

PRESCRIBING INFORMATION

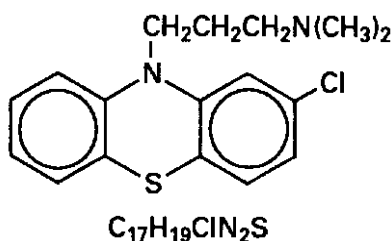
THORAZINE[®]

brand of
chlorpromazine

antipsychotic • tranquilizer • antiemetic

DESCRIPTION

Thorazine (chlorpromazine) is 10-(3-dimethylaminopropyl)-2-chlorphenothiazine, a dimethylamine derivative of phenothiazine. It is present in oral and injectable forms as the hydrochloride salt, and in the suppositories as the base.



Tablets—Each round, orange, coated tablet contains chlorpromazine hydrochloride as follows: 10 mg imprinted SKF and T73; 25 mg imprinted SKF and T74; 50 mg imprinted SKF and T76; 100 mg imprinted SKF and T77; 200 mg imprinted SKF and T79. Inactive ingredients consist of benzoic acid, croscarmellose sodium, D&C Yellow No. 10, FD&C Blue No. 2, FD&C Yellow No. 6, gelatin, hydroxypropyl methylcellulose, lactose, magnesium stearate, methylparaben, polyethylene glycol, propylparaben, talc, titanium dioxide and trace amounts of other inactive ingredients.

Ampuls—Each mL contains, in aqueous solution, chlorpromazine hydrochloride, 25 mg; ascorbic acid, 2 mg; sodium bisulfite, 1 mg; sodium chloride, 6 mg; sodium sulfite, 1 mg.

Multi-Dose Vials—Each mL contains, in aqueous solution, chlorpromazine hydrochloride, 25 mg; ascorbic acid, 2 mg; sodium bisulfite, 1 mg; sodium chloride, 1 mg; sodium sulfite, 1 mg; benzyl alcohol, 2%, as a preservative.

Syrup—Each 5 mL (1 teaspoonful) of clear, orange-custard flavored liquid contains chlorpromazine hydrochloride, 10 mg. Inactive ingredients consist of citric acid, flavors, sodium benzoate, sodium citrate, sucrose and water.

Suppositories—Each suppository contains chlorpromazine, 25 or 100 mg, glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated coconut oil fatty acids and hydrogenated palm kernel oil fatty acids.

ACTIONS

The precise mechanism whereby the therapeutic effects of chlorpromazine are produced is not known. The principal pharmacological actions are psychotropic. It also exerts sedative and

antiemetic activity. Chlorpromazine has actions at all levels of the central nervous system—primarily at subcortical levels—as well as on multiple organ systems. Chlorpromazine has strong antiadrenergic and weaker peripheral anticholinergic activity; ganglionic blocking action is relatively slight. It also possesses slight antihistaminic and antiserotonin activity.

INDICATIONS

For the treatment of schizophrenia.

To control nausea and vomiting.

For relief of restlessness and apprehension before surgery.

For acute intermittent porphyria.

As an adjunct in the treatment of tetanus.

To control the manifestations of the manic type of manic-depressive illness.

For relief of intractable hiccups.

For the treatment of severe behavioral problems in children (1 to 12 years of age) marked by combativeness and/or explosive hyperexcitable behavior (out of proportion to immediate provocations), and in the short-term treatment of hyperactive children who show excessive motor activity with accompanying conduct disorders consisting of some or all of the following symptoms: impulsivity, difficulty sustaining attention, aggressivity, mood lability and poor frustration tolerance.

CONTRAINDICATIONS

Do not use in patients with known hypersensitivity to phenothiazines.

Do not use in comatose states or in the presence of large amounts of central nervous system depressants (alcohol, barbiturates, narcotics, etc.).

WARNINGS

The extrapyramidal symptoms which can occur secondary to Thorazine (chlorpromazine) may be confused with the central nervous system signs of an undiagnosed primary disease responsible for the vomiting, e.g., Reye's syndrome or other encephalopathy. The use of *Thorazine* and other potential hepatotoxins should be avoided in children and adolescents whose signs and symptoms suggest Reye's syndrome.

Tardive Dyskinesia: Tardive dyskinesia, a syndrome consisting of potentially irreversible, involuntary, dyskinetic movements, may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

Both the risk of developing the syndrome and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses.

There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying disease process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown.

