

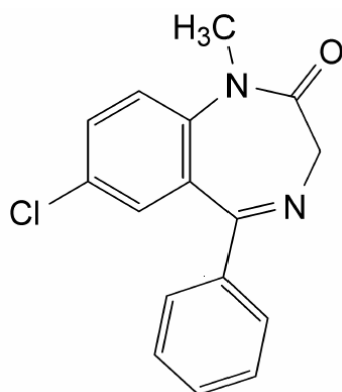
Product Information

Diazepam Elixir 10mg/10mL, Diazepam Suppositories 10mg

Name of Drug:

The active ingredient of both products is diazepam, chemically it is 7-Chloro-1,3-dihydro-1-methyl-5-phenyl-2H-1,4-benzodiazepin-2-one, C₁₆H₁₃ClN₂O.

Chemical Structure:



CAS 439-14-5

Description:

Diazepam is a benzodiazepine derivative. It is a colourless, crystalline compound, insoluble in water and soluble in alcohol with a molecular weight of 284.74.

Diazepam Elixir contains 10mg/10mL of diazepam as the active ingredient and the following excipients: ethanol, propylene glycol, glycerol, citric acid anhydrous, sodium citrate, purified water and blackcurrant flavour.

The suppository contains 10mg of the active ingredient diazepam and also macrogol 400 and macrogol 4000 as the excipients.

Pharmacology:

Diazepam is a long acting benzodiazepine. Benzodiazepines, in general act as depressants of the central nervous system (CNS) and exhibit anxiolytic, anticonvulsant, sedative and muscle relaxant properties. Its actions are presumed to be mediated by enhancement of the activity of gamma-aminobutyric acid (GABA), the major natural inhibitory neurotransmitter in the brain. GABA acts at this receptor to open the chloride channel, allowing the flow of chloride ions into the neuron. Entry of chloride ions results in hyperpolarisation, which inhibits firing of the neuron and translates into decreased neuronal excitability, thus attenuating the effects of subsequent depolarising excitatory transmitters. Diazepam enhances the actions of GABA by causing GABA to bind more tightly to GABA type A receptors.

Pharmacokinetics:

Absorption: Following oral administration diazepam is well absorbed from the gastrointestinal tract with peak plasma levels occurring within about 30 to 90 minutes.

Following rectal administration of a suppository with a macrogol (polyethylene glycol) base peak serum concentrations occur after about 50 to 100 minutes.

Distribution: Diazepam is highly lipid soluble and widely distributed into body tissues and crosses the blood brain barrier. Diazepam and its metabolites also cross the placental barrier and are also distributed into breast milk. Diazepam is 98% protein bound in the plasma. The plasma concentration time curve is biphasic, with an initial rapid and extensive distribution phase with a half life of up to 3 hours, followed by a prolonged terminal elimination phase (half life 20-48 hours).

Metabolism: Diazepam is extensively metabolised to one major active metabolite (desmethyldiazepam), and two minor active metabolites, 3-hydroxydiazepam (temazepam) and 3-hydroxy-N-diazepam (oxazepam) in plasma. At therapeutic doses, desmethyldiazepam is found in plasma at concentrations equivalent to those of diazepam while oxazepam and temazepam are not usually detectable. Diazepam undergoes hepatic demethylation and hydroxylation, involving cytochrome P450 (CYP) 2C19 and CYP3A4 isoenzymes, followed by glucuronidation.

Excretion: It is largely excreted in the urine (70%), predominately as its conjugated metabolites or in its free form.

Indications:

Diazepam is indicated in the management of anxiety disorders and for the short term relief of the symptoms of anxiety. Diazepam is a useful adjunct for the relief of reflex muscle spasm due to local trauma (injury, inflammation) to muscles, bones and joints. It is also indicated in the management of cerebral spasticity due to upper motor neuron lesions such as cerebral palsy and paraplegia, and spasticity in athetosis and stiff man syndrome. In acute alcohol withdrawal, diazepam may be useful in the symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis.

