Mirtazapine is a white to creamy white crystalline powder which is slightly soluble in water.

Mirtazapine is available for oral administration as an orally disintegrating tablet (ODT) containing 15 mg, 30 mg, or 35 mg of mirtazapine. Each tablet contains the following inactive ingredients: butylated hydroxyanisole, butylated hydroxytoluene, calcium carbonate, crospovidone, dextrin, croscarmellose sodium, light magnesium stearate, lactose monohydrate, microcrystalline cellulose, polyethylene glycol 3500, xanthan gum, and yellow iron oxide.

Mirtazapine orally disintegrating tablets are rapidly and completely absorbed when administered with or without water. Mirtazapine orally disintegrating tablets also can be swallowed with or without water. Mirtazapine orally disintegrating tablets are not approved for use in pediatric patients. (See WARNINGS and PRECAUTIONS, Pediatric Use.)

Mirtazapine orally disintegrating tablets are available in 15 mg, 30 mg, and 35 mg strengths. Each tablet contains the following inactive ingredients: butylated hydroxyanisole, butylated hydroxytoluene, calcium carbonate, crospovidone, dextrin, croscarmellose sodium, light magnesium stearate, lactose monohydrate, microcrystalline cellulose, polyethylene glycol 3500, xanthan gum, and yellow iron oxide.

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and non-U.S. patients treated with mirtazapine. However, no controlled studies have been carried out in patients with a history of seizures. Therefore, care should be exercised when mirtazapine is used in these patients. Use of mirtazapine in the elderly and in patients with liver disease or renal impairment may require a reduction in dosage.

Clinical experience with mirtazapine orally disintegrating tablets in patients with hepatic or renal impairment has not been systematically evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or other significant heart disease. Mirtazapine was associated with weight gain and with significant increases in systolic and diastolic blood pressure in clinical trials with depressed patients. Mirtazapine should be used with caution in patients with known cardiovascular or cerebrovascular disease that could be exacerbated by hypotension (history of syncope, dizziness, or prolonged QTc interval) or hypertension. Patients who are predisposed to hypotension (dehydration, hypovolemia, and treatment with medications affecting blood pressure) should be observed closely.

Mirtazapine clearance is decreased in patients with moderate [glomerular filtration rate (GFR) = 11 to 30 mL/min/1.73 m²] and severe [GFR < 10 mL/min/1.73 m²] renal impairment. Mirtazapine tablets should be used in patients with known cardiovascular or cerebrovascular disease that could be exacerbated by hypotension (history of syncope, dizziness, or prolonged QTc interval) or hypertension. Patients who are predisposed to hypotension (dehydration, hypovolemia, and treatment with medications affecting blood pressure) should be observed closely.

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Overdose Management

Treatment should consist of those general measures employed in the management of overdose with any drug effective in the treatment of major depressive disorder. Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. General supportive and symptomatic measures are also recommended. Induction of emesis is not recommended. Gastric lavage with a large-bore orogastric tube with appropriate airway protection, if needed, may be indicated if performed soon after ingestion, or in symptomatic patients. Because of the rapid disintegration of mirtazapine orally disintegrating tablets, pill fragments may not appear in gastric contents obtained with lavage. Activated charcoal should be administered. There is no experience with the use of forced diuresis, dialysis, hemoperfusion or exchange transfusion in the treatment of mirtazapine overdose. No specific antidotes for mirtazapine are known. In managing overdosage, consider the possibility of multiple-drug involvement. The physician should consider contacting a poison control center for additional information on the treatment of any overdose. Telephone numbers for certified poison control centers are listed in the Physician’s Desk Reference (PDR).

DOSAGE AND ADMINISTRATION

Initial Treatment

The recommended starting dose for mirtazapine orally disintegrating tablets is 15 mg/day, administered in a single dose, preferably in the evening prior to sleep. In the controlled clinical trials establishing the efficacy of mirtazapine in the treatment of major depressive disorder, the effective dose range was generally 15 to 45 mg/day. While the relationship between dose and satisfactory response in the treatment of major depressive disorder for mirtazapine has not been adequately explored, patients not responding to the initial 15 mg dose may benefit from dose increases up to a maximum of 45 mg/day. Mirtazapine has an elimination half-life of approximately 20 to 40 hours; therefore, dose changes should not be made at intervals of less than one to two weeks in order to allow sufficient time for evaluation of the therapeutic response to a given dose.

Administration of Mirtazapine Orally Disintegrating Tablets

Patients should be instructed to open tablet blister pack with dry hands and place the tablet on the tongue. The tablet should be used immediately after removal from its blister; once removed, it cannot be stored. Mirtazapine orally disintegrating tablets will disintegrate rapidly on the tongue and can be swallowed with saliva. No water is needed for taking the tablet. Patients should not attempt to split the tablet.

Elderly and Patients with Renal or Hepatic Impairment

The clearance of mirtazapine is reduced in elderly patients and in patients with moderate to severe renal or hepatic impairment. Consequently, the prescriber should be aware that plasma mirtazapine levels may be increased in these patient groups, compared to levels observed in younger adults without renal or hepatic impairment (see PRECAUTIONS and CLINICAL PHARMACOLOGY). Maintenance/Extended Treatment

It is generally agreed that acute episodes of depression require several months of sustained pharmacological therapy beyond response to the acute episode. Systematic evaluation of mirtazapine has demonstrated that its efficacy in major depressive disorder is maintained for periods of up to 40 weeks following 8 to 12 weeks of initial treatment at a dose of 15 to 45 mg/day (see CLINICAL PHARMACOLOGY). Based on these limited data, it is unknown whether or not the dose of mirtazapine orally disintegrating tablets needed for maintenance treatment is identical to the dose needed to achieve an initial response. Patients should be periodically reassessed to determine the need for maintenance treatment and the appropriate dose for such treatment.

Switching Patients To or From a Monoamine Oxidase Inhibitor

At least 14 days should elapse between discontinuation of an MAOI and initiation of therapy with mirtazapine orally disintegrating tablets. In addition, at least 14 days should be allowed after stopping mirtazapine orally disintegrating tablets before starting an MAOI.

HOW SUPPLIED

Mirtazapine orally disintegrating tablets are available as follows:

15 mg Tablets — White to off-white, flat bevelled edge tablets. One side of the tablet debossed with the number “93”. The other side of the tablet debossed with the number “7305”. They are available in boxes of 30 (10 x 3 unit dose blisters).

30 mg Tablets — White to off-white, round, flat bevelled edge tablets. One side of the tablet debossed with the number “93”. The other side of the tablet debossed with the number “7304”. They are available in boxes of 30 (10 x 3 unit dose blisters).

45 mg Tablets — White to off-white, round, flat bevelled edge tablets. One side of the tablet debossed with the number “93”. The other side of the tablet debossed with the number “7305”. They are available in boxes of 30 (10 x 3 unit dose blisters).

Storage

Store at 20° to 25°C (68° to 77°F) (See USP Controlled Room Temperature). Protect from light and moisture. Use immediately upon opening individual tablet blister.

Manufactured In Israel By:
TEVA PHARMACEUTICAL IND. LTD.
Jerusalem, 91010, Israel

Manufactured For:
TEVA PHARMACEUTICALS USA
Sellersville, PA 18960

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