective serotonin re-uptake inhibitors (SSRIs), serotonin norepinephrine re-uptake inhibitors (SNRIs) or tricyclic antidepressants as the risk of serotonin syndrome, a potentially life-threatening condition, is increased (see section 4.4).

Caution should be exercised treating patients receiving other medications having anticholinergic (muscarinic) effects (see section 4.4).

Cytochrome P450 (CYP) 3A4 is the enzyme that is primarily responsible for the cytochrome P450 mediated metabolism of quetiapine. In an interaction study in

healthy volunteers, concomitant administration of quetiapine (dose of 25 mg) with ketoconazole, a CYP3A4 inhibitor, caused a 5-to 8-fold increase in the AUC of quetiapine. On the basis of this, concomitant use of quetiapine with CYP3A4 inhibitors is contraindicated. It is also not recommended to consume grapefruit juice while on quetiapine therapy.

In a multiple dose trial in patients to assess the pharmacokinetics of quetiapine given before and during treatment with carbamazepine (a known hepatic enzyme inducer), co-administration of carbamazepine significantly increased the clearance of quetiapine. This increase in clearance reduced systemic quetiapine exposure (as measured by AUC) to an average of 13% of the exposure during administration of quetiapine alone; although a greater effect was seen in some patients. As a consequence of this interaction, lower plasma concentrations can occur, which could affect the efficacy of quetiapine therapy. Co-administration of quetiapine and phenytoin (another microsomal enzyme inducer) caused a greatly increased clearance of quetiapine by approx. 450%. In patients receiving a hepatic enzyme inducer, initiation of quetiapine treatment should only occur if the physician considers that the benefits of quetiapine outweigh the risks of removing the hepatic enzyme inducer. It is important that any change in the inducer is gradual, and if required, replaced with a non-inducer (e.g. sodium valproate) (see section 4.4).

The pharmacokinetics of quetiapine were not significantly altered by co-administration of the antidepressants imipramine (a known CYP 2D6 inhibitor) or fluoxetine (a known CYP 3A4 and CYP 2D6 inhibitor).

The pharmacokinetics of quetiapine were not significantly altered by co-administration of the antipsychotics risperidone or haloperidol. Concomitant use of quetiapine and thioridazine caused an increased clearance of quetiapine with approx. 70%.

The pharmacokinetics of quetiapine were not altered following co-administration with cimetidine.

The pharmacokinetics of lithium were not altered when co-administered with quetiapine.

In a 6-week, randomised, study of lithium and quetiapine versus placebo and quetiapine in adult patients with acute mania, a higher incidence of extrapyramidal related events (in particular tremor), somnolence, and weight gain were observed in the lithium add-on group compared to the placebo add-on group (see section 5.1).

The pharmacokinetics of sodium valproate and quetiapine were not altered to a clinically relevant extent when co-administered. A retrospective study of children and adolescents who received valproate, quetiapine, or both, found a higher incidence of leucopenia and neutropenia in the combination group versus the monotherapy groups

Formal interaction studies with commonly used cardiovascular medicinal products have not been performed.

Caution should be exercised when quetiapine is used concomitantly with medicinal products known to cause electrolyte imbalance or to increase QT interval.

There have been reports of false positive results in enzyme immunoassays for methadone and tricyclic antidepressants in patients who have taken quetiapine. Confirmation of questionable immunoassay screening results by an appropriate chromatographic technique is recommended.

## 4.6 Fertility, pregnancy and lactation

## 4.7 Effects on ability to drive and use machines

Given its primary central nervous system effects, quetiapine may interfere with activities requiring mental alertness. Therefore, patients should be advised not to drive or operate machinery, until individual susceptibility to this is known.

## 4.8 Undesirable effects

The most commonly reported Adverse Drug Reactions (ADRs) with quetiapine (>10%) are somnolence, headache, dizziness, dry mouth, withdrawal (discontinuation) symptoms, elevations in serum triglyceride levels, elevations in total cholesterol (predominantly LDL cholesterol), decreases in HDL cholesterol, weight gain, decreased haemoglobin and extrapyramidal symptoms.

The incidences of ADRs associated with quetiapine therapy, are tabulated below (Table 1) according to the format recommended by the Council for International Organizations of Medical Sciences (CIOMS III Working Group 1995).

**Table 1 ADRs associated with quetiapine therapy**

The frequencies of adverse events are ranked according to the following: Very common (≥1/10), common (≥1/100, <1/10), uncommon (≥1/1000, <1/100, rare (≥1/10,000, <1/1000), very rare (<1/10,000) and not known (cannot be estimated from the available data).

| SOC | Very Common | Common | Uncommon: | Rare | Very Rare | Not known |
|---|---|---|---|---|---|---|
| *Blood and lymphatic system disorders* | Decreased haemoglobin[22] | Leucopenia [1, 28], decreased neutrophil count, eosinophils increased[27] | Neutropenia [1], Thrombocytopenia, Anaemia, platelet count decreased[13] | Agranulocytosis[26] | | |
| *Immune system disorders* | | | Hypersensitivity (including allergic skin | | Anaphylactic reaction[5] | |