Given these considerations, antipsychotics should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who suffer from a chronic illness that, 1) is known to respond to antipsychotic drugs, and, 2) for whom alternative, equally effective, but potentially less harmful treatments are *not* available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically.

If signs and symptoms of tardive dyskinesia appear in a patient on antipsychotics, drug discontinuation should be considered. However, some patients may require treatment despite the presence of the syndrome.

For further information about the description of tardive dyskinesia and its clinical detection, please refer to the sections on PRECAUTIONS and ADVERSE REACTIONS.

Neuroleptic Malignant Syndrome (NMS): A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis and cardiac dysrhythmias).

The diagnostic evaluation of patients with this syndrome is complicated. In arriving at a diagnosis, it is important to identify cases where the clinical presentation includes both serious medical illness (e.g., pneumonia, systemic infection, etc.) and untreated or inadequately treated extrapyramidal signs and symptoms (EPS). Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever and primary central nervous system (CNS) pathology.

The management of NMS should include 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy, 2) intensive symptomatic treatment and medical monitoring, and 3) treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for uncomplicated NMS.

If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrences of NMS have been reported.

An encephalopathic syndrome (characterized by weakness, lethargy, fever, tremulousness and confusion, extrapyramidal symptoms, leukocytosis, elevated serum enzymes, BUN and FBS) has occurred in a few patients treated with lithium plus an antipsychotic. In some instances, the syndrome was followed by irreversible brain damage. Because of a possible causal relationship between these events and the concomitant administration of lithium and antipsychotics, patients receiving such combined therapy should be monitored closely for early evidence of neurologic

toxicity and treatment discontinued promptly if such signs appear. This encephalopathic syndrome may be similar to or the same as neuroleptic malignant syndrome (NMS).

Thorazine (chlorpromazine) ampuls and multi-dose vials contain sodium bisulfite and sodium sulfite, sulfites that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than in nonasthmatic people.

Patients with bone marrow depression or who have previously demonstrated a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) with a phenothiazine should not receive any phenothiazine, including *Thorazine*, unless in the judgment of the physician the potential benefits of treatment outweigh the possible hazard.

Thorazine may impair mental and/or physical abilities, especially during the first few days of therapy. Therefore, caution patients about activities requiring alertness (e.g., operating vehicles or machinery).

The use of alcohol with this drug should be avoided due to possible additive effects and hypotension.

Thorazine may counteract the antihypertensive effect of guanethidine and related compounds.

Usage in Pregnancy: Safety for the use of Thorazine (chlorpromazine) during pregnancy has not been established. Therefore, it is not recommended that the drug be given to pregnant patients except when, in the judgment of the physician, it is essential. The potential benefits should clearly outweigh possible hazards. There are reported instances of prolonged jaundice, extrapyramidal signs, hyperreflexia or hyporeflexia in newborn infants whose mothers received phenothiazines.

Reproductive studies in rodents have demonstrated potential for embryotoxicity, increased neonatal mortality and nursing transfer of the drug. Tests in the offspring of the drug-treated rodents demonstrate decreased performance. The possibility of permanent neurological damage cannot be excluded.

Nursing Mothers: There is evidence that chlorpromazine is excreted in the breast milk of nursing mothers. Because of the potential for serious adverse reactions in nursing infants from chlorpromazine, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

PRECAUTIONS

General

Given the likelihood that some patients exposed chronically to antipsychotics will develop tardive dyskinesia, it is advised that all patients in whom chronic use is contemplated be given, if possible, full information about this risk. The decision to inform patients and/or their guardians must obviously take into account the clinical circumstances and the competency of the patient to understand the information provided.

Thorazine (chlorpromazine) should be administered cautiously to persons with cardiovascular, liver or renal disease. There is evidence that patients with a history of hepatic encephalopathy

due to cirrhosis have increased sensitivity to the CNS effects of *Thorazine* (i.e., impaired cerebation and abnormal slowing of the EEG).

Because of its CNS depressant effect, *Thorazine* should be used with caution in patients with chronic respiratory disorders such as severe asthma, emphysema and acute respiratory infections, particularly in children (1 to 12 years of age).

Because *Thorazine* can suppress the cough reflex, aspiration of vomitus is possible.

