

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Melatonin 4 mg film-coated tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 4 mg melatonin.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.

White/off-white to beige, biconvex, round tablet with a score line and marked “4” on one side, of size 8 mm.

The tablet can be divided into equal doses.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Melatonin tablets are indicated for:

- Short term treatment of jet lag in adults (see section 5.1).
- Insomnia in children and adolescents aged 6–17 years with ADHD where sleep hygiene measures have been insufficient.

4.2 Posology and method of administration

Posology

Adults with jet lag

The recommended dose is 1–5 mg for a maximum of 5 days. The maximum daily dose is 5 mg once daily.

The dose should be taken at the time of destination bedtime for journeys of 5 time zones or longer, especially when traveling in an easterly direction.

Due to the potential for incorrectly timed intake of melatonin to have no effect, or an adverse effect, on re-synchronisation following jet lag, melatonin should not be taken before 20:00 hr or after 04:00 hr at destination.

As alcohol can impair sleep and potentially worsen certain symptoms of jet lag (e.g. headache, morning fatigue, concentration) it is recommended that alcohol is not consumed when taking melatonin.

A maximum of 16 treatment cycles may occur per year.

Insomnia in children and adolescents with ADHD

Treatment should be initiated by physicians experienced in ADHD and/or paediatric sleep medicine.

Recommended starting dose of melatonin: 1–2 mg 30–60 minutes before bedtime.

The dose of melatonin can be increased by 1 mg every week until effect up to a maximum 5 mg per day, independent of age. The lowest effective dose should be sought.

Limited data are available for up to 3 years of treatment. After at least 3 months of treatment, the physician should evaluate the treatment effect and consider stopping treatment if no clinically relevant treatment effect is seen. The patient should be monitored at regular intervals (at least every 6 months) to check that melatonin is still the most appropriate treatment. During ongoing treatment, especially if the treatment effect is uncertain, discontinuation attempts should be done regularly, e.g. once per year.

If the sleep disorder has started during treatment with medicinal products for ADHD, dose adjustment or switching to another product should be considered.

Other formulations and strengths suitable for paediatric patients may also be available on the market.

Special populations

Elderly

As the pharmacokinetics of melatonin (immediate release) is comparable in young adults and elderly persons in general, no specific dosage recommendations for elderly persons are provided (see section 5.2).

Renal impairment

The effect of any stage of renal impairment on melatonin pharmacokinetics has not been studied. Caution should be used when melatonin is administered to patients with renal impairment.

Hepatic impairment

Limited data indicate that plasma clearance of melatonin is significantly reduced in patients with liver cirrhosis. Melatonin is not recommended in patients with moderate or severe hepatic impairment (see section 5.2).

Children below 6 years of age

Melatonin is not recommended for children below 6 years with ADHD.

Method of administration

Oral use.

The tablet can be crushed and mixed with water directly before the administration.

Food can enhance the increase in plasma melatonin concentration (see section 5.2). Intake of melatonin with carbohydrate-rich meals may impair blood glucose control for several hours (see section 4.4). It is recommended that food is not consumed 2 h before and 2 h after intake of melatonin.

4.3 Contraindications

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

4.4 Special warnings and precautions for use

Melatonin may cause drowsiness. Melatonin should be used with caution if the effects of drowsiness are likely to be associated with a risk to patient safety.

Elderly

Exposure levels to melatonin after oral administration in young and moderately older adults are comparable. It is unclear if significantly older persons are especially sensitive to exogenous melatonin. Caution should therefore be exercised in treatment of this age group and individual dosage is recommended.

Immunological diseases

Occasional case reports have described exacerbation of an autoimmune disease in patients taking melatonin. There are no data regarding use of melatonin tablets in patients with autoimmune diseases. Melatonin is not recommended in patients with autoimmune diseases.

Epilepsy

Melatonin has been reported to increase, decrease and have no effect on seizure frequency. Because of the uncertainty of the effect of melatonin on epileptic seizures, some caution should be exercised for use in people with epilepsy.

Diabetes

Limited data suggest that melatonin taken in close proximity to ingestion of carbohydrate-rich meals may impair blood glucose control for several hours. Melatonin tablets should be taken at least 2 hours before and at least 2 hours after a meal; ideally at least 3 hours after meal by persons with significantly impaired glucose tolerance or diabetes.