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| | | | reactions) | | | |
| *Endocrine disorders* | | Hyperprolactinemia[15], decreases in total T4[24], decreases in free T4[24], decreases in total T3[24], increases in TSH [24] | Decreases in free T3[24], Hypothyroidism[21] | | Inappropriate antidiuretic hormone secretion | |
| *Metabolism and nutritional disorders* | Elevations in serum triglyceride levels [10,30] Elevations in total cholesterol (predominantly LDL cholesterol) [11,30] Decreases in HDL cholesterol [17,30], Weight gain [8,30] | Increased appetite, blood glucose increased to hyperglycaemic levels [6, 30] | Hyponatraemia [19], Diabetes Mellitus [1,5] ,Exacerbation of pre-existing diabetes | Metabolic syndrome[29] | | |
| *Psychiatric disorders* | | Abnormal dreams and nightmares, Suicidal ideation and suicidal behaviour[20] | | Somnambulism and related reactions such as sleep talking and sleep related eating disorder | | |
| *Nervous system disorders* | Dizziness [4, 16], somnolence [2, 16], headache, Extrapyramidal symptoms[1, 21] | Dysarthria | Seizure [1], Restless legs syndrome, Tardive dyskinesia [1, 5], Syncope [4, 16] Confusional state | | | |
| *Cardiac disorders* | | Tachycardia [4], Palpitations [23] | QT prolongation [1,12, 18], Bradycardia[32] | | | Cardiomyopathy, Myocarditis |
| *Eye Disorders* | | Vision blurred | | | | |
| *Vascular disorders* | | Orthostatic hypotension [4, 16] | | Venous thromboembolism[1] | | Stroke[33] |
| *Respiratory, thoracic and mediastinal disorder* | | *Dyspnoea [23]* | *Rhinitis* | | | |
| *Gastrointestinal disorders* | *Dry mouth* | Constipation, dyspepsia, vomiting[25] | Dysphagia[7] | Pancreatitis[1], Intestinal obstruction/Ileus | | |
| *Hepato-* | | Elevations in | Elevations in | Jaundice[5], | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *biliary disorders* | | serum alanine aminotransferase (ALT)[3] Elevations in gamma-GT levels[3] | serum aspartate aminotransferase (AST)[3] | Hepatitis | | |
| *Skin and subcutaneous tissue disorders* | | | | | Angioedema[5], Stevens-Johnson syndrome[5] | Toxic Epidermal Necrolysis, Erythema Multiforme, Acute Generalized Exanthematous Pustulosis (AGEP) Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) , cutaneous vasculitis |
| *Musculoskeletal and connective tissue disorders* | | | | | Rhabdomyolysis | |
| *Renal and urinary disorders* | | | Urinary retention | | | |
| *Pregnancy, puerperium and perinatal conditions* | | | | | | Drug withdrawal syndrome neonatal[31] |
| *Reproductive system and breast disorders* | | | Sexual dysfunction | Priapism, galactorrhoea, breast swelling, menstrual disorder | | |
| *General disorders and administration site conditions* | Withdrawal (discontinuation) symptoms [1, 9] | Mild asthenia, peripheral oedema, irritability, pyrexia | | Neuroleptic malignant syndrome [1], hypothermia | | |
| *Investigations* | | | | Elevations in blood creatine phosphokinase[14] | | |

(1) See Section 4.4.
(2) Somnolence may occur, usually during the first two weeks of treatment and generally resolves with the continued administration of quetiapine.
(3) Asymptomatic elevations (shift from normal to > 3x ULN at any time) in serum transaminase (ALT, AST) or gamma-GT-levels have been observed in some patients

administered quetiapine. These elevations were usually reversible on continued quetiapine treatment.
(4) As with other antipsychotics with alpha1 adrenergic blocking activity, quetiapine may commonly induce orthostatic hypotension, associated with dizziness, tachycardia and, in some patients, syncope, especially during the initial dose-titration period. (See section 4.4).
(5) Calculation of Frequency for these ADR's have only been taken from postmarketing data with the immediate release formulation of quetiapine.
(6) Fasting blood glucose ≥126 mg/dL(≥7.0 mmol/L) or a non fasting blood glucose ≥200 mg/dL (≥11.1 mmol/L) on at least one occasion.
(7) An increase in the rate of dysphagia with quetiapine vs. placebo was only observed in the clinical trials in bipolar depression.
(8) Based on >7% increase in body weight from baseline. Occurs predominantly during the early weeks of treatment in adults.
(9) The following withdrawal symptoms have been observed most frequently in acute placebo-controlled, monotherapy clinical trials, which evaluated discontinuation symptoms: insomnia, nausea, headache, diarrhoea, vomiting, dizziness, and irritability. The incidence of these reactions had decreased significantly after 1 week post-discontinuation.
(10) Triglycerides ≥200 mg/dL (≥2.258 mmol/L) (patients ≥18 years of age) or ≥150 mg/dL (≥1.694 mmol/L) (patients <18 years of age) on at least one occasion
(11) Cholesterol ≥240 mg/dL (≥6.2064 mmol/L) (patients ≥18 years of age) or ≥200 mg/dL (≥5.172 mmol/L) (patients <18 years of age) on at least one occasion. An increase in LDL cholesterol of ≥30 mg/dL (≥0.769 mmol/L) has been very commonly observed. Mean change among patients who had this increase was 41.7 mg/dL (≥1.07 mmol/L).
(12) See text below
(13) Platelets ≤100 x 109/L on at least one occasion
(14) Based on clinical trial adverse event reports of blood creatine phosphokinase increase not associated with neuroleptic malignant syndrome
(15) Prolactin levels (patients >18 years of age): >20 μg/L (>869.56 pmol/L) males; >30 μg/L
(>1304.34 pmol/L) females at any time.
(16) May lead to falls.
(17) HDL cholesterol: <40 mg/dL (1.025 mmol/L) males; <50 mg/dL (1.282 mmol/L) females at any time.
(18) Incidence of patients who have a QTc shift from <450 msec to ≥450 msec with a ≥30 msec increase. In placebo-controlled trials with quetiapine the mean change and the incidence of patients who have a shift to a clinically significant level is similar between quetiapine and placebo.
(19) Shift from >132 mmol/L to ≤132 mmol/L on at least one occasion.
(20) Cases of suicidal ideation and suicidal behaviours have been reported during quetiapine therapy or early after treatment discontinuation (see Sections 4.4 and 5.1).
(21) See Section 5.1
(22) Decreased haemoglobin to ≤13 g/dL (8.07 mmol/L) males, ≤12 g/dL (7.45 mmol/L) females on at least one occasion occurred in 11% of quetiapine patients in all trials including open label extensions. For these patients, the mean maximum decrease in hemoglobin at any time was -1.50 g/dL.
(23) These reports often occurred in the setting of tachycardia, dizziness, orthostatic hypotension, and/or underlying cardiac/respiratory disease.