Thorazine (chlorpromazine) prolongs and intensifies the action of CNS depressants such as anesthetics, barbiturates and narcotics. When *Thorazine* is administered concomitantly, about $\frac{1}{4}$ to $\frac{1}{2}$ the usual dosage of such agents is required. When *Thorazine* is not being administered to reduce requirements of CNS depressants, it is best to stop such depressants before starting *Thorazine* treatment. These agents may subsequently be reinstated at low doses and increased as needed.

Note: *Thorazine* does *not* intensify the anticonvulsant action of barbiturates. Therefore, dosage of anticonvulsants, including barbiturates, should *not* be reduced if *Thorazine* is started. Instead, start *Thorazine* at low doses and increase as needed.

Use with caution in persons who will be exposed to extreme heat, organophosphorus insecticides, and in persons receiving atropine or related drugs.

Antipsychotic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately $\frac{1}{3}$ of human breast cancers are prolactin-dependent *in vitro*, a factor of potential importance if the prescribing of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of antipsychotic drugs. Neither clinical nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Chromosomal aberrations in spermatocytes and abnormal sperm have been demonstrated in rodents treated with certain antipsychotics.

As with all drugs which exert an anticholinergic effect, and/or cause mydriasis, chlorpromazine should be used with caution in patients with glaucoma.

Chlorpromazine diminishes the effect of oral anticoagulants.

Phenothiazines can produce alpha-adrenergic blockade.

Chlorpromazine may lower the convulsive threshold; dosage adjustments of anticonvulsants may be necessary. Potentiation of anticonvulsant effects does not occur. However, it has been reported that chlorpromazine may interfere with the metabolism of Dilantin^{®*} and thus precipitate *Dilantin* toxicity.

Concomitant administration with propranolol results in increased plasma levels of both drugs.

Thiazide diuretics may accentuate the orthostatic hypotension that may occur with phenothiazines.

The presence of phenothiazines may produce false-positive phenylketonuria (PKU) test results.

Drugs which lower the seizure threshold, including phenothiazine derivatives, should not be used with Amipaque^{®†}. As with other phenothiazine derivatives, *Thorazine* should be discontinued at least 48 hours before myelography, should not be resumed for at least 24 hours postprocedure, and should not be used for the control of nausea and vomiting occurring either prior to myelography or postprocedure with *Amipaque*.

Long-Term Therapy: To lessen the likelihood of adverse reactions related to cumulative drug effect, patients with a history of long-term therapy with *Thorazine* and/or other antipsychotics should be evaluated periodically to decide whether the maintenance dosage could be lowered or drug therapy discontinued.

Antiemetic Effect: The antiemetic action of *Thorazine* may mask the signs and symptoms of overdosage of other drugs and may obscure the diagnosis and treatment of other conditions such as intestinal obstruction, brain tumor and Reye's syndrome. (See WARNINGS.)

When *Thorazine* is used with cancer chemotherapeutic drugs, vomiting as a sign of the toxicity of these agents may be obscured by the antiemetic effect of *Thorazine*.

Abrupt Withdrawal: Like other phenothiazines, *Thorazine* (chlorpromazine) is not known to cause psychic dependence and does not produce tolerance or addiction. There may be, however, following abrupt withdrawal of high-dose therapy, some symptoms resembling those of physical dependence such as gastritis, nausea and vomiting, dizziness and tremulousness. These symptoms can usually be avoided or reduced by gradual reduction of the dosage or by continuing concomitant anti-parkinsonism agents for several weeks after *Thorazine* is withdrawn.

ADVERSE REACTIONS

Note: Some adverse effects of *Thorazine* may be more likely to occur, or occur with greater intensity, in patients with special medical problems, e.g., patients with mitral insufficiency or pheochromocytoma have experienced severe hypotension following recommended doses.

Drowsiness, usually mild to moderate, may occur, particularly during the first or second week, after which it generally disappears. If troublesome, dosage may be lowered.

Jaundice: Overall incidence has been low, regardless of indication or dosage. Most investigators conclude it is a sensitivity reaction. Most cases occur between the second and fourth weeks of therapy. The clinical picture resembles infectious hepatitis, with laboratory features of obstructive jaundice, rather than those of parenchymal damage. It is usually promptly reversible on withdrawal of the medication; however, chronic jaundice has been reported.

There is no conclusive evidence that preexisting liver disease makes patients more susceptible to jaundice. Alcoholics with cirrhosis have been successfully treated with *Thorazine* (chlorpromazine) without complications. Nevertheless, the medication should be used cautiously in patients with liver disease. Patients who have experienced jaundice with a phenothiazine should not, if possible, be reexposed to *Thorazine* or other phenothiazines.