4.5 Interaction with other medicinal products and other forms of interaction

Pharmacokinetic interactions

Melatonin is mainly metabolised by CYP1A enzymes. Interactions between melatonin and other active substances that affect CYP1A enzymes are therefore possible.

CYP1A2 inhibitors

CYP1A2 inhibitors may increase the plasma concentrations of melatonin considerably. Concomitant treatment with melatonin and the CYP1A2 inhibitor fluvoxamine (also a CYP2C19 inhibitor) should be avoided. Caution should be exercised when melatonin is used concomitantly with the following CYP1A2 inhibitors: ciprofloxacin, norfloxacin and verapamil.

Combined hormonal contraception: Contraceptives containing ethinylestradiol and gestagen can inhibit CYP1A2 and lead to a 4-5 times increase of the melatonin concentration. The dose of melatonin may need to be reduced.

Hormonal substitution therapy: In post-menopausal women, hormonal substitution therapy has been reported to delay melatonin T_{max} without other effects on the melatonin concentration or melatonin rhythm.

Through interaction with moderately pronounced inhibitors of CYP1A2, increase of the plasma concentration of melatonin is expected. Caution is therefore indicated in patients taking 5- or 8-methoxypsoralen (5 or 8-MOP), cimetidine or caffeine.

Caution is indicated in patients taking cimetidine, since this agent increases plasma melatonin levels by inhibiting its metabolism by CYP1A.

CYP1A2 inducers

CYP1A2 inducers may decrease the plasma concentrations of melatonin.

Dose adjustment of melatonin may be needed if given concomitantly with the following CYP1A2 inducers: carbamazepine, phenytoin, rifampicin, omeprazole and cigarette smoking (halved exposure compared to after 7 days of smoking abstinence).

Pharmacodynamic interactions

Adrenergic agonists/antagonists, opiate agonists/antagonists, antidepressants, prostaglandin inhibitors, tryptophan and alcohol affect the endogenous secretion of melatonin in the epiphysis, but do not affect the metabolism of melatonin. It is not known if these interactions are of clinical significance.

Alcohol

Alcohol should not be used concomitantly with melatonin since it may reduce the effect of melatonin on sleep.

Nifedipine

Melatonin may reduce the hypotensive effect of nifedipine. Caution must be taken during concomitant use of melatonin and adjustment of the nifedipine dose may be needed. As it is not known if this is a class effect, caution should be exercised when combining melatonin and other calcium antagonists.

Warfarin

It has been reported in case reports that concomitant use of melatonin and vitamin K antagonists such as warfarin can lead to either increased or decreased prothrombin levels, and a study has shown decreased levels of factor VIII:C and fibrinogen. The combination of warfarin and other vitamin K antagonists with melatonin may require dose adjustment of the anticoagulant drugs and should be avoided.

Benzodiazepine-related hypnotics

Melatonin may enhance the sedative properties of benzodiazepine-related hypnotics, e.g. zolpidem. Concomitant treatment with melatonin should be avoided.

NSAIDs

Prostaglandin synthesis inhibitors (NSAIDs) such as acetylsalicylic acid and ibuprofen, taken in the evening, may suppress endogenous melatonin levels. If possible, administration of NSAIDs should be avoided in the evening.

Beta-blockers

Beta-blockers may suppress the endogenous melatonin and should therefore be administered in the morning.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are no data from the use of melatonin in pregnant women. Animal studies are incomplete regarding effects on pregnancy, embryonic / fetal development, childbirth and postnatal development (see section 5.3). Exogenous melatonin readily crosses the human placenta. Considering the lack of clinical data, treatment with melatonin is not recommended during pregnancy or in women of childbearing potential not using contraceptives.

Breastfeeding

Data from animal studies indicate maternal transfer of melatonin to the foetus via the placenta or in the milk. Endogenous melatonin has also been measured in breast milk from breast-feeding women, and therefore exogenous melatonin is most likely also excreted in human milk. Melatonin is therefore not recommended to breastfeeding women.

Fertility

No adequate data on the effect of melatonin on human fertility are available. Animal studies are incomplete in terms of effects on fertility. High doses of melatonin and use for longer periods than indicated may compromise fertility in humans.

