

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Oxycodone Hydrochloride 10 mg/ml Solution for Injection or Infusion.

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each ml contains oxycodone hydrochloride 10 mg (equivalent to 9 mg of oxycodone base).

Each 1 ml ampoule contains oxycodone hydrochloride 10 mg (equivalent to 9 mg of oxycodone base).

Each 2 ml contains oxycodone hydrochloride 20 mg (equivalent to 18mg of oxycodone base).

This medicinal product contains less than 1 mmol sodium (23 mg) per dose.
For full list of excipients, see Section 6.1.

3 PHARMACEUTICAL FORM

Solution for injection or infusion (injection or infusion).

A Clear, colourless solution practically free of particles.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

For the treatment of moderate to severe pain in patients with cancer and post-operative pain. For the treatment of severe pain requiring the use of a strong opioid.

4.2 Posology and method of administration

Route of administration:

Subcutaneous injection or infusion.

Intravenous injection or infusion.

Posology:

The dose should be adjusted according to the severity of pain, the total condition of the patient and previous or concurrent medication.

Adults over 18 years:

The following starting doses are recommended. A gradual increase in dose may be required if analgesia is inadequate or if pain severity increases.

i.v. (Bolus): Where necessary dilute to 1 mg/ml in 0.9% saline, 5% dextrose or water for injections. Administer a bolus dose of 1 to 10 mg slowly over one to two minutes.

Doses should not be administered more frequently than every four hours.

i.v. (Infusion): Dilute to 1 mg/ml in 0.9% saline, 5% dextrose or water for injections. A starting dose of 2 mg/hour is recommended.

i.v. (PCA): Dilute to 1 mg/ml in 0.9% saline, 5% dextrose or water for injections. Bolus doses of 0.03 mg/kg should be administered with a minimum lock-out time of five minutes.

s.c. (Bolus): Where necessary dilute to 10 mg/ml concentration using 0.9% saline, 5% dextrose or water for injection. A starting dose of 5 mg is recommended, repeated at four-hourly intervals as required.

s.c. (Infusion): Dilute to 1 mg/ml in 0.9% saline, 5% dextrose or water for injections if required. A starting dose of 7.5 mg/day is recommended in opioid naïve patients, titrating gradually according to symptom control. Cancer patients transferring from oral oxycodone may require much higher doses (see below).

Transferring patients between oral and parenteral oxycodone:

The dose should be based on the following ratio: 2 mg of oral oxycodone is equivalent to 1 mg of parenteral oxycodone. It must be emphasised that this is a guide to the dose required. Inter-patient variability requires that each patient is carefully titrated to the appropriate dose.

Conversion from morphine:

Patients switching from parenteral morphine to parenteral oxycodone therapy should do so on the basis of a one to one dose ratio. It must be emphasised that this is a guide to the dose of Oxycodone injection required. Inter-patient variability requires that each patient is carefully titrated to the appropriate dose.

Elderly:

Elderly patients should be treated with caution. The lowest dose should be administered with careful titration to pain control.

Patients with renal and hepatic impairment:

The dose initiation should follow a conservative approach in these patients. The recommended adult starting dose should be reduced by 50% (for example a total daily dose of 10mg orally in opioid naïve patients), and each patient should be titrated to adequate pain control according to their clinical situation.

Children under 18 years:

There are no data on the use of Oxycodone injection in patients under 18 years of age.

Use in non-malignant pain:

Opioids are not first-line therapy for chronic non-malignant pain, nor are they recommended as the only treatment. Types of chronic pain which have been shown to be alleviated by strong opioids include chronic osteoarthritic pain and intervertebral disc disease.

Method of administration

Subcutaneous injection or infusion

Intravenous injection or infusion

Treatment goals and discontinuation

Before initiating treatment with Oxycodone Injection, a treatment strategy including treatment duration and treatment goals, and a plan for end of the treatment, should be agreed together with the patient, in accordance with pain management guidelines. During treatment, there should be frequent contact between the physician and the patient to evaluate the need for continued treatment, consider discontinuation and to adjust dosages if needed. When a patient no longer requires therapy with oxycodone, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. In absence of adequate pain control, the possibility of hyperalgesia, tolerance and progression of underlying disease should be considered (see section 4.4).

Duration of treatment

Oxycodone should not be used for longer than necessary.