If fever with grippelike symptoms occurs, appropriate liver studies should be conducted. If tests indicate an abnormality, stop treatment.

Liver function tests in jaundice induced by the drug may mimic extrahepatic obstruction; withhold exploratory laparotomy until extrahepatic obstruction is confirmed.

Hematological Disorders, including agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, aplastic anemia, thrombocytopenic purpura and pancytopenia have been reported.

Agranulocytosis—Warn patients to report the sudden appearance of sore throat or other signs of infection. If white blood cell and differential counts indicate cellular depression, stop treatment and start antibiotic and other suitable therapy.

Most cases have occurred between the fourth and tenth weeks of therapy; patients should be watched closely during that period.

Moderate suppression of white blood cells is not an indication for stopping treatment unless accompanied by the symptoms described above.

Cardiovascular:

Hypotensive Effects—Postural hypotension, simple tachycardia, momentary fainting and dizziness may occur after the first injection; occasionally after subsequent injections; rarely, after the first oral dose. Usually recovery is spontaneous and symptoms disappear within ½ to 2 hours. Occasionally, these effects may be more severe and prolonged, producing a shock-like condition.

To minimize hypotension after injection, keep patient lying down and observe for at least ½ hour. To control hypotension, place patient in head-low position with legs raised. If a vasoconstrictor is required, Levophed^{®†} and Neo-Synephrine^{®§} are the most suitable. Other pressor agents, including epinephrine, should not be used as they may cause a paradoxical further lowering of blood pressure.

EKG Changes—particularly nonspecific, usually reversible Q and T wave distortions—have been observed in some patients receiving phenothiazine antipsychotics, including Thorazine (chlorpromazine).

Note: Sudden death, apparently due to cardiac arrest, has been reported.

CNS Reactions:

Neuromuscular (Extrapyramidal) Reactions—Neuromuscular reactions include dystonias, motor restlessness, pseudo-parkinsonism and tardive dyskinesia, and appear to be dose-related. They are discussed in the following paragraphs:

Dystonias: Symptoms may include spasm of the neck muscles, sometimes progressing to acute, reversible torticollis; extensor rigidity of back muscles, sometimes progressing to opisthotonos; carpopedal spasm, trismus, swallowing difficulty, oculogyric crisis and protrusion of the tongue.

These usually subside within a few hours, and almost always within 24 to 48 hours after the drug has been discontinued.

In mild cases, reassurance or a barbiturate is often sufficient. *In moderate cases*, barbiturates will usually bring rapid relief. *In more severe adult cases*, the administration of an anti-parkinsonism agent, except levodopa (see *PDR*), usually produces rapid reversal of symptoms. *In children (1 to 12 years of age)*, reassurance and barbiturates will usually control symptoms. (Or, parenteral Benadryl^{®||} may be useful. See *Benadryl* prescribing information for appropriate children's

dosage.) If appropriate treatment with anti-parkinsonism agents or *Benadryl* fails to reverse the signs and symptoms, the diagnosis should be reevaluated.

Suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed when needed. If therapy is reinstated, it should be at a lower dosage. Should these symptoms occur in children or pregnant patients, the drug should not be reinstated.

Motor Restlessness: Symptoms may include agitation or jitteriness and sometimes insomnia. These symptoms often disappear spontaneously. At times these symptoms may be similar to the original neurotic or psychotic symptoms. Dosage should not be increased until these side effects have subsided.

If these symptoms become too troublesome, they can usually be controlled by a reduction of dosage or change of drug. Treatment with anti-parkinsonian agents, benzodiazepines or propranolol may be helpful.

Pseudo-parkinsonism: Symptoms may include: mask-like facies, drooling, tremors, pillrolling motion, cogwheel rigidity and shuffling gait. In most cases these symptoms are readily controlled when an anti-parkinsonism agent is administered concomitantly. Anti-parkinsonism agents should be used only when required. Generally, therapy of a few weeks to 2 or 3 months will suffice. After this time patients should be evaluated to determine their need for continued treatment. (Note: Levodopa has not been found effective in antipsychotic-induced pseudo-parkinsonism.) Occasionally it is necessary to lower the dosage of Thorazine (chlorpromazine) or to discontinue the drug.