(24) Based on shifts from normal baseline to potentially clinically important value at anytime post-baseline in all trials. Shifts in total T4, free T4, total T3 and free T3 are defined as <0.8 x LLN (pmol/L) and shift in TSH is > 5 mIU/L at any time.
(25) Based upon the increased rate of vomiting in elderly patients (≥65 years of age).
(26) Based on shift in neutrophils from >=1.5 x $10^9$/L at baseline to <0.5 x $10^9$/L at any time during treatment and based on patients with severe neutropenia (<0.5 x 109/L) and infection during all quetiapine clinical trials (See Section 4.4).
(27) Based on shifts from normal baseline to potentially clinically important value at anytime post-baseline in all trials. Shifts in eosinophils are defined as >1x $10^9$ cells/L at any time.
(28) Based on shifts from normal baseline to potentially clinically important value at anytime post-baseline in all trials. Shifts in WBCs are defined as ≤ 3x$10^9$ cells/L at any time.
(29) Based on adverse event reports of metabolic syndrome from all clinical trials with quetiapine.
(30) In some patients, a worsening of more than one of the metabolic factors of weight, blood glucose and lipids was observed in clinical studies (See Section 4.4).
(31) See Section 4.6.
(32) May occur at or near initiation of treatment and be associated with hypotension and/or syncope. Frequency based on adverse event reports of bradycardia and related events in all clinical trials with quetiapine.
(33) Based on one retrospective non-randomised epidemiological study.

Cases of QT prolongation, ventricular arrhythmia, sudden unexplained death, cardiac arrest and torsades de pointes have been reported with the use of neuroleptics and are considered class effects.

Severe cutaneous adverse reactions (SCARs), including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS) have been reported in association with quetiapine treatment.

**Paediatric population**
The same ADRs described above for adults should be considered for children and adolescents. The following table summarises ADRs that occur in a higher frequency category in children and adolescents patients (10-17 years of age) than in the adult population or ADRs that have not been identified in the adult population.

**Table 2 ADRs in children and adolescents associated with quetiapine therapy that occur in a higher frequency than adults, or not identified in the adult population**

The frequencies of adverse events are ranked according to the following: Very common (≥1/10), common (≥1/100, <1/10), uncommon (≥1/1000, <1/100), rare (≥1/10,000, <1/1000) and very rare (<1/10,000).

| SOC | Very Common | Common |
|---|---|---|
| Endocrine disorders | Elevations in prolactin[1] | |
| Metabolism and nutritional disorders | Increased appetite | |

| | | |
|---|---|---|
| Nervous system disorders | Extrapyramidal symptoms [3, 4] | Syncope |
| Vascular disorders | Increases in blood pressure[2] | |
| Respiratory, thoracic and mediastinal disorders | | Rhinitis |
| Gastrointestinal disorders | Vomiting | |
| General disorders and administration site conditions | | Irritability[3] |

1. Prolactin levels (patients < 18 years of age): >20 ug/L (>869.56 pmol/L) males; >26 ug/L (>1130.428 pmol/L) females at any time. Less than 1% of patients had an increase to a prolactin level >100 ug/L.
2. Based on shifts above clinically significant thresholds (adapted from the National Institutes of Health criteria) or increases >20 mmHg for systolic or >10 mmHg for diastolic blood pressure at any time in two acute (3-6 weeks) placebo-controlled trials in children and adolescents.
3. Note: The frequency is consistent to that observed in adults, but might be associated with different clinical implications in children and adolescents as compared to adults.
4. See section 5.1

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the Yellow Card Scheme (www.mhra.gov.uk/yellowcard) or search for MHRA Yellow Card in Google play or Apple App store.

## 4.9 Overdose

Symptoms
In general, reported signs and symptoms were those resulting from an exaggeration of the active substance's known pharmacological effects, ie, drowsiness and sedation, tachycardia, hypotension and anticholinergic effects.