Contra-indications:

Diazepam Elixir and Suppositories are contraindicated in patients with:

- Known hypersensitivity to benzodiazepines or to the excipients of the products (see **Description**)
- Chronic obstructive airway disease with incipient respiratory failure
- Severe respiratory insufficiency
- Severe hepatic insufficiency
- Sleep apnoea syndrome
- Myasthenia gravis
- Alcohol dependence unless being treated for acute alcohol withdrawal

Diazepam should not be used as sole therapy for the treatment of depression or anxiety associated with depression as suicide may occur in such patients, nor should it be used as primary treatment of psychotic illness.

Diazepam elixir or suppositories are not recommended to control status epilepticus or other acute management situations.

Precautions: Use with caution in the following circumstances:

Hypotension: Diazepam should be administered with caution to patients in whom a drop in blood pressure might lead to cardiac or cerebral complications, although hypotension has occurred rarely. This is particularly important in elderly patients.

Amnesia: Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines. Anterograde amnesia can occur using therapeutic doses and the risk increases with higher doses. Amnesic effects may be associated with inappropriate behaviour.

Acute narrow angle glaucoma: Caution should be used in the treatment of patients with acute narrow angle glaucoma (because of atropine-like side effects).

Effect on ability to drive or operate machinery: Diazepam Elixir and Suppositories may modify patients' performance at skilled tasks (driving, operating machinery etc) to a varying degree depending upon dosage and individual susceptibility. Patients should be warned not to operate machinery or motor vehicles until it is known that they do not become drowsy or dizzy. Abilities may be impaired on the day following use.

Alcohol tolerance: Patients should be further advised that their tolerance for alcohol will be diminished and alcohol should therefore be avoided during treatment.

Prolonged use: Benzodiazepines should be prescribed for short periods only (2-4 weeks). Continuous long-term use of diazepam is not recommended. There is evidence that tolerance

develops to the sedative effects of benzodiazepines. After as little as one week of therapy, withdrawal symptoms can appear following cessation of recommended doses (eg rebound insomnia following cessation of a hypnotic benzodiazepine).

Withdrawal: Following prolonged use of diazepam withdrawal from medication should be gradual. A withdrawal timetable should be planned for each patient. For patients with known or suspected dependence withdrawal periods from four weeks to four months have been suggested.

Impaired Renal/Liver Function and Blood Dyscrasias: Patients with impaired renal or hepatic function should use benzodiazepine medication with caution and dosage reduction may be advisable. In rare instances some patients taking benzodiazepines have developed blood dyscrasias, and some have had elevation in liver enzymes, periodic blood counts and liver function tests are recommended.

Depression, Psychosis and Schizophrenia: Diazepam is not recommended as primary therapy in patients with depression and/or psychosis. In such conditions psychiatric assessment and supervision are necessary if benzodiazepines are indicated. Benzodiazepines may increase depression in some patients, and may contribute to deterioration in severely disturbed schizophrenics with confusion and withdrawal. Suicidal tendencies may be present or uncovered and protective measures may be required.

Paradoxical reactions: Paradoxical reactions such as restlessness, agitation, irritability, aggressiveness, delusion, nightmares, hallucinations, psychoses, inappropriate behaviour and other reactions such as acute rage, stimulation or excitement may occur. If such reactions occur, diazepam should be discontinued. These reactions are more likely to occur in children and the elderly.

Geriatric or debilitated patients: Such patients may be particularly susceptible to the sedative effects of benzodiazepines and associated giddiness, ataxia and confusion, which may increase the possibility of a fall. Lower doses should be used for elderly and debilitated patients.

Impaired respiratory function: Caution in the use of diazepam is recommended in patients with respiratory depression. In patients with chronic obstructive pulmonary disease, benzodiazepines can cause increased arterial carbon dioxide tension and decreased oxygen tension. Due to the risk of respiratory depression, lower doses are recommended for patients with chronic respiratory insufficiency.