4.3 Contraindications

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

Oxycodone must not be used in any situation where opioids are contraindicated:

- severe respiratory depression with hypoxia
- paralytic ileus
- acute abdomen

- severe chronic obstructive lung disease
- cor pulmonale
- severe bronchial asthma
- elevated carbon dioxide levels in the blood
- chronic constipation

4.4 Special warnings and precautions for use

Caution must be exercised when administering oxycodone to the debilitated elderly; patients with severely impaired pulmonary function, patients with impaired hepatic or renal function; patients with myxoedema, hypothyroidism, Addison's disease, toxic psychosis, prostate hypertrophy, adrenocortical insufficiency, alcoholism, delirium tremens, diseases of the biliary tract, pancreatitis, inflammatory bowel disorders, hypotension, hypovolaemia, raised intracranial pressure, head injury (due to risk of increased intracranial pressure) or patients taking benzodiazepines, other CNS depressants (including alcohol) or MAO inhibitors (see section 4.5).

The primary risk of opioid excess is respiratory depression.

Concomitant use of oxycodone and sedative medicines such as benzodiazepines or related drugs may result in sedation, respiratory depression, coma and death. Because of these risks, concomitant prescribing with these sedative medicines should be reserved for patients for whom alternative treatment options are not possible.

If a decision is made to prescribe oxycodone concomitantly with sedative medicines, the lowest effective dose should be used, and the duration of treatment should be as short as possible (see also general dose recommendation in section 4.2).

The patients should be followed closely for signs and symptoms of respiratory depression and sedation. In this respect, it is strongly recommended to inform patients and their caregivers to be aware of these symptoms (see section 4.5).

Oxycodone injection must be administered with caution in patients taking MAOIs or who have received MAOIs within the previous two weeks (see section 4.5).

Oxycodone injection should not be used where there is a possibility of paralytic ileus occurring. Should paralytic ileus be suspected or occur during use, Oxycodone injection should be discontinued immediately.

Oxycodone injection should be used with caution pre- or intra-operatively and within the first 12-24 hours post-operatively.

As with all opioid preparations, oxycodone products should be used with caution following abdominal surgery as opioids are known to impair intestinal motility and should not be used until the physician is assured of normal bowel function.

For appropriate patients who suffer with chronic non-malignant pain, opioids should be used as part of a comprehensive treatment programme involving other medications and treatment modalities. A crucial part of the assessment of a patient with chronic non-malignant pain is the patient's addiction and substance abuse history.

If opioid treatment is considered appropriate for the patient, then the main aim of treatment is not to minimise the dose of opioid but rather to achieve a dose which provides adequate pain relief with a minimum of side effects. See section 4.2 for additional information on treatment goals and discontinuation.

Tolerance, Dependence and Opioid Use Disorder

Tolerance and physical and/or psychological dependence may develop upon repeated administration of opioids such as oxycodone.

Repeated use of Oxycodone may lead to Opioid Use Disorder (OUD). A higher dose and longer duration of opioid treatment can increase the risk of developing OUD. Abuse or intentional misuse of Oxycodone may result in overdose and/or death. The risk of developing OUD is increased in patients with a personal or a family history (parents or siblings) of substance use disorders (including alcohol use disorder), in current tobacco users or in patients with a personal history of other mental health disorders (e.g. major depression, anxiety and personality disorders).

Before initiating treatment with Oxycodone and during the treatment, treatment goals and a discontinuation plan should be agreed with the patient (see section 4.2). Before and during treatment the patient should also be informed about the risks and signs of OUD. If these signs occur, patients should be advised to contact their physician.

Patients will require monitoring for signs of drug-seeking behaviour (e.g. too early requests for refills). The prescriber should conduct a review of concomitant opioids and psycho-active drugs (like benzodiazepines). For patients with signs and symptoms of OUD, consultation with an addiction specialist should be considered.

The patient may develop tolerance to the drug with chronic use and require progressively higher doses to maintain pain control. A withdrawal syndrome may occur upon abrupt cessation of therapy following prolonged use of this product. When a patient no longer requires therapy with oxycodone, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal.

The opioid abstinence or withdrawal syndrome is characterised by some or all of the following: restlessness, lacrimation, rhinorrhoea, yawning, perspiration, chills, myalgia, mydriasis and palpitations. Other symptoms also may develop, including: irritability, anxiety, backache, joint pain, weakness, abdominal cramps, insomnia, nausea, anorexia, vomiting, diarrhoea, or increased blood pressure, respiratory rate or heart rate.