Tardive Dyskinesia: As with all antipsychotic agents, tardive dyskinesia may appear in some patients on long-term therapy or may appear after drug therapy has been discontinued. The syndrome can also develop, although much less frequently, after relatively brief treatment periods at low doses. This syndrome appears in all age groups. Although its prevalence appears to be highest among elderly patients, especially elderly women, it is impossible to rely upon prevalence estimates to predict at the inception of antipsychotic treatment which patients are likely to develop the syndrome. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities. In rare instances, these involuntary movements of the extremities are the only manifestations of tardive dyskinesia. A variant of tardive dyskinesia, tardive dystonia, has also been described.

There is no known effective treatment for tardive dyskinesia; anti-parkinsonism agents do not alleviate the symptoms of this syndrome. If clinically feasible, it is suggested that all antipsychotic agents be discontinued if these symptoms appear. Should it be necessary to reinstate treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Adverse Behavioral Effects—Psychotic symptoms and catatonic-like states have been reported rarely.

Other CNS Effects—Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. (See WARNINGS.)

Cerebral edema has been reported.

Convulsive seizures (*petit mal* and *grand mal*) have been reported, particularly in patients with EEG abnormalities or history of such disorders.

Abnormality of the cerebrospinal fluid proteins has also been reported.

Allergic Reactions of a mild urticarial type or photosensitivity are seen. Avoid undue exposure to sun. More severe reactions, including exfoliative dermatitis, have been reported occasionally.

Contact dermatitis has been reported in nursing personnel; accordingly, the use of rubber gloves when administering *Thorazine* liquid or injectable is recommended.

In addition, asthma, laryngeal edema, angioneurotic edema and anaphylactoid reactions have been reported.

Endocrine Disorders: Lactation and moderate breast engorgement may occur in females on large doses. If persistent, lower dosage or withdraw drug. False-positive pregnancy tests have been reported, but are less likely to occur when a serum test is used. Amenorrhea and gynecomastia have also been reported. Hyperglycemia, hypoglycemia and glycosuria have been reported.

Autonomic Reactions: Occasional dry mouth; nasal congestion; nausea; obstipation; constipation; adynamic ileus; urinary retention; priapism; miosis and mydriasis, atonic colon, ejaculatory disorders/impotence.

Special Considerations in Long-Term Therapy: Skin pigmentation and ocular changes have occurred in some patients taking substantial doses of *Thorazine* (chlorpromazine) for prolonged periods.

Skin Pigmentation—Rare instances of skin pigmentation have been observed in hospitalized mental patients, primarily females who have received the drug usually for 3 years or more in dosages ranging from 500 mg to 1500 mg daily. The pigmentary changes, restricted to exposed areas of the body, range from an almost imperceptible darkening of the skin to a slate gray color, sometimes with a violet hue. Histological examination reveals a pigment, chiefly in the dermis, which is probably a melanin-like complex. The pigmentation may fade following discontinuance of the drug.

Ocular Changes—Ocular changes have occurred more frequently than skin pigmentation and have been observed both in pigmented and nonpigmented patients receiving *Thorazine* (chlorpromazine) usually for 2 years or more in dosages of 300 mg daily and higher. Eye changes are characterized by deposition of fine particulate matter in the lens and cornea. In more advanced cases, star-shaped opacities have also been observed in the anterior portion of the lens. The nature of the eye deposits has not yet been determined. A small number of patients with more severe ocular changes have had some visual impairment. In addition to these corneal and lenticular changes, epithelial keratopathy and pigmentary retinopathy have been reported. Reports suggest that the eye lesions may regress after withdrawal of the drug.

Since the occurrence of eye changes seems to be related to dosage levels and/or duration of therapy, it is suggested that long-term patients on moderate to high dosage levels have periodic ocular examinations.

Etiology—The etiology of both of these reactions is not clear, but exposure to light, along with dosage/duration of therapy, appears to be the most significant factor. If either of these reactions is observed, the physician should weigh the benefits of continued therapy against the possible risks and, on the merits of the individual case, determine whether or not to continue present therapy, lower the dosage, or withdraw the drug.

Other Adverse Reactions: Mild fever may occur after large I.M. doses. Hyperpyrexia has been reported. Increases in appetite and weight sometimes occur. Peripheral edema and a systemic lupus erythematosus-like syndrome have been reported.