Overdose could lead to QT-prolongation, seizures, status epilepticus, rhabdomyolysis, respiratory depression, urinary retention, confusion, delirium, and/or agitation, coma and death.

Patients with pre-existing severe cardiovascular disease may be at an increased risk of the effects of overdose. (See section 4.4: Orthostatic Hypotension).

**Management of overdose**

There is no specific antidote to quetiapine. In cases of severe signs, the possibility of multiple drug involvement should be considered, and intensive care procedures are recommended, including establishing and maintaining a patent airway, ensuring

adequate oxygenation and ventilation, and monitoring and support of the cardiovascular system.

Based on public literature, patients with delerium and agitation and a clear anticholinergic syndrome may be treated with physostigmine, 1-2 mg (under continuous ECG monitoring). This is not recommended as standard treatment, because of potential negative effect of physostigmine on cardiac conductance. Physostigmine may be used if there are no ECG aberrations. Do not use physostigmine in case of dysrhythmias, any degree of heart block or QRS-widening.

Whilst the prevention of absorption in overdose has not been investigated, gastric lavage can be indicated in severe poisonings and if possible to perform within one hour of ingestion. The administration of activated charcoal should be considered.

In cases of quetiapine overdose, refractory hypotension should be treated with appropriate measures such as intravenous fluids and/or sympathomimetic agents. Epinephrine and dopamine should be avoided, since beta stimulation may worsen hypotension in the setting of quetiapine-induced alpha blockade.

In case of overdose with prolonged-release quetiapine there is a delayed peak sedation and peak pulse and prolonged recovery compared with immediate-release quetiapine overdose.

In case of a quetiapine prolonged-release overdose gastric bezoar formation has been reported and appropriate diagnostic imaging is recommended to further guide patient management. Endoscopic pharmacobezoar removal has been performed successfully in some cases.

Close medical supervision and monitoring should be continued until the patient recovers.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antipsychotics; Diazepines, oxazepines and thiazepines.
ATC code: N05A H04

***Mechanism of action:***
Quetiapine is an atypical antipsychotic agent. Quetiapine and the active human plasma metabolite, norquetiapine interact with a broad range of neurotransmitter receptors. Quetiapine and norquetiapine exhibit affinity for brain serotonin (5HT2) and dopamine D1- and D2- receptors. It is this combination of receptor antagonism with a higher selectivity for 5HT2 relative to D2- receptors, which is believed to contribute to the clinical antipsychotic properties and low extrapyramidal undesirable effect (EPS) liability of quetiapine compared to typical antispychotics. Quetiapine and norquetiapine have no appreciable affinity at benzodiazepine receptors but high affinity at histaminergic and adrenergic $\alpha_1$- receptors and moderate affinity at

adrenergic $\alpha_2$ receptors . Quetiapine also has low or no affinity for muscarinic receptors, while norquetiapine has moderate to high affinity at several muscarinic receptors, which may explain anticholinergic (muscarinic) effects. Inhibition of NET and partial agonist action at 5HT1A sites by norquetiapine may contribute to quetiapine's therapeutic efficacy as an antidepressant.

***Pharmacodynamic effects:***
Quetiapine is active in tests for antipsychotic activity, such as conditioned avoidance. It also blocks the action of dopamine agonists, measured either behaviourally or electrophysiologically, and elevates dopamine metabolite concentrations, a neurochemical index of D2-receptor blockade.
In pre-clinical tests predictive of EPS, quetiapine is unlike typical antipsychotics and has an atypical profile. Quetiapine does not produce dopamine D2-receptor supersensitivity after chronic administration. Quetiapine produces only weak catalepsy at effective dopamine D2-receptor blocking doses. Quetiapine demonstrates selectivity for the limbic system by producing depolarisation blockade of the mesolimbic but not the nigrostriatal dopamine-containing neurones following chronic administration. Quetiapine exhibits minimal dystonic liability in haloperidol-sensitised or drug-naive Cebus monkeys after acute and chronic administration. (See Section 4.8)

***Clinical efficacy:***

**Schizophrenia**
The efficacy of quetiapine prolonged release in the treatment of schizophrenia was demonstrated in one 6-week placebo-controlled trial in patients who met DSM-IV criteria for schizophrenia, and one active-controlled quetiapine immediate release-to-quetiapine prolonged release switching study in clinically stable outpatients with schizophrenia.
The primary outcome variable in the placebo-controlled trial was change from baseline to final assessment in the PANSS total score. Quetiapine prolonged release 400 mg/day, 600 mg/day and 800 mg/day were associated with statistically significant improvements in psychotic symptoms compared to placebo. The effect size of the 600 mg and 800 mg doses was greater than that of the 400 mg dose. In the 6 week active-controlled switching study the primary outcome variable was the proportion of patients who showed lack of efficacy, ie, who discontinued study treatment due to lack of efficacy or whose PANSS total score increased 20% or more from randomization to any visit. In patients stabilised on quetiapine immediate release 400 mg to 800 mg, efficacy was maintained when patients were switched to an equivalent daily dose of quetiapine prolonged release given once daily.

In a long-term study in stable schizophrenic patients who had been maintained on quetiapine prolonged release for 16 weeks, quetiapine prolonged release was more effective than placebo in preventing relapse. The estimated risks of relapse after 6 months treatments was 14.3% for the quetiapine prolonged release treatment group compared to 68.2% for placebo. The average dose was 669 mg. There were no additional safety findings associated with treatment with quetiapine prolonged release for up to 9 months (median 7 months). In particular, reports of adverse events related

to EPS and weight gain did not increase with longer-term treatment with quetiapine prolonged release.