Epilepsy: When diazepam is administered to patients with convulsive disorders an increase in the frequency and/or the severity of grand mal seizures may occur, necessitating increased anticonvulsant medication. Abrupt withdrawal of benzodiazepines in persons with convulsive disorders may be associated with a temporary increase in the frequency and or severity of seizures.

Abuse: Caution must be exercised in administering diazepam to individuals known to be addiction prone or those with a history which suggests they may increase the dosage on their own initiative. It is desirable to limit repeat prescription without adequate medical supervision.

Dependence: The use of benzodiazepines may lead to dependence as defined by a withdrawal syndrome on discontinuation of the drug. The risk of dependence increases with dosage and the duration of treatment. Patients on long term therapy and/or high dosage can have more marked dependence and it occurs in predisposed patients with a history of drug and/or alcohol abuse. Tolerance as defined by a need to increase the dose in order to achieve the same therapeutic effect seldom occurs in patients receiving recommended doses under medical supervision. Tolerance to sedation may occur with benzodiazepines particularly in those with drug seeking behaviour.

Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred once physical dependence to benzodiazepines has developed or following abrupt discontinuation of benzodiazepines. These symptoms range from insomnia, anxiety, dysphoria, palpitations, panic attacks, vertigo, myoclonus, akinesia, hypersensitivity to light sound and touch, abnormal body sensations (e.g. feeling of motion, metallic taste), depersonalisation, derealisation, delusional

beliefs, hyperreflexia and loss of short term memory, to a major syndrome which may include, convulsions, tremor, abdominal and muscle cramps, confusional state, delusional state, delirium, hallucinations, hyperthermia, psychosis, vomiting and sweating. Such manifestations of withdrawal especially the more serious ones are more common in patients who have received excessive doses over a prolonged period. However, withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines taken continuously at therapeutic levels. Accordingly, diazepam should be terminated by tapering the dose to minimise the occurrence of withdrawal symptoms. Patients should be advised to consult their physician before increasing the dose or abruptly discontinuing the medication.

Rebound phenomena have been described in the context of benzodiazepine use. Rebound insomnia and anxiety mean an increase in the severity of the symptoms beyond pretreatment levels following the cessation of the benzodiazepines. Rebound phenomena in general possibly reflect re-emergence of pre-existing symptoms combined with withdrawal symptoms described earlier. Withdrawal/rebound symptoms may follow high doses for relatively short periods.

Use in Pregnancy: Category C. The safety of diazepam for use in human pregnancy has not been established. An increased risk of congenital malformation associated with benzodiazepine use in the first trimester has been suggested. Benzodiazepines should be avoided during pregnancy unless there is no safer alternative. Benzodiazepines cross the placenta and may cause hypotension, hypotonia, reduced respiratory function and hypothermia in the new born infant. Continuous treatment during pregnancy and high doses in connection with delivery should be avoided. Special care must be taken during labour and delivery; if diazepam is used as single high doses it may produce irregularities in the foetal heart rate, hypotonia, poor sucking, hypothermia, and moderate respiratory depression in the neonate. With newborn infants it must be remembered that the enzyme system involved in the breakdown of the drug is not yet fully developed, especially in premature infants. Withdrawal symptoms in new born infants have been reported with this class of drugs. The categorisation definition of **Category C:** Drugs which owing to their pharmacological effects, have caused or may be suspected of causing, harmful effects on the human foetus or neonate without causing malformations. These effects may be reversible.

Use in Lactation: Breast feeding is not recommended in patients receiving diazepam. Diazepam is excreted in the breast milk and may cause drowsiness and feeding difficulties in the infant.

Use in Children: Prolonged central nervous system depression has been observed in neonates due to an inability to biotransform diazepam to inactive metabolites and so they, especially the very young, are usually more sensitive to it. Chronic use of diazepam is not recommended in children younger than 6 months due to a lack of adequate clinical experience.

Pharmacodynamic Interactions: Diazepam produces additive CNS depressant effects when co-administered with other medications which themselves produce CNS depression, e.g. alcohol, barbiturates, anxiolytics, sedatives, antidepressants including tricyclic antidepressants, non selective MAO inhibitors, hypnotics, antiepileptic drugs, phenothiazines and other antipsychotics, skeletal muscle relaxants, antihistamines, narcotic analgesics and anaesthetics. The effect of these drugs may potentiate or be potentiated by diazepam.

Concomitant use with alcohol is not recommended due to the enhancement of the sedative effect.

The anticholinergic effects of drugs including atropine and similar drugs, antihistamines and antidepressants may be potentiated.

Cisapride may lead to a temporary increase in the sedative effects of orally administered diazepam due to a faster absorption.

Pharmacokinetic interactions: There is a potentially relevant interaction between diazepam and drugs that inhibit certain hepatic enzymes, particularly CYP3A4 and CYP2C19 which are the principal isoenzymes involved in the initial oxidative metabolism of diazepam. Potential hepatic enzyme inhibitors (eg cimetidine, omeprazole, disulfiram, fluvoxamine, fluoxetine, probenecid, ketoconazole, macrolide antibiotics such as erythromycin and clarithromycin, HIV-protease inhibitors such as ritonavir and indinavir, oral contraceptives) could decrease the rate of diazepam elimination and may lead to increased and prolonged sedation. Patients receiving diazepam

should be monitored for signs of an exaggerated response if any of the above drugs are used concomitantly; some patients may require a reduction in diazepam dosage.

Inducers of hepatic enzymes (eg rifampicin, carbamazepine, phenytoin, and phenobarbitone) can increase the rate of elimination of diazepam.

Interactions have been reported between some benzodiazepines and anticonvulsants, with changes in the serum concentration of the benzodiazepines or anticonvulsant. It is recommended that patients be observed for altered responses when benzodiazepines and anticonvulsants are prescribed together and that the serum level monitoring of the anticonvulsant is performed more frequently.

There have been reports that the metabolic elimination of phenytoin is affected by diazepam.

Effects on clinical, laboratory or other tests: Minor EEG changes, usually low voltage, fast activity, of no known clinical significance have been noted with benzodiazepine administration.

Diazepam can inhibit binding of thyroxine and liothyronine to their binding proteins resulting in erroneously abnormal values from a thyroid function test.

Effects on Diagnostic tests: No effects have been seen when diazepam has been administered orally or rectally.

Adverse Reactions:

Common (usually dose related)

Central Nervous System: fatigue, drowsiness, and ataxia

Musculoskeletal: muscle weakness

Uncommon:

Cardiovascular: hypotension

Central Nervous System: amnesia (anterograde), confusion, depression, headache, tremor, vertigo, blurred vision, slurred speech and dysarthria

Dermatological: skin rash

Gastrointestinal: constipation, gastrointestinal disturbances, dry mouth, nausea and hypersalivation

Genito-urinary: incontinence, urinary retention, increase or decrease in libido

Rare

Central Nervous System: dizziness with oral diazepam

Cardiovascular: cardiac arrest

Very rare

Haematopoietic: isolated instances of neutropaenia have been reported

Hepatic: jaundice, elevated transaminases and alkaline phosphatase

Other

Anterograde amnesia may occur using therapeutic dosages, the risk increasing at higher doses. Paradoxical reactions such as acute hyperexcitation, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of diazepam should be discontinued.

Dependence: Chronic use (even at therapeutic doses) of oral diazepam may lead to the development of physical dependence; discontinuation of therapy may result in withdrawal or rebound phenomena.

Dosage and Administration:

General: The lowest dose which can control the symptoms should be used. The dosage should be carefully individualised for maximum benefit. Dosage may need to be reduced in patients with hepatic or renal disease as the elimination half life may be prolonged in this group. Treatment with benzodiazepines should always be withdrawn gradually. Elderly patients should be given a

reduced dose. These patients should be checked regularly at the start of treatment in order to minimize the dosage and/or frequency of administration to prevent overdose due to accumulation.

In general benzodiazepines should be prescribed for short periods (for example 2-4 weeks). Long term use of diazepam is not recommended. There is evidence that tolerance develops to the sedative effects of benzodiazepines. Withdrawal symptoms can occur after one week's treatment, (e.g. rebound insomnia, following cessation of benzodiazepines).

Elixir:

Usual adult dose: 5 – 40mg (5-40mL) daily.

Average dosage for ambulatory patients: 2mg (2mL) three times daily or 5mg (5mL) in the evening and 2mg (2mL) once or twice during the day.

Elderly or debilitated patients: 2mg (2mL) twice daily or half the usual adult dose.

Children: Benzodiazepines should not be given to children without careful assessment of the indication; duration of treatment must be kept to a minimum.

Children younger than 6 months of age: Use not recommended.

6 months to 3 years: 1-6mg (1-6mL) daily.

4 to 14 years: 4-12mg (4-12mL) daily or calculated from 0.1-0.3mg/kg (0.1-0.3mL/kg) body weight.

Hospital treatment of tension, excitation, motor unrest: 10 to 15 mg (10 to 15mL) three times daily until the acute symptoms subside.

Suppositories:

For rectal use only.

Usual adult dose: 10 - 40 mg daily

Children: not recommended

Anxiety states: Adults 10 - 40 mg daily in divided doses, adjusted on an individual basis

Insomnia associated with anxiety: Adults 10 mg before retiring

Symptomatic relief in acute alcohol withdrawal: Adults 10 - 20 mg repeated if necessary in 2 to 4 hours.

Conditions associated with muscle spasm: Muscle spasm: Adults 10 - 30 mg daily

Management of cerebral spasticity in selected cases: Adults: 10 - 60 mg daily in divided doses, adjusted on an individual basis. The lowest dose which can control symptoms should be used.

Adjunct to the management of some types of epilepsy: Adults: 10 - 60 mg daily in divided doses, adjusted on an individual basis. The lowest dose which can control symptoms should be used.

Premedication: Adults: 10 - 20 mg. Out patients or day cases should be advised about the potential effect of diazepam on their ability to operate machinery or motor vehicles, possible amnesia and alcohol tolerance. See (**Precautions**).

Overdosage:

Symptoms: Overdosage of benzodiazepines is usually manifested by degrees of central nervous system depression ranging from drowsiness to coma. In mild cases, symptoms include drowsiness, mental confusion and lethargy. In more serious cases, symptoms may include ataxia, hypotonia, hypotension, respiratory depression, coma, and very rarely death.

Treatment: In the management of overdosage with any medication, it should be borne in mind that multiple agents may have been taken. Treatment should be symptomatic and supportive. Following overdosage, activated charcoal should be administered within one to two hours after ingestion to decrease absorption. In patients who are not fully conscious or have impaired gag reflex, consideration should be given to administering activated charcoal via a nasogastric tube once the airway is protected. In the management of overdosage special attention should be paid to the respiratory and cardiovascular functions in intensive care. Hypotension and respiratory depression should be managed according to general principles. Haemoperfusion and haemodialysis are not useful in benzodiazepine intoxication.

The benzodiazepine antagonist, flumazenil may be useful in hospitalised patients for the reversal of acute benzodiazepine overdose effects. The flumazenil product information should be consulted prior to use. The use of flumazenil is not recommended in epileptic patients who have

been treated with diazepam. The reversal of the benzodiazepine effect in these patients may induce convulsions.

Presentation:

AUST R 42852: Diazepam Elixir contains diazepam 10 mg per 10 mL. It is a clear, colourless to yellow, slightly viscous liquid with an odour of blackcurrant and is available in a 100mL bottle.

AUST R 21149: Diazepam Suppositories contain diazepam 10mg. It is a white to off white, bullet-shaped waxy suppository and is available in jars of 20.

Storage Conditions:

Elixir: Store below 25°C. Protect from light.

Suppositories: Store below 25°C

Schedule:

All states and ACT S4 (Prescription Only Medication)

Name and Address of the Sponsor:

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