Note: There have been occasional reports of sudden death in patients receiving phenothiazines. In some cases, the cause appeared to be cardiac arrest or asphyxia due to failure of the cough reflex.

DOSAGE AND ADMINISTRATION—ADULTS

Adjust dosage to individual and the severity of his condition, recognizing that the milligram for milligram potency relationship among all dosage forms has not been precisely established clinically. It is important to increase dosage until symptoms are controlled. Dosage should be increased more gradually in debilitated or emaciated patients. In continued therapy, gradually reduce dosage to the lowest effective maintenance level, after symptoms have been controlled for a reasonable period.

The 100 mg and 200 mg tablets are for use in severe neuropsychiatric conditions.

Increase parenteral dosage only if hypotension has not occurred. Before using I.M., see IMPORTANT NOTES ON INJECTION.

Elderly Patients—In general, dosages in the lower range are sufficient for most elderly patients. Since they appear to be more susceptible to hypotension and neuromuscular reactions, such patients should be observed closely. Dosage should be tailored to the individual, response carefully monitored, and dosage adjusted accordingly. Dosage should be increased more gradually in elderly patients.

Psychotic Disorders—Increase dosage gradually until symptoms are controlled. Maximum improvement may not be seen for weeks or even months. Continue optimum dosage for 2 weeks; then gradually reduce dosage to the lowest effective maintenance level. Daily dosage of 200 mg is not unusual. Some patients require higher dosages (e.g., 800 mg daily is not uncommon in discharged mental patients).

HOSPITALIZED PATIENTS: ACUTE SCHIZOPHRENIC OR MANIC STATES—*I.M.*: 25 mg (1 mL). If necessary, give additional 25 to 50 mg injection in 1 hour. Increase subsequent I.M. doses gradually over several days—up to 400 mg q4 to 6h in exceptionally severe cases—until patient is controlled. Usually patient becomes quiet and cooperative within 24 to 48 hours and oral doses may be substituted and increased until the patient is calm. 500 mg a day is generally sufficient. While gradual increases to 2,000 mg a day or more may be necessary, there is usually little therapeutic gain to be achieved by exceeding 1,000 mg a day for extended periods. In general, dosage levels should be lower in the elderly, the emaciated and the debilitated. **LESS ACUTELY DISTURBED**—*Oral*: 25 mg t.i.d. Increase gradually until effective dose is reached—

usually 400 mg daily. **OUTPATIENTS**—*Oral*: 10 mg t.i.d. or q.i.d., or 25 mg b.i.d. or t.i.d. **MORE SEVERE CASES**—*Oral*: 25 mg t.i.d. After 1 or 2 days, daily dosage may be increased by 20 to 50 mg at semiweekly intervals until patient becomes calm and cooperative. **PROMPT CONTROL OF SEVERE SYMPTOMS**—*I.M.*: 25 mg (1 mL). If necessary, repeat in 1 hour. Subsequent doses should be oral, 25 to 50 mg t.i.d.

Nausea and Vomiting—*Oral*: 10 to 25 mg q4 to 6h, p.r.n., increased, if necessary. *I.M.*: 25 mg (1 mL). If no hypotension occurs, give 25 to 50 mg q3 to 4h, p.r.n., until vomiting stops. Then switch to oral dosage. *Rectal*: One 100 mg suppository q6 to 8h, p.r.n. In some patients, half this dose will do.

DURING SURGERY—*I.M.*: 12.5 mg (0.5 mL). Repeat in ½ hour if necessary and if no hypotension occurs. *I.V.*: 2 mg per fractional injection, at 2-minute intervals. Do not exceed 25 mg. Dilute to 1 mg/mL, i.e., 1 mL (25 mg) mixed with 24 mL of saline.

Presurgical Apprehension—*Oral*: 25 to 50 mg, 2 to 3 hours before the operation. *I.M.*: 12.5 to 25 mg (0.5 to 1 mL), 1 to 2 hours before operation.

Intractable Hiccups—*Oral*: 25 to 50 mg t.i.d. or q.i.d. If symptoms persist for 2 to 3 days, give 25 to 50 mg (1 to 2 mL) I.M. Should symptoms persist, use *slow I.V.* infusion with patient flat in bed: 25 to 50 mg (1 to 2 mL) in 500 to 1,000 mL of saline. Follow blood pressure closely.