**Bipolar disorder**
In the treatment of moderate to severe manic episodes, quetiapine demonstrated superior efficacy to placebo in reduction of manic symptoms at 3 and 12 weeks, in two monotherapy trials. The efficacy of quetiapine prolonged release was further demonstrated with significance versus placebo in an additional 3 week study. Quetiapine prolonged release was dosed in the range of 400 to 800 mg/day and the mean dose was approximately 600 mg/day. Quetiapine data in combination with divalproex or lithium in acute moderate to severe manic episodes at 3 and 6 weeks is limited; however, combination therapy was well tolerated. The data showed an additive effect at week 3. A second study did not demonstrate an additive effect at week 6.

In a clinical trial, in patients with depressive episodes in bipolar I or bipolar II disorder, 300 mg/day quetiapine prolonged release showed superior efficacy to placebo in reduction of MADRS total score.

In 4 additional clinical trials with quetiapine, with a duration of 8 weeks in patients with moderate to severe depressive episodes in bipolar I or bipolar II disorder, quetiapine immediate release 300 mg and 600 mg was significantly superior to placebo treated patients for the relevant outcome measures: mean improvement on the MADRS and for response defined as at least a 50% improvement in MADRS total score from baseline. There was no difference in magnitude of effect between the patients who received 300 mg quetiapine immediate release and those who received 600 mg dose.

In the continuation phase in two of these studies, it was demonstrated that long-term treatment, of patients who responded on quetiapine immediate release 300 or 600 mg, was efficacious compared to placebo treatment with respect to depressive symptoms, but not with regard to manic symptoms.

In two recurrence prevention studies evaluating quetiapine in combination with mood stabilizers, in patients with manic, depressed or mixed mood episodes, the combination with quetiapine was superior to mood stabilizers monotherapy in increasing the time to recurrence of any mood event (manic, mixed or depressed). Quetiapine was administered twice-daily totalling 400 mg to 800 mg a day as combination therapy to lithium or valproate.

In a 6-week, randomised, study of lithium and quetiapine prolonged release versus placebo and quetiapine prolonged release in adult patients with acute mania, the difference in YMRS mean improvement between the lithium add-on group and the placebo add-on group was 2.8 points and the difference in % responders (defined as 50% improvement from baseline on the YMRS) was 11% (79% in the lithium add-on group vs. 68% in the placebo add-on group).

In one long-term study (up to 2 years treatment) evaluating recurrence prevention in patients with manic, depressed or mixed mood episodes quetiapine was superior to

placebo in increasing the time to recurrence of any mood event (manic, mixed or depressed), in patients with bipolar I disorder. The number of patients with a mood event was 91 (22.5%) in the quetiapine group, 208 (51.5%) in the placebo group and 95 (26.1%) in the lithium treatment groups respectively. In patients who responded to quetiapine, when comparing continued treatment with quetiapine to switching to lithium, the results indicated that a switch to lithium treatment does not appear to be associated with an increased time to recurrence of a mood event.

**Major depressive episodes in MDD**
Two short-term (6 week) studies enrolled patients who had shown an inadequate response to at least one antidepressant. Quetiapine prolonged release 150 mg and 300 mg/day, given as add-on treatment to ongoing antidepressant therapy (amitriptyline, bupropion, citalopram, duloxetine, escitalopram, fluoxetine, paroxetine, sertraline or venlafaxine) demonstrated superiority over antidepressant therapy alone in reducing depressive symptoms as measured by improvement in MADRS total score (LS mean change vs. placebo of 2-3.3 points).

Long-term efficacy and safety in patients with MDD has not been evaluated as add-on therapy, however long-term efficacy and safety has been evaluated in adult patients as monotherapy (see below).

The following studies were conducted with quetiapine prolonged release as monotherapy treatment, however quetiapine prolonged release is only indicated for use as add-on therapy:

In three out of four short term (up to 8 weeks) monotherapy studies, in patients with major depressive disorder, quetiapine prolonged release 50 mg, 150 mg and 300 mg/day demonstrated superior efficacy to placebo in reducing depressive symptoms as measured by improvement in the Montgomery-Åsberg Depression Rating Scale (MADRS) total score (LS mean change vs. placebo of 2-4 points).

In a monotherapy relapse prevention study, patients with depressive episodes stabilised on open-label quetiapine prolonged release treatment for at least 12 weeks were randomised to either quetiapine prolonged release once daily or placebo for up to 52 weeks. The mean dose of quetiapine prolonged release during the randomised phase was 177 mg/day. The incidence of relapse was 14.2% for quetiapine prolonged release treated patients and 34.4% for placebo-treated patients.

In a short-term (9 week) study non-demented elderly patients (aged 66 to 89 years) with major depressive disorder, quetiapine prolonged release dosed flexibly in the range of 50 mg to 300 mg/day demonstrated superior efficacy to placebo in reducing depressive symptoms as measured by improvement in MADRS total score (LS mean change vs placebo -7.54). In this study patients randomised to quetiapine prolonged release received 50 mg/day on Days 1- 3, the dose could be increased to 100 mg/day on Day 4, 150 mg/day on Day 8 and up to 300 mg/day depending on clinical response and tolerability. The mean dose of quetiapine prolonged release was 160 mg/day. Other than the incidence of extrapyramidal symptoms (see section 4.8 and ‘Clinical Safety’ below) the tolerability of quetiapine prolonged release once daily in elderly patients was comparable to that seen in adults (aged 18-65 years). The proportion of randomized patients over 75 years of age was 19%.

***Clinical safety***
In short-term, placebo-controlled clinical trials in schizophrenia and bipolar mania the aggregated incidence of extrapyramidal symptoms was similar to placebo (schizophrenia: 7.8% for quetiapine and 8.0% for placebo; bipolar mania: 11.2% for quetiapine and 11.4% for placebo). Higher rates of extrapyramidal symptoms were seen in quetiapine treated patients compared to those treated with placebo in short-term, placebo-controlled clinical trials in MDD and bipolar depression. In short-term, placebo-controlled bipolar depression trials the aggregated incidence of extrapyramidal symptoms was 8.9% for quetiapine compared to 3.8% for placebo. In short-term, placebo-controlled monotherapy clinical trials in major depressive disorder the aggregated incidence of extrapyramidal symptoms was 5.4% for quetiapine prolonged release and 3.2% for placebo. In a short-term placebo-controlled monotherapy trial in elderly patients with major depressive disorder, the aggregated incidence of extrapyramidal symptoms was 9.0% for quetiapine prolonged release and 2.3% for placebo. In both bipolar depression and MDD, the incidence of the individual adverse events (eg, akathisia, extrapyramidal disorder, tremor, dyskinesia, dystonia, restlessness, muscle contractions involuntary, psychomotor hyperactivity and muscle rigidity) did not exceed 4% in any treatment group.

In short term, fixed dose (50mg/d to 800 mg/d), placebo-controlled studies (ranging from 3 to 8 weeks), the mean weight gain for quetiapine-treated patients ranged from 0.8 kg for the 50 mg daily dose to 1.4 kg for the 600 mg daily dose (with lower gain for the 800 mg daily dose), compared to 0.2 kg for the placebo treated patients. The percentage of quetiapine treated patients who gained ≥7% of body weight ranged from 5.3% for the 50 mg daily dose to 15.5% for the 400 mg daily dose (with lower gain for the 600 and 800 mg daily doses), compared to 3.7% for placebo treated patients.

A 6-week, randomised, study of lithium and quetiapine prolonged release versus placebo and quetiapine prolonged release in adult patients with acute mania indicated that the combination of quetiapine prolonged release with lithium leads to more adverse events (63% versus 48% in quetiapine prolonged release in combination with placebo). The safety results showed a higher incidence of extrapyramidal symptoms reported in 16.8% of patients in the lithium add-on group and 6.6% in the placebo add-on group, the majority of which consisted of tremor, reported in 15.6% of the patients in the lithium add-on group and 4.9% in the placebo add-on group. The incidence of somnolence was higher in the quetiapine prolonged release with lithium add-on group (12.7%) compared to the quetiapine prolonged release with the placebo add-on group (5.5%). In addition, a higher percentage of patients treated in the lithium add-on group (8.0%) had weight gain (≥7%) at the end of treatment compared to patients in the placebo add-on group (4.7%).

Longer term relapse prevention trials had an open label period (ranging from 4 to 36 weeks) during which patients were treated with quetiapine, followed by a randomized withdrawal period during which patients were randomized to quetiapine or placebo. For patients who were randomized to quetiapine, the mean weight gain during the open label period was 2.56 kg, and by week 48 of the randomized period, the mean weight gain was 3.22 kg, compared to open label baseline. For patients who were randomized to placebo, the mean weight gain during the open label period was 2.39

kg, and by week 48 of the randomized period the mean weight gain was 0.89 kg, compared to open label baseline.

In placebo-controlled studies in elderly patients with dementia-related psychosis, the incidence of cerebrovascular adverse events per 100 patient years was not higher in quetiapine-treated patients than in placebo-treated patients.

In all short-term placebo-controlled monotherapy trials in patients with a baseline neutrophil count $\geq 1.5 \times 10^9$/L, the incidence of at least one occurrence of a shift to neutrophil count $< 1.5 \times 10^9$/L, was 1.9% in patients treated with quetiapine compared to 1. 5% in placebo-treated patients. The incidence of shifts to $> 0.5$-$< 1.0 \times 10^9$/L was the same (0.2%) in patients treated with quetiapine as with placebo-treated patients. In all clinical trials (placebo-controlled, open-label, active comparator) in patients with a baseline neutrophil count $\geq 1.5 \times 10^9$/L, the incidence of at least one occurrence of a shift to neutrophil count $< 1.5 \times 10^9$/L was
2.9% and to $< 0.5 \times 10^9$/L was 0.21% in patients treated with quetiapine.

Quetiapine treatment was associated with dose-related decreases in thyroid hormone levels. The incidences of shifts in TSH was 3.2 % for quetiapine versus 2.7 % for placebo. The incidence of reciprocal, potentially clinically significant shifts of both T3 or T4 and TSH in these trials were rare, and the observed changes in thyroid hormone levels were not associated with clinically symptomatic hypothyroidism. The reduction in total and free T4 was maximal within the first six weeks of quetiapine treatment, with no further reduction during long-term treatment. For about 2/3 of all cases, cessation of quetiapine treatment was associated with a reversal of the effects on total and free T4, irrespective of the duration of treatment.

Cataracts/lens opacities
In a clinical trial to evaluate the cataractogenic potential of quetiapine (200-800 mg/ day) versus risperidone (2-8 mg/day) in patients with schizophrenia or schizoaffective disorder, the percentage of patients with increased lens opacity grade was not higher in quetiapine (4%) compared with risperidone (10%), for patients with at least 21 months of exposure.

**Paediatric population**

Clinical efficacy

The efficacy and safety of quetiapine was studied in a 3-week placebo controlled study for the treatment of mania (n= 284 patients from the US, aged 10-17). About 45% of the patient population had an additional diagnosis of ADHD. In addition, a 6-week placebo controlled study for the treatment of schizophrenia (n=222 patients, aged 13-17) was performed. In both studies, patients with known lack of response to quetiapine were excluded. Treatment with quetiapine was initiated at 50 mg/day and on day 2 increased to 100 mg/day; subsequently the dose was titrated to a target dose (mania 400-600 mg/day; schizophrenia 400-800 mg/day) using increments of 100 mg/day given two or three times daily.

In the mania study, the difference in LS mean change from baseline in YMRS total score (active minus placebo) was –5.21 for quetiapine 400 mg/day and –6.56 for

quetiapine 600 mg/day. Responder rates (YMRS improvement ≥50%) were 64% for quetiapine 400 mg/day, 58% for 600 mg/day and 37% in the placebo arm.

In the schizophrenia study, the difference in LS mean change from baseline in PANSS total score (active minus placebo) was –8.16 for quetiapine 400 mg/day and –9.29 for quetiapine 800 mg/day. Neither low dose (400 mg/day) nor high dose regimen (800 mg/day) quetiapine was superior to placebo with respect to the percentage of patients achieving response, defined as ≥30% reduction from baseline in PANSS total score. Both in mania and schizophrenia higher doses resulted in numerically lower response rates.

In a third short-term placebo-controlled monotherapy trial with quetiapine prolonged release in children and adolescent patients (10-17 years of age) with bipolar depression, efficacy was not demonstrated.

No data are available on maintenance of effect or recurrence prevention in this age group.

Clinical safety

In the short-term pediatric trials with quetiapine described above, the rates of EPS in the active arm vs. placebo were 12.9% vs. 5.3% in the schizophrenia trial, 3.6% vs. 1.1% in the bipolar mania trial, and 1.1% vs. 0% in the bipolar depression trial. The rates of weight gain ≥ 7% of baseline body weight in the active arm vs. placebo were 17% vs. 2.5% in the schizophrenia and bipolar mania trials, and 13.7% vs. 6.8% in the bipolar depression trial. The rates of suicide related events in the active arm vs. placebo were 1.4% vs. 1.3% in the schizophrenia trial, 1.0% vs. 0% in the bipolar mania trial, and 1.1% vs. 0% in the bipolar depression trial. During an extended post-treatment follow-up phase of the bipolar depression trial, there were two additional suicide related events in two patients; one of these patients was on quetiapine at the time of the event.

Long-term safety
A 26-week open-label extension to the acute trials (n=380 patients), with quetiapine flexibly dosed at 400-800 mg/day, provided additional safety data. Increases in blood pressure were reported in children and adolescents and increased appetite, extrapyramidal symptoms and elevations in serum prolactin were reported with higher frequency in children and adolescents than in adult patients (see sections 4.4 and 4.8). With respect to weight gain, when adjusting for normal growth over the longer term, an increase of at least 0.5 standard deviation from baseline in Body Mass Index (BMI) was used as a measure of a clinically significant change; 18.3% of patients who were treated with quetiapine for at least 26 weeks met this criterion.

## 5.2 Pharmacokinetic properties

Absorption:
Quetiapine is well absorbed following oral administration. Quetiapine prolonged release achieves peak quetiapine and norquetiapine plasma concentrations at

approximately 6 hours after administration (Tmax). Steady-state peak molar concentrations of the active metabolite norquetiapine are 35% of that observed for quetiapine.

The pharmacokinetics of quetiapine and norquetiapine are linear and dose-proportional for doses up to 800 mg administered once daily. When quetiapine prolonged release administered once daily is compared to the same total daily dose of immediate-release quetiapine fumarate administered twice daily, the area under the plasma concentration-time curve (AUC) is equivalent, but the maximum plasma concentration (Cmax) is 13% lower at steady state. When quetiapine prolonged release is compared to quetiapine immediate release, the norquetiapine metabolite AUC is 18% lower.
In a study examining the effects of food on the bioavailability of quetiapine, a high-fat meal was found to produce statistically significant increases in the quetiapine prolonged release Cmax and AUC of approximately 50% and 20% respectively., It cannot be excluded that the effect of a high fat meal on the formulation may be larger. In comparison, a light meal had no significant effect on the Cmax or AUC of quetiapine. It is recommended that quetiapine prolonged release is taken once daily without food.

Distribution:
Quetiapine is approximately 83% bound to plasma proteins.

Biotransformation:
Quetiapine is extensively metabolised by the liver, with parent compound accounting for less than 5% of unchanged drug-related material in the urine or faeces, following the administration of radiolabelled quetiapine.
*In vitro* investigations established that CYP3A4 is the primary enzyme responsible for cytochrome P450 mediated metabolism of quetiapine. Norquetiapine is primarily formed and eliminated via CYP3A4.

Quetiapine and several of its metabolites (including norquetiapine) were found to be weak inhibitors of human cytochrome P450 1A2, 2C9, 2C19, 2D6 and 3A4 activities in vitro. In vitro CYP inhibition is observed only at concentrations approximately 5 to 50 fold higher than those observed at a dose range of 300 to 800 mg/day in humans. Based on these in vitro results, it is unlikely that co-administration of quetiapine with other drugs will result in clinically significant drug inhibition of cytochrome P450 mediated metabolism of the other drug. From animal studies it appears that quetiapine can induce cytochrome P450 enzymes. In a specific interaction study in psychotic patients, however, no increase in the cytochrome P450 activity was found after administration of quetiapine.

Elimination:
The elimination half lives of quetiapine and norquetiapine are approximately 7 and 12 hours, respectively. Approximately 73% of a radiolabelled drug was excreted in the urine and 21% in the faeces with less than 5% of the total radioactivity representing unchanged drug-related material. The average molar dose fraction of free quetiapine and the active human plasma metabolite norquetiapine is <5% excreted in the urine.

*Special populations*

Gender:
The pharmacokinetics of quetiapine does not differ between men and women.

Elderly:
The mean clearance of quetiapine in the elderly is approximately 30 to 50% lower than that seen in adults aged 18 to 65 years.

Renal impairment:
The mean plasma clearance of quetiapine was reduced by approximately 25% in subjects with severe renal impairment (creatinine clearance less than 30 ml/min/1.73 m2), but the individual clearance values are within the range for normal subjects.

Hepatic impairment:
The mean quetiapine plasma clearance decreases with approximately 25% in persons with known hepatic impairment (stable alcoholcirrhosis). As quetiapine is extensively metabolised by the liver, elevated plasma levels are expected in the population with hepatic impairment. Dose adjustments may be necessary in these patients (see section 4.2).

**Paediatric population**
Pharmacokinetic data were sampled in 9 children aged 10-12 years old and 12 adolescents, who were on steady-state treatment with 400 mg quetiapine twice daily. At steady-state, the dose-normalized plasma levels of the parent compound, quetiapine, in children and adolescents (10-17 years of age) were in general similar to adults, though Cmax in children was at the higher end of the range observed in adults. The AUC and Cmax for the active metabolite, norquetiapine, were higher, approximately 62% and 49% in children (10-12 years), respectively and 28% and 14% in adolescents (13-17 years), respectively, compared to adults.

No information is available for quetiapine prolonged release in children and adolescents.

## 5.3 Preclinical safety data

There was no evidence of genotoxicity in a series of *in vitro* and *in vivo* genotoxicity studies. In laboratory animals at a clinically relevant exposure level the following deviations were seen, which as yet have not been confirmed in long-term clinical research:
In rats, pigment deposition in the thyroid gland has been observed; in cynomolgus monkeys thyroid follicular cell hypertrophy, a lowering in plasma T3 levels, decreased haemoglobin concentration and a decrease of red and white blood cell count have been observed; and in dogs lens opacity and cataracts. (For cataracts/lens opacities see section 5.1).

In an embryofoetal toxicity study in rabbits the foetal incidence of carpal/tarsal flexure was increased. This effect occurred in the presence of overt maternal effects such as reduced body weight gain. These effects were apparent at maternal exposure levels similar or slightly above those in humans at the

maximal therapeutic dose. The relevance of this finding for humans is unknown.

In a fertility study in rats, marginal reduction in male fertility and pseudopregnancy, protracted periods of diestrus, increased precoital interval and reduced pregnancy rate were seen. These effects are related to elevated prolactin levels and not directly relevant to humans because of species differences in hormonal control of reproduction.

# 6 PHARMACEUTICAL PARTICULARS

## 6.1 List of excipients

**Core**
Methacrylic acid – ethyl acrylate copolymer (1:1), type A
Lactose anhydrous
Magnesium stearate
Crystalline Maltose
Talc

**Coating**
Methacrylic acid – ethyl acrylate copolymer (1:1), type A
Triethyl Citrate

## 6.2 Incompatibilities

Not applicable.

## 6.3 Shelf life

3 years

HDPE bottle
The shelf life is not affected after opening the bottle.

## 6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

### 6.5 Nature and contents of container

The prolonged-release tablets are packed in white opaque PVC/PCTFE-aluminium foil blisters or in a white opaque HDPE bottle with child resistant polypropylene screw cap and induction seal liner and inserted in a carton.

The pack sizes for the blisters are: 10, 30, 50, 56, 60 and 100 tablets.

The pack sizes for the bottles are: 60 and 120 tablets.
The pack size of 120 tablets is limited for hospital use and dose dispensing.

Not all pack sizes may be marketed.

### 6.6 Special precautions for disposal

No special requirements.

## 7 MARKETING AUTHORISATION HOLDER

Sandoz Limited
Park View, Riverside Way
Watchmoor Park
Camberley, Surrey
GU15 3YL
United Kingdom

## 8 MARKETING AUTHORISATION NUMBER(S)

PL 04416/1473

## 9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

09/12/2014

## 10 DATE OF REVISION OF THE TEXT

22/08/2024