

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

OxyNorm Dispersa 20 mg orodispersible tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each orodispersible tablet contains 18 mg of oxycodone as 20 mg of oxycodone hydrochloride.

Excipients with known effect:

Each 20 mg tablet contains 10.8 mg of aspartame (E 951) and 56.8 mg of sucrose.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Orodispersible tablets are white to off-white round, flat, bevelled edged tablets, marked O on one side and 20 on the other.

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

Adults over 18 years:

OxyNorm Dispersa orodispersible tablets should be taken at 4-6 hourly intervals. The dosage is dependent on the severity of the pain, and the patient's previous history of analgesic requirements.

Generally, the lowest effective dose for analgesia should be selected. Increasing severity of pain will require an increased dosage of **OxyNorm Dispersa** orodispersible tablets. The correct dosage for any individual patient is that which controls the pain and is well tolerated throughout the dosing period. Patients should be titrated to pain relief unless unmanageable adverse drug reactions prevent this.

The usual starting dose for opioid naive patients or patients presenting with severe pain uncontrolled by weaker opioids is 5 mg, 4-6 hourly. The dose should then be carefully titrated, as frequently as once a day if necessary, to achieve pain relief.

Prior to starting treatment with opioids, a discussion should be held with patients to put in place a strategy for ending treatment with oxycodone in order to minimise the risk of addiction and drug withdrawal syndrome (see section 4.4).

Conversion from oral morphine:

Patients receiving oral morphine before oxycodone therapy should have their daily dose based on the following ratio: 10 mg of oral oxycodone is equivalent to 20 mg of oral morphine. It must be emphasised that this is a guide to the dose of **OxyNorm Dispersa** orodispersible tablets required. Inter-patient variability requires that each patient is carefully titrated to the appropriate dose.

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.

Elderly patients:

A dose adjustment is not usually necessary in elderly patients. Controlled pharmacokinetic studies in elderly patients (aged over 65 years) have shown that, compared with younger adults, the clearance of oxycodone is only slightly reduced. No untoward adverse drug reactions were seen based on age, therefore adult doses and dosage intervals are appropriate.

Patients with renal or hepatic impairment:

The plasma concentration in this patient population may be increased. 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 10 mg orally in opioid naïve patients), and each patient should be titrated to adequate pain control according to their clinical situation.

Paediatric population:

OxyNorm Dispersa orodispersible tablets should not be used in patients under 18 years.

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. The need for continued treatment in non-malignant pain should be assessed at regular intervals.

Method of administration

OxyNorm Dispersa orodispersible tablets are for oral use.

The orodispersible tablet is to be placed in the mouth where it disperses rapidly before being swallowed.

Before initiating treatment with *OxyNorm Dispersa* orodispersible tablets, 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 longer than necessary. In common with other strong opioids, the need for continued treatment should be assessed at regular intervals.

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, delayed gastric emptying, severe chronic obstructive lung disease, cor pulmonale, severe bronchial asthma, elevated carbon dioxide levels in the blood, moderate to severe hepatic impairment, chronic constipation. .

4.4 Special warnings and precautions for use

Caution must be exercised when administering oxycodone to the debilitated elderly; opioid-dependent patients; 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, intracranial lesions or head injury (due to risk of increased intracranial pressure), reduced level of consciousness of uncertain origin, sleep apnoea or patients taking benzodiazepines, other CNS depressants (including alcohol) or MAO inhibitors(see section 4.5).

The major risk of opioid excess is respiratory depression.

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.

OxyNorm Dispersa orodispersible tablets must be administered with caution in patients taking MAOIs or who have received MAOIs within the previous two weeks.

OxyNorm Dispersa orodispersible tablets should not be used where there is a possibility of paralytic ileus occurring. Should paralytic ileus be suspected or occur during use, *OxyNorm Dispersa* orodispersible tablets should be discontinued immediately.

OxyNorm Dispersa orodispersible tablets should be used with caution pre-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.

Patients about to undergo additional pain relieving procedures (e.g. surgery, plexus blockade) should not receive *OxyNorm Dispersa* orodispersible tablets for 6 hours prior to the intervention. If further treatment with oxycodone is then indicated the dosage should be adjusted to the new post-operative requirement.

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.

The patient may develop tolerance to the drug with chronic use and require progressively higher doses to maintain pain control. Prolonged use of this product may lead to physical dependence and a withdrawal syndrome may occur upon abrupt cessation of therapy. 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.

Opioid Use Disorder (abuse and dependence)

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

Repeated use of *OxyNorm Dispersa* orodispersible tablets can 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 *OxyNorm Dispersa* orodispersible tablets 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 *OxyNorm Dispersa* orodispersible tablets 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 behavior (e.g. too early requests for refills).

This includes the 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.

A comprehensive patient history should be taken to document concomitant medications, including over-the-counter medicines and medicines obtained on-line, and past and present medical and psychiatric conditions.

Tolerance

Patients may find that treatment is less effective with chronic use and express a need to increase the dose to obtain the same level of pain control as initially experienced. Patients may also supplement their treatment with additional pain relievers. These could be signs that the patient is developing tolerance.

The risks of developing tolerance should be explained to the patient.

Overuse or misuse may result in overdose and/or death. It is important that patients only use medicines that are prescribed for them at the dose they have been prescribed and do not give this medicine to anyone else.

Patients should be closely monitored for signs of misuse, abuse, or addiction.

The clinical need for analgesic treatment should be reviewed regularly.

Drug withdrawal syndrome

Prior to starting treatment with any opioids, a discussion should be held with patients to put in place a withdrawal strategy for ending treatment with oycodone.

Drug withdrawal syndrome may occur upon abrupt cessation of therapy or dose reduction. When a patient no longer requires therapy, it is advisable to taper the dose gradually to minimise symptoms of withdrawal. Tapering from a high dose may take weeks to months.

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

If women take this drug during pregnancy, there is a risk that their newborn infants will experience neonatal withdrawal syndrome.

Hyperalgesia

Hyperalgesia may be diagnosed if the patient on long-term opioid therapy presents with increased pain.

This might be qualitatively and anatomically distinct from pain related to disease progression or to breakthrough pain resulting from development of opioid tolerance. Pain associated with hyperalgesia tends to be more diffuse than the pre-existing pain and less defined in quality. Symptoms of hyperalgesia may resolve with a reduction of opioid dose.

Abuse of oral dosage forms by parenteral administration can be expected to result in serious adverse events, such as local tissue necrosis, infection, pulmonary granulomas, increased risk of endocarditis, and valvular heart injury, which may be fatal.

Concomitant use of alcohol and *OxyNorm Dispersa* orodispersible tablets may increase the undesirable effects of *OxyNorm Dispersa* orodispersible tablets; concomitant use should be avoided.

Opioids such as oxycodone, 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.

This medicine contains 10.80 mg aspartame in each tablet. Aspartame is a source of phenylalanine. It may be harmful if you have phenylketonuria (PKU), a rare genetic disorder in which phenylalanine builds up because the body cannot remove it properly.

This medicine contains sucrose and maltodextrin. Maltodextrin is a form of glucose. Chronic use (e.g. for two weeks or more) of these tablets may be harmful to teeth due to the presence of sucrose and glucose.

Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

Chronic use (e.g., for two weeks or more) of these tablets may be harmful to teeth due to the presence of sucrose and glucose.

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, alcohol, tranquillisers, anaesthetics, hypnotics and sedatives (including benzodiazepines), antipsychotics, antidepressants, phenothiazines, anaesthetics, muscle relaxants, antihypertensives and alcohol.

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, in coordination, 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). Co-administration with monoamine oxidase inhibitors or within two weeks of discontinuation of their use should be avoided.

Alcohol may enhance the pharmacodynamic effects of *OxyNorm Dispersa*, 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 John's 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. Concurrent administration of quinidine resulted in an increase in oxycodone C_{max} by 11%, AUC by 13%, and $t_{1/2}$ elim. by 14%. Also an increase in noroxycodone level was observed, (C_{max} by 50%; AUC by 85%, and $t_{1/2}$ elim. by 42%). The pharmacodynamic effects of oxycodone were not altered.

4.6 Fertility, pregnancy and lactation

Pregnancy

OxyNorm Dispersa orodispersible tablets are not recommended for use in pregnancy nor during labour. There are limited data from the use of oxycodone in pregnant women

Regular use during 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 a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

Administration during labour may depress respiration in the neonate and an antidote for the child should be readily available.

Breastfeeding

Administration to nursing women is not recommended as oxycodone may be secreted in breast milk and may cause respiratory depression in the infant.

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 taken it according to the instructions given by the prescriber and in the information provided with the medicine.
- Please note that 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 and vomiting are troublesome, oxycodone may be combined with an anti-emetic.

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

Term	Frequency
Very common	≥ 1/10
Common	≥ 1/100 to <1/10
Uncommon	≥ 1/1,000 to <1/100
Rare	≥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, , disorientation, mood altered, restlessness, dysphoria.

Frequency not known: aggression.

General disorders and administration site conditions.

Nervous system disorders:

Very common: somnolence, dizziness, headache.

Common: tremor, lethargy, sedation.

Uncommon: amnesia, convulsion, hypertonia, hypoesthesia, 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.

Not known: c.

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.

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: drug withdrawal syndrome, malaise, oedema, peripheral oedema, drug tolerance, thirst, pyrexia, chills.

Frequency not known: drug withdrawal syndrome neonatal

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

Acute overdose with oxycodone can be manifested by miosis, respiratory depression, hypotension, and hallucinations. Circulatory failure and somnolence progressing to stupor or deepening coma, hypotonia, bradycardia, pulmonary oedema and death may occur in more severe cases.

Toxic leukoencephalopathy has been observed with oxycodone overdose.

Treatment of oxycodone overdosage: 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 overdosage, administer naloxone intravenously (0.4 to 2 mg for an adult and 0.01 mg/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 overdosage, administer naloxone 0.2 mg intravenously followed by increments of 0.1 mg every 2 minutes if required. Naloxone should not be administered in the absence of clinically significant respiratory or circulatory depression secondary to oxycodone overdosage.

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.

Additional/other considerations:

- Consider activated charcoal (50 g for adults, 10-15 g for children), if a substantial amount has been ingested within 1 hour, provided the airway can be protected.
- Gastric contents may need to be emptied as this can be useful in removing unabsorbed drug.

- Patients should be informed of the signs and symptoms of overdose and to ensure that family and friends are also aware of these signs and to seek immediate medical help if they occur.

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 opiate receptors in the brain and spinal cord. The therapeutic effect is mainly analgesic, anxiolytic 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

Absorption

From immediate release formulations peak concentrations are generally attained around 1 hour.

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 3.5 hours. The active drug and its metabolites are excreted in urine.

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

Oxycodone was not mutagenic in the following assays: Ames Salmonella and E. Coli test with and without metabolic activation at doses of up to 5000 µg, chromosomal aberration test in human lymphocytes (in the absence of metabolic activation and with activation after 48 hours of exposure) at doses of up to 1500 µg/ml, and in the in vivo bone marrow micronucleus assay in mice (at plasma levels of up to 48 µg/ml). Mutagenic results occurred in the presence of metabolic activation in the human chromosomal aberration test (at greater than or equal to 1250 µg/ml) at 24 but not 48 hours of exposure and in the mouse lymphoma assay at doses of 50 µg/ml or greater with metabolic activation and at 400 µg/ml or greater without metabolic activation. The data from these tests indicate that the genotoxic risk to humans may be considered low.

Studies of oxycodone in animals to evaluate its carcinogenic potential have not been conducted owing to the length of clinical experience with the drug substance.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Sucrose

Maize Starch

Polyacrylate dispersion 30%

Hypromellose

Mannitol
Silicon dioxide
Cellulose, microcrystalline
Crosspovidone
Aspartame
Spearmint flavour (contains maltodextrin)
Magnesium Stearate

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 months

6.4 Special precautions for storage

Do not store above 25°C.

6.5 Nature and contents of container

Polyamide/Aluminium/PVC blister packs with a peelable aluminium backing foil.
Pack sizes: 14, 28 or 56 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements

7 MARKETING AUTHORISATION HOLDER

Ethypharm
194, Bureaux de la Colline – Bâtiment D
92213 Saint-Cloud cedex
France

8 MARKETING AUTHORISATION NUMBER(S)

PL 06934/0221

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

06/02/2025

10 DATE OF REVISION OF THE TEXT

06/02/2025