Hyperalgesia that will not respond to a further dose increase of oxycodone may occur, particularly in high doses. An oxycodone dose reduction or change to an alternative opioid may be required.

As with other opioids, infants who are born to dependent mothers may exhibit withdrawal symptoms and may have respiratory depression at birth.

Concomitant use of alcohol and Oxycodone injection may increase the undesirable effects of Oxycodone injection; concomitant use should be avoided.

Oxycodone injection contains approximately 3mg sodium per ml i.e. essentially 'sodium-free'.

Opioids, such as oxycodone hydrochloride, may influence the hypothalamic-pituitary-adrenal or – gonadal axes. Some changes that can be seen include an increase in serum prolactin, and decreases in plasma cortisol and testosterone. Clinical symptoms may manifest from these hormonal changes.

Sleep-related breathing disorders

Opioids can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia. Opioid use increases the risk of CSA in a dose-dependent fashion. In patients who present with CSA, consider decreasing the total opioid dosage. Opioids may also cause worsening of pre-existing central sleep apnoea (see section 4.8).

Hepatobiliary disorders

Oxycodone may cause dysfunction and spasm of the sphincter of Oddi, thus increasing the risk of biliary tract symptoms and pancreatitis. Therefore, oxycodone has to be administered with caution in patients with pancreatitis and diseases of the biliary tract.

4.5 Interaction with other medicinal products and other forms of interaction

The concomitant use of opioids with sedative medicines such as benzodiazepines or related drugs increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. The dosage and duration of concomitant use should be limited (see section 4.4).

Drugs which affect the CNS include, but are not limited to: other opioids, gabapentinoids such as pregabalin, anxiolytics, hypnotics and sedatives (including benzodiazepines), antipsychotics, antidepressants, phenothiazines, anaesthetics, muscle relaxants, antihypertensives and alcohol. Oxycodone should be used with caution and the dosage may need to be reduced in patients using these medications.

Concomitant administration of oxycodone with serotonin agents, such as a Selective Serotonin Re-uptake Inhibitor (SSRI) or a Serotonin Norepinephrine Re-uptake Inhibitor (SNRI) may cause serotonin toxicity. The symptoms of serotonin toxicity may include mental-status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g. tachycardia, labile blood pressure, hyperthermia), neuromuscular abnormalities (e.g. hyperreflexia, incoordination, rigidity), and/or gastrointestinal symptoms (e.g. nausea,

vomiting, diarrhoea). Oxycodone should be used with caution and the dosage may need to be reduced in patients using these medications.

Concomitant administration of oxycodone with anticholinergics or medicines with anticholinergic activity (e.g. tricyclic anti-depressants, antihistamines, antipsychotics, muscle relaxants, anti-Parkinson drugs) may result in increased anticholinergic adverse effects. Oxycodone should be used with caution and the dosage may need to be reduced in patients using these medications.

MAO inhibitors are known to interact with narcotic analgesics. MAO inhibitors cause CNS excitation or depression associated with hypertensive or hypotensive crisis (see section 4.4). Oxycodone should be used with caution in patients administered MAO-inhibitors or who have received MAO inhibitors during the last two weeks (see section 4.4).

Alcohol may enhance the pharmacodynamic effects of Oxycodone, concomitant use should be avoided.

Oxycodone is metabolised mainly by CYP3A4, with a contribution from CYP2D6. The activities of these metabolic pathways may be inhibited or induced by various co-administered drugs or dietary elements. Oxycodone doses may need to be adjusted accordingly.

CYP3A4 inhibitors, such as macrolide antibiotics (e.g. clarithromycin, erythromycin and telithromycin), azole-antifungals (e.g. ketoconazole, voriconazole, itraconazole, and posaconazole), protease inhibitors (e.g. boceprevir, ritonavir, indinavir, nelfinavir and saquinavir), cimetidine and grapefruit juice may cause a reduced clearance of oxycodone that could cause an increase of the plasma concentrations of oxycodone. Therefore the oxycodone dose may need to be adjusted accordingly.

Some specific examples are provided below:

- Itraconazole, a potent CYP3A4 inhibitor, administered 200 mg orally for five days, increased the AUC of oral oxycodone. On average, the AUC was approximately 2.4 times higher (range 1.5 - 3.4).
- Voriconazole, a CYP3A4 inhibitor, administered 200 mg twice-daily for four days (400 mg given as first two doses), increased the AUC of oral oxycodone. On average, the AUC was approximately 3.6 times higher (range 2.7 - 5.6).
- Telithromycin, a CYP3A4 inhibitor, administered 800 mg orally for four days, increased the AUC of oral oxycodone. On average, the AUC was approximately 1.8 times higher (range 1.3 – 2.3).
- Grapefruit Juice, a CYP3A4 inhibitor, administered as 200 ml three times a day for five days, increased the AUC of oral oxycodone. On average, the AUC was approximately 1.7 times higher (range 1.1 – 2.1).

CYP3A4 inducers, such as rifampicin, carbamazepine, phenytoin and St John's Wort may induce the metabolism of oxycodone and cause an increased clearance of oxycodone that could cause a reduction of the plasma

concentrations of oxycodone. The oxycodone dose may need to be adjusted accordingly.

Some specific examples are provided below:

- St Johns Wort, a CYP3A4 inducer, administered as 300 mg three times a day for fifteen days, reduced the AUC of oral oxycodone. On average, the AUC was approximately 50% lower (range 37-57%).
- Rifampicin, a CYP3A4 inducer, administered as 600 mg once-daily for seven days, reduced the AUC of oral oxycodone. On average, the AUC was approximately 86% lower

Drugs that inhibit CYP2D6 activity, such as paroxetine and quinidine, may cause decreased clearance of oxycodone which could lead to an increase in oxycodone plasma concentrations.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are limited data from the use of oxycodone in pregnant women. Regular use in pregnancy may cause drug dependence in the foetus, leading to withdrawal symptoms in the neonate. If opioid use is required for a prolonged period in pregnant women, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

No studies on fertility or the post-natal effects of intrauterine exposure have been carried out. However, studies in rats and rabbits with oral doses of oxycodone equivalent to 3 and 47 times an adult dose of 160 mg/day, respectively, did not reveal evidence of harm to the foetus due to oxycodone. Oxycodone injection is not recommended for use in pregnancy nor during labour.

Breastfeeding

Oxycodone may be secreted in breast milk and may cause respiratory depression in the newborn. Oxycodone should therefore not be used in breast-feeding mothers.

Fertility

No human data on the effect of oxycodone on fertility are available. In rats there was no effect on mating or fertility with oxycodone treatment (see section 5.3).

4.7 Effects on ability to drive and use machines

Oxycodone may impair the ability to drive and use machines. Oxycodone may modify patients' reactions to a varying extent depending on the dosage and individual susceptibility. Therefore patients should not drive or operate machinery, if affected.

This medicine can impair cognitive function and can affect a patient's ability to drive safely. This class of medicine is in the list of drugs included in regulations under 5a of the Road Traffic Act 1988. When prescribing this medicine, patients should be told:

- The medicine is likely to affect your ability to drive
- Do not drive until you know how the medicine affects you
- It is an offence to drive while you have this medicine in your body over a specified limit unless you have a defence (called the 'statutory defence').
- This defence applies when:
 - The medicine has been prescribed to treat a medical or dental problem; and
 - You have used it according to the instructions given by the prescriber and in the information provided with the medicine and
- Please note it is still an offence to drive if you are unfit because of the medicine (i.e. your ability to drive is being affected).

Details regarding a new driving offence concerning driving after drugs have been taken in the UK may be found here: <https://www.gov.uk/drug-driving-law>

4.8 Undesirable effects

Adverse drug reactions are typical of full opioid agonists. Tolerance and dependence may occur (see section 4.4). Constipation may be prevented with an appropriate laxative. If nausea or vomiting are troublesome, oxycodone may be combined with an antiemetic.

The following frequency categories form the basis for classification of the undesirable effects:

Term	Frequency
Very common	$\geq 1/10$
Common	$\geq 1/100$ to $<1/10$
Uncommon	$\geq 1/1,000$ to $<1/100$
Rare	$\geq 1/10,000$ to $<1/1,000$
Very rare	$<1/10,000$
Frequency not known	Cannot be estimated from the available data

Immune system disorders:

Uncommon: hypersensitivity.

Frequency not known: anaphylactic reaction, anaphylactoid reaction.

Metabolism and nutrition disorders:

Common: decreased appetite.

Uncommon: dehydration.

Psychiatric disorders:

Common: anxiety, confusional state, depression, insomnia, nervousness, abnormal thinking, abnormal dreams

Uncommon: agitation, affect lability, euphoric mood, hallucinations, decreased libido, drug dependence (see section 4.4), disorientation, mood altered, restlessness, dysphoria

Frequency not known: aggression.

Nervous system disorders:

Very common: somnolence, dizziness, headache.

Common: tremor, lethargy, sedation.

Uncommon: amnesia, convulsion, hypertonia, hypoaesthesia, involuntary muscle contractions, speech disorder, syncope, paraesthesia, dysgeusia, hypotonia.

Frequency not known: hyperalgesia.

Eye disorders:

Uncommon: visual impairment, miosis.

Ear and labyrinth disorders:

Uncommon: vertigo.

Cardiac disorders:

Uncommon: palpitations (in the context of withdrawal syndrome), supraventricular tachycardia.

Vascular disorders:

Uncommon: vasodilatation, facial flushing.

Rare: hypotension, orthostatic hypotension.

Respiratory, thoracic and mediastinal disorders:

Common: dyspnoea, bronchospasm, cough decreased.

Uncommon: respiratory depression, hiccups.

Frequency not known: Central sleep apnoea syndrome.

Gastrointestinal disorders:

Very common: constipation, nausea, vomiting.

Common: abdominal pain, diarrhoea, dry mouth, dyspepsia.

Uncommon: dysphagia, flatulence, eructation, ileus, gastritis.

Frequency not known: dental caries.

Hepato-biliary disorders:

Uncommon: increased hepatic enzymes, biliary colic.

Frequency not known: cholestasis, sphincter of Oddi dysfunction

Skin and subcutaneous tissue disorders:

Very common: pruritus.

Common: rash, hyperhidrosis.

Uncommon: dry skin, exfoliative dermatitis.

Rare: urticaria.

Renal and urinary disorders:

Uncommon: urinary retention, ureteral spasm.

Reproductive system and breast disorders:
Uncommon: erectile dysfunction, hypogonadism.
Frequency not known: amenorrhoea.

General disorders and administration site conditions:
Common: asthenia, fatigue.
Uncommon: syndrome, malaise, oedema, peripheral oedema, , thirst, pyrexia, chills.
Frequency not known: drug withdrawal syndrome neonatal, opioid tolerance, opioid withdrawal syndrome.

Opioid Tolerance and Opioid Withdrawal Syndrome

The frequency of opioid tolerance and the frequency of opioid withdrawal syndrome cannot be estimated from available evidence (e.g. clinical trials, spontaneous reporting, and the medical literature) and therefore is classified as “not known” (see section 4.8). ‘Not known’ should not be interpreted as an indication of the rarity of the occurrence of opioid tolerance and opioid withdrawal syndrome, but a reflection of the limitations in the available evidence that do not support a precise estimate of frequency.

Description of selected adverse reactions

Drug dependence

The frequency above regarding drug dependence reflects the current evidence, including cumulative data from clinical trials and additional post marketing sources, and indicates that the risk of drug dependence with opioids is highly variable depending upon: definition of drug dependence; duration of treatment; dose; individual patient risk factors; and clinical settings. ‘Not known’ should not be interpreted as an indication of the rarity of occurrence of drug dependence, but a reflection of the limitations in available evidence that do not support a precise estimate of frequency.

Repeated use of Oxycodone can lead to drug dependence, even at therapeutic doses. The risk of drug dependence may vary depending on a patient’s individual risk factors, dosage, and duration of opioid treatment (see section 4.4).

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

Symptoms of overdose

Acute overdose with oxycodone can be manifested by miosis, respiratory depression, hypotension and hallucinations. Nausea and vomiting are common in less severe cases. Non-cardiac pulmonary oedema and rhabdomyolysis are particularly common after intravenous injection of opioid analgesics. Circulatory failure and somnolence progressing to stupor or coma, hypotonia, bradycardia, pulmonary oedema and death

may occur in more severe cases. Toxic leukoencephalopathy has been observed with oxycodone overdose.

The effects of overdose will be potentiated by the simultaneous ingestion of alcohol or other psychotropic drugs

Treatment of overdose

Primary attention should be given to the establishment of a patent airway and institution of assisted or controlled ventilation. The pure opioid antagonists such as naloxone are specific antidotes against symptoms from opioid overdose. Other supportive measures should be employed as needed.

In the case of massive overdose, administer naloxone intravenously (0.4 to 2mg for an adult and 0.01mg/kg body weight for children) if the patient is in a coma or respiratory depression is present. Repeat the dose at 2 minute intervals if there is no response. If repeated doses are required then an infusion of 60% of the initial dose per hour is a useful starting point. A solution of 10 mg made up in 50 ml dextrose will produce 200 micrograms/ml for infusion using an IV pump (dose adjusted to the clinical response). Infusions are not a substitute for frequent review of the patient's clinical state.

Intramuscular naloxone is an alternative in the event that IV access is not possible. As the duration of action of naloxone is relatively short, the patient must be carefully monitored until spontaneous respiration is reliably re-established. Naloxone is a competitive antagonist and large doses (4 mg) may be required in seriously poisoned patients.

For less severe overdose, administer naloxone 0.2 mg intravenously followed by increments of 0.1 mg every 2 minutes if required.

The patient should be observed for at least 6 hours after the last dose of naloxone.

Naloxone should not be administered in the absence of clinically significant respiratory or circulatory depression secondary to oxycodone overdose. Naloxone should be administered cautiously to persons who are known, or suspected, to be physically dependent on oxycodone. In such cases, an abrupt or complete reversal of opioid effects may precipitate pain and an acute withdrawal syndrome.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Natural opium alkaloids

ATC code: N02A A05

Oxycodone is a full opioid agonist with no antagonist properties. It has an affinity for kappa, mu and delta opioid receptors in the brain and spinal cord. Oxycodone is similar to morphine in its action. The therapeutic effect is mainly analgesic, anxiolytic, antitussive and sedative.

Gastrointestinal System

Opioids may induce spasm of the sphincter of Oddi.

Endocrine system

See section 4.4.

Other pharmacological effects

In vitro and animal studies indicate various effects of natural opioids, such as morphine, on components of the immune system; the clinical significance of these findings is unknown. Whether oxycodone, a semisynthetic opioid, has immunological effects similar to morphine is unknown.

5.2 Pharmacokinetic properties

Pharmacokinetic studies in healthy subjects demonstrated an equivalent availability of oxycodone from Oxycodone injection when administered by the intravenous and subcutaneous routes, as a single bolus dose or a continuous infusion over 8 hours.

Distribution

Following absorption, oxycodone is distributed throughout the entire body. Approximately 45% is bound to plasma protein.

Metabolism

Oxycodone is metabolised in the liver via CYP3A4 and CYP2D6 to noroxycodone, oxymorphone and noroxymorphone, which are subsequently glucuronidated. Noroxycodone and noroxymorphone are the major circulating metabolites. Noroxycodone is a weak mu opioid agonist. Noroxymorphone is a potent mu opioid agonist; however, it does not cross the blood-brain barrier to a significant extent. Oxymorphone is a potent mu opioid agonist but is present at very low concentrations following oxycodone administration. None of these metabolites are thought to contribute significantly to the analgesic effect of oxycodone.

Elimination

The plasma elimination half-life is approximately 4.5 hours. The active drug and its metabolites are excreted in both urine and faeces.

The plasma concentrations of oxycodone are only minimally affected by age, being 15% greater in elderly as compared to young subjects.

Female subjects have, on average, plasma oxycodone concentrations up to 25% higher than males on a body weight adjusted basis.

The drug penetrates the placenta and can be found in breast milk.

When compared to normal subjects, patients with mild to severe hepatic dysfunction may have higher plasma concentrations of oxycodone and noroxycodone, and lower plasma concentrations of oxymorphone. There may be an increase in the elimination half-life of oxycodone and this may be accompanied by an increase in drug effects.

When compared to normal subjects, patients with mild to severe renal dysfunction may have higher plasma concentrations of oxycodone and its metabolites. There may be an increase in the elimination half-life of oxycodone and this may be accompanied by an increase in drug effects.

5.3 Preclinical safety data

Reproductive and Development Toxicology

Oxycodone had no effect on fertility or early embryonic development in male and female rats at doses as high as 8 mg/kg/day. Also, oxycodone was not teratogenic in rats at doses as high as 8 mg/kg/day or in rabbits at doses as high as 125 mg/kg/day. Dose-related increases in developmental variations (increased incidences of extra (27) presacral vertebrae and extra pairs of ribs) were observed in rabbits when the data for individual fetuses were analysed. However, when the same data were analysed using litters as opposed to individual fetuses, there was no dose-related increase in developmental variations although the incidence of extra presacral vertebrae remained significantly higher in the 125 mg/kg/day group compared to the control group. Since this dose level was associated with severe pharmacotoxic effects in the pregnant animals, the fetal findings may have been a secondary consequence of severe maternal toxicity.

In a prenatal and postnatal development study in rats, maternal body weight and food intake parameters were reduced for doses ≥ 2 mg/kg/day compared to the control group. Body weights were lower in the F1 generation from maternal rats in the 6 mg/kg/day dosing group.

Genotoxicity

The results of in-vitro and in-vivo studies indicate that the genotoxic risk of oxycodone to humans is minimal or absent at the systemic oxycodone concentrations that are achieved therapeutically. Oxycodone was not genotoxic in a bacterial mutagenicity assay or genotoxic in an in-vivo micronucleus assay in the mouse. Oxycodone was genotoxic in the in-vitro mouse lymphoma assay in the presence of rat liver S9 metabolic activation at

dose levels greater than 25 µg/ml and two in-vitro chromosomal aberrations assays with human lymphocytes provided equivocal results.

Carcinogenicity

Carcinogenicity was evaluated in a 2-year oral gavage study conducted in Sprague-Dawley rats. Oxycodone did not increase the incidence of tumours in male and female rats at doses up to 6 mg/kg/day. The doses were limited by opioid-related pharmacological effects of oxycodone.

Mutagenicity

Oxycodone was not mutagenic in bacterial mutation tests or in in-vivo micronucleus assay(s) in mice. As is the case with other opioids, oxycodone was shown to be genotoxic in some in-vitro assays (e.g. mouse lymphoma and human lymphocyte chromosomal aberration assays).

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Citric acid monohydrate

Sodium citrate

Sodium chloride

Hydrochloric acid (for pH adjustment)

Sodium hydroxide (for pH adjustment)

Water for injections

6.2 Incompatibilities

This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.6.

Cyclizine at concentrations of 3 mg/ml or less, when mixed with Oxycodone injection, either undiluted or diluted with water for injections, shows no sign of precipitation over a period of 24 hours storage at room temperature. Precipitation has been shown to occur in mixtures with Oxycodone injection at cyclizine concentrations greater than 3 mg/ml or when diluted with 0.9% saline. It is recommended that water for injections be used as a diluent when cyclizine and oxycodone hydrochloride are co-administered either intravenously or subcutaneously as an infusion.

Prochlorperazine is chemically incompatible with Oxycodone injection.

6.3 Shelf life

Unopened: 3 years.

The injection should be given immediately after opening the ampoule. Once opened, any unused portion should be discarded. Chemical and physical in-use stability has been demonstrated for 24 hours at room temperature.

From a microbiological point of view, the product should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2 to 8°C, unless reconstitution, dilution, etc as taken place in controlled and validated aseptic conditions.

6.4 Special precautions for storage

This medicinal product does not require any special temperature storage conditions. Keep the ampoules in the outer carton in order to protect from light.

6.5 Nature and contents of container

Type I clear glass ampoules: 1 ml and 2 ml.

Pack size: 5 ampoules.

6.6 Special precautions for disposal and other handling

Oxycodone injection has been shown to be compatible with the following drugs:

Hyoscine butylbromide
Hyoscine hydrobromide
Dexamethasone sodium phosphate
Haloperidol
Midazolam hydrochloride
Metoclopramide hydrochloride
Levomopromazine hydrochloride

Oxycodone injection, undiluted or diluted to 1 mg/ml with 0.9% w/v saline, 5% w/v dextrose or water for injections, is physically and chemically stable when in contact with representative brands of polypropylene or polycarbonate syringes, polyethylene or PVC tubing, and PVC or EVA infusion bags, over a 24 hour period at room temperature.

The injection, whether undiluted or diluted to 1 mg/ml in the infusion fluids used in these studies and contained in the various assemblies, does not need to be protected from light.

Inappropriate handling of the undiluted solution after opening of the original ampoule, or of the diluted solutions may compromise the sterility of the product.

7 MARKETING AUTHORISATION HOLDER

Wockhardt UK Ltd

Ash Road North

Wrexham

LL13 9UF

UK

8 MARKETING AUTHORISATION NUMBER(S)

PL 29831/0359

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

07/05/2010

10 DATE OF REVISION OF THE TEXT

28/01/2026