4.7 Effects on ability to drive and use machines

Melatonin has moderate effect on the ability to drive and use machines. Melatonin may cause drowsiness and should therefore be used with caution if the effects of drowsiness are likely to be associated with a safety risk.

4.8 Undesirable effects

Summary of the safety profile

Melatonin causes few, and no serious, adverse reactions in the short term, up to three months. Long-term effects are poorly studied. Reported adverse reactions to melatonin are mainly headache, nausea and fatigue in both adults and children. These adverse reactions are however also common for placebo-treated patients in presented clinical studies and there is no significant difference between patients who received active treatments and placebo in these studies.

No common or very common adverse reactions have been reported.

Adverse reactions in adults are listed according to MedDRA system organ class and presented within each frequency category according to the following: Very common ($\geq 1/10$); Common ($\geq 1/100$ to $< 1/10$); Uncommon ($\geq 1/1,000$ to $< 1/100$); Rare

(≥1/10,000 to <1/1,000); Very rare (<1/10,000); Not known (cannot be estimated from the available data).

| System organ class | Common | Uncommon | Rare | Not known |
|--------------------------------------|----------------------|---|---|---------------------------|
| Infections and infestations | | | Herpes zoster | |
| Blood and lymphatic system disorders | | | Leukopenia, thrombocytopenia | |
| Immune system disorders | | | | Hypersensitivity reaction |
| Metabolism and nutrition disorders | | | Hypertriglyceridemia, hypocalcaemia, hyponatraemia | Hyperglycaemia |
| Psychiatric disorders | | Irritability, nervousness, restlessness, insomnia, abnormal dreams, nightmares, anxiety | Mood altered, aggression, agitation, crying, stress symptoms, disorientation, early morning awakening, libido increased, depressed mood, depression | |
| Nervous system disorders | Headache, somnolence | Migraine, lethargy, psychomotor hyperactivity, dizziness | Syncope, memory impairment, disturbance in attention, dreamy state, restless legs syndrome, poor quality sleep, paraesthesia | |
| Eye disorders | | | Visual acuity reduced, vision blurred, lacrimation increased | |
| Ear and labyrinth disorders | | | Vertigo positional, vertigo | |
| Cardiac disorders | | | Angina pectoris, palpitations | |
| Vascular disorders | | Hypertension | Hot flush | |
| Gastrointestinal disorders | | Abdominal pain, abdominal pain upper, dyspepsia, | Gastro-oesophageal reflux disease, gastrointestinal disorder, oral mucosal blistering, tongue | |

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|--|--|--|--|--|
| | | mouth ulceration, dry mouth, nausea | ulceration, gastrointestinal upset, vomiting, bowel sounds abnormal, flatulence, salivary hypersecretion, halitosis, abdominal discomfort, gastric disorder, gastritis | |
| Hepatobiliary disorders | | Hyperbilirubinemia | | |
| Skin and subcutaneous tissue disorders | | Dermatitis, night sweats, pruritus, rash, pruritus generalised, dry skin | Eczema, erythema, hand dermatitis, psoriasis, rash generalised, rash pruritic, nail disorder | Angioedema, oedema of mouth, tongue oedema |
| Musculoskeletal and connective tissue disorders | | Pain in extremity | Arthritis, muscle spasms, neck pain, night cramps | |
| Renal and urinary disorders | | Glycosuria, proteinuria | Polyuria, haematuria, nocturia | |
| Reproductive system and breast disorders | | Menopausal symptoms | Priapism, prostatitis | Galactorrhoea |
| General disorders and administration site conditions | | Asthenia, chest pain | Fatigue, pain, thirst | |
| Investigations | | Liver function test abnormal, weight increased | Hepatic enzyme increased, blood electrolytes abnormal, laboratory test abnormal | |

Paediatric population

A low frequency of in general mild adverse reactions have been reported in the paediatric population. The number of adverse reactions has not differed significantly between children who have received placebo compared to melatonin. The most common adverse reactions were headache, hyperactivity, dizziness and abdominal pain. No serious adverse reactions have been observed.

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 at: www.mhra.gov.uk/yellowcard or search for MHRA

Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Drowsiness, headache, dizziness, and nausea are the most commonly reported signs and symptoms of overdose with oral melatonin.

Daily doses of 20-50 mg as well as 300 mg in up to 2 years have been reported in the literature, without any clinically significant adverse reactions.

One dose of 250 mg taken 4 times daily during 25-30 days have only been reported to cause drowsiness/sleepiness. Also, in several cases of reported overdosing, mildly to moderately severe somnolence was the most commonly reported adverse reaction.

After doses of 3.0-6.6 grams for 15-36 days, 6 of 11 patients reported somnolence during daytime and 4 of 11 patients reported stomach cramps, diarrhoea or migraine headaches.

Clearance of the active substance is expected within 12 hours of ingestion. A physician should assess if conventional overdose measures should be taken.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Hypnotics and sedatives, melatonin receptor agonists, ATC code: N05CH01.

Melatonin is a hormone produced by the pineal gland. It is structurally related to serotonin. Melatonin secretion increases shortly after dark, reaching its peak between 2 am and 4 am and decreases during the latter half of the night. Melatonin is involved in controlling the circadian rhythm and adaptation to the light-dark cycle. Melatonin is also associated with a sedative effect and an increased propensity for sleep.

Mechanism of action

Melatonin activity on MT1 and MT2 receptors is considered to contribute to its effect on sleep, as these receptors are involved in the regulation of circadian rhythm and sleep.

Pharmacodynamic effects

Melatonin has a hypnotic / sedative effect and increases propensity for sleep. Melatonin administered earlier or later than the nocturnal peak in melatonin secretion can, respectively, advance or delay the circadian rhythmicity of melatonin secretion. Administration of melatonin at bedtime (between 22:00 and 24:00 hr) at destination following rapid transmeridian travel (aircraft flight) hastens resynchronisation of circadian rhythmicity from 'departure time' to 'destination time', and ameliorates the collection of symptoms known as jet lag that are a consequence of such desynchronisation.

Clinical efficacy and safety

Typical symptoms of jet lag are sleep disturbances and daytime tiredness and fatigue, though mild cognitive impairment, irritability, and gastrointestinal disturbances may also occur.

Jet lag is worse the more time-zones crossed, and is typically worse following eastward travel. Eight of ten clinical trials found that melatonin, taken close to the target bedtime at the destination (10 pm to midnight), decreased jet lag from flights crossing five or more time zones. The benefit is likely to be greater the more time zones are crossed, and less for westward flights. Daily doses of melatonin between 0.5 and 5 mg are similarly effective, except that people fall asleep faster and sleep better after 5 mg than 0.5 mg.

Clinical trials have found melatonin to reduce patient-assessed overall symptoms of jet lag by ~44%, and to shorten the duration of jet lag. In 2 studies of flights over 12 time-zones melatonin effectively reduced the duration of jet lag by ~33%. Due to the potential for incorrectly timed intake of melatonin to have no effect, or to cause an adverse effect, on re-synchronisation of circadian rhythmicity/jet lag, melatonin should not be taken before 20:00 hr or after 04:00 hr at destination.

Adverse reactions reported in jet lag studies involving melatonin doses of 0.5 to 8 mg were typically mild, and often difficult to distinguish from symptoms of jet lag. Transient drowsiness/sedation, headache and dizziness/disorientation were reported; these same adverse reactions, plus nausea, are those typically associated with short-term use of melatonin in reviews of the safety of melatonin in humans.

Paediatric population

Melatonin treatment has been studied in a 4-week randomized, double-blind, placebo-controlled study conducted in 105 children between 6-12 years of age, with ADHD and chronic sleep onset insomnia (van der Heijden KB et al. 2007). Participants received melatonin (3 mg when body weight <40 kg [n = 44]; or 6 mg when body weight >40 kg [n = 9]) in fast-release tablets or placebo.

Mean actigraphic estimate of sleep onset advanced by 26.9 ± 47.8 minutes with melatonin, whereas there was a delay of 10.5 ± 37.4 minutes with placebo ($p < 0.0001$). 48.8% of children who received melatonin showed an advance of sleep onset >30 minutes compared to 12.8% with placebo ($p = 0.001$). There was an increase in mean total time asleep of 19.8 ± 61.9 minutes with melatonin and a decrease of 13.6 ± 50.6 minutes with placebo ($p = 0.01$). As compared with placebo, the melatonin

group showed a decrease in sleep latency ($p = 0.001$) and increase in sleep efficiency ($p = 0.01$). The mean score on sleep log item difficulty falling asleep decreased by 1.2 ± 1.3 points (35.3% of baseline) with melatonin and by 0.1 ± 0.8 points (4.3% of baseline) with placebo ($p < 0.0001$).

There was no significant effect on behaviour, cognition, and quality of life. There were no discontinuations or withdrawals caused by adverse events.

5.2 Pharmacokinetic properties

Absorption

Absolute bioavailability of melatonin has been estimated in two studies to average 13% of the given dose via solution and 14–16% of the given dose via tablet.

Maximum concentration of orally administered melatonin occurs after 15–90 minutes (median $T_{\max} = 52$ min).

Maximum concentration and exposure of melatonin after oral dosing of tablets increases proportionally to the dose from 0.25 up to 10 mg.

Data on the effect of intake of food at or around the time of intake of melatonin on its pharmacokinetics are limited, though suggest that concomitant food intake may increase the absorption almost 2-fold. Food appears to have a limited effect on t_{\max} for immediate-release melatonin. This is not expected to affect the efficacy or safety of melatonin, however, it is recommended that food is not consumed approximately 2 h before and 2 h after intake of melatonin.

Distribution

The plasma protein binding of melatonin in vitro is about 60%. Distribution volume during terminal elimination phase is proportional to body weight, averaging just over 1 L/kg.

Biotransformation

Melatonin is mainly eliminated by hydroxylation to 6-hydroxymelatonin in the liver, primarily mediated by CYP1A2 (to a lesser extent by CYP1A1). Quantitatively less important O-demethylation to N-acetyl-5-hydroxytryptamine mediated by CYP2C19 occurs. Melatonin metabolites are mainly eliminated by the urine, ~ 90% as sulphate and glucuronide conjugates of 6-hydroxymelatonin. Less than ~ 1% of a melatonin dose is excreted unchanged in urine.

Elimination and accumulation

Plasma elimination half-life ($T_{1/2}$) is ~ 45 minutes (normal range ~ 30–60 minutes) in healthy adults. The half-life, on average, is comparable or slightly shorter in children compared to adults. Dosage once daily in combination with the short half-life means minimal accumulation of melatonin during regular treatment.

Special populations

Elderly

In a comparative study of serum melatonin with and without exogenous supplementation, lower concentrations were found in moderately older adults without treatment, while a trend toward higher concentrations was observed compared to healthy younger adults after treatment. The difference during treatment was not statistically significant; the same dosage may be recommended for moderately older as for younger adults.

Hepatic impairment

Limited data indicate that the daytime endogenous blood melatonin concentration is markedly elevated in patients with liver cirrhosis, probably due to reduced clearance (metabolism) of melatonin.

Serum $t_{1/2}$ for exogenous melatonin in cirrhosis patients was double that of controls in a small study. As the liver is the primary site of melatonin metabolism, hepatic impairment can be expected to result in increased exposure to exogenous melatonin.

Renal impairment

See section 4.2 Special populations.

5.3 Preclinical safety data

Preclinical data reveal no special hazard for humans based on limited studies of repeated dose toxicity, genotoxicity and reproductive toxicity.

A study in pregnant rats did not show direct or indirect harmful effects with respect to pregnancy, foetal survival or foetal development.

Data from animal studies indicate that melatonin is transmitted to the foetus via the placenta and to breast milk.

There are no safety studies in juvenile animals.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Microcrystalline cellulose

Maltodextrin

Colloidal anhydrous silica

Magnesium stearate

Hypromellose

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months.

6.4 Special precautions for storage

Do not store above 30°C.

Store in the original package in order to protect from light.

6.5 Nature and contents of container

HDPE container (white polyethylene bottle) with LDPE/HDPE lid containing desiccant.

Pack sizes: 10, 30 and 100 film-coated tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

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T/A Orifarm Healthcare A/S
Energivej 15
5260 Odense S
Denmark

8 MARKETING AUTHORISATION NUMBER(S)

PL 20254/0098

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

24/10/2025

10 DATE OF REVISION OF THE TEXT

08/01/2026