Acute Intermittent Porphyria—*Oral*: 25 to 50 mg t.i.d. or q.i.d. Can usually be discontinued after several weeks, but maintenance therapy may be necessary for some patients. *I.M.*: 25 mg (1 mL) t.i.d. or q.i.d. until patient can take oral therapy.

Tetanus—*I.M.*: 25 to 50 mg (1 to 2 mL) given 3 or 4 times daily, usually in conjunction with barbiturates. Total doses and frequency of administration must be determined by the patient's response, starting with low doses and increasing gradually. *I.V.*: 25 to 50 mg (1 to 2 mL). Dilute to at least 1 mg per mL and administer at a rate of 1 mg per minute.

DOSAGE AND ADMINISTRATION—PEDIATRIC PATIENTS (6 months to 12 years of age)

Thorazine (chlorpromazine) should generally not be used in pediatric patients under 6 months of age except where potentially lifesaving. It should not be used in conditions for which specific pediatric dosages have not been established.

Severe Behavioral Problems—**OUTPATIENTS**—Select route of administration according to severity of patient's condition and increase dosage gradually as required. *Oral*: ¼ mg/lb body weight q4 to 6h, p.r.n. (e.g., for 40 lb child—10 mg q4 to 6h). *Rectal*: ½ mg/lb body weight q6 to 8h, p.r.n. (e.g., for 20 to 30 lb child—half a 25 mg suppository q6 to 8h). *I.M.*: ¼ mg/lb body weight q6 to 8h, p.r.n.

HOSPITALIZED PATIENTS—As with outpatients, start with low doses and increase dosage gradually. In severe behavior disorders, higher dosages (50 to 100 mg daily, and in older children, 200 mg daily or more) may be necessary. There is little evidence that behavior improvement in severely disturbed mentally retarded patients is further enhanced by doses beyond 500 mg per day. *Maximum I.M. Dosage*: Children up to 5 years (or 50 lbs), not over 40 mg/day; 5 to 12 years (or 50 to 100 lbs), not over 75 mg/day except in unmanageable cases.

Nausea and Vomiting—Dosage and frequency of administration should be adjusted according to the severity of the symptoms and response of the patient. The duration of activity following intramuscular administration may last up to 12 hours. Subsequent doses may be given by the same route if necessary. *Oral*: ¼ mg/lb body weight (e.g., 40 lb child—10 mg q4 to 6h). *Rectal*: ½ mg/lb body weight q6 to 8h, p.r.n. (e.g., 20 to 30 lb child—half of a 25 mg suppository q6 to 8h). *I.M.*: ¼ mg/lb body weight q6 to 8h, p.r.n. *Maximum I.M. Dosage*: Pediatric patients 6 months to 5 yrs. (or 50 lbs), not over 40 mg/day; 5 to 12 yrs. (or 50 to 100 lbs), not over 75 mg/day except in severe cases. **DURING SURGERY**—*I.M.*: ⅛ mg/lb body weight. Repeat in ½ hour if necessary and if no hypotension occurs. *I.V.*: 1 mg per fractional injection at 2-minute intervals and not exceeding recommended I.M. dosage. Always dilute to 1 mg/mL, i.e., 1 mL (25 mg) mixed with 24 mL of saline.

Presurgical Apprehension—¼ mg/lb body weight, either *orally* 2 to 3 hours before operation, or *I.M.* 1 to 2 hours before.

Tetanus—*I.M. or I.V.*: ¼ mg/lb body weight q6 to 8h. When given *I.V.*, dilute to at least 1 mg/mL and administer at rate of 1 mg per 2 minutes. In patients up to 50 lbs, do not exceed 40 mg daily; 50 to 100 lbs, do not exceed 75 mg, except in severe cases.

IMPORTANT NOTES ON INJECTION

Inject slowly, deep into upper outer quadrant of buttock.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection. If irritation is a problem, dilute Injection with saline or 2% procaine; mixing with other agents in the syringe is not recommended. Subcutaneous injection is not advised. Avoid injecting undiluted Thorazine (chlorpromazine) into vein. *I.V.* route is only for severe hiccups, surgery and tetanus.

Because of the possibility of contact dermatitis, avoid getting solution on hands or clothing. This solution should be protected from light. This is a clear, colorless to pale yellow solution; a slight yellowish discoloration will not alter potency. If markedly discolored, solution should be discarded. For information on sulfite sensitivity, see the WARNINGS section of this labeling.

Note on Concentrate: When the Concentrate is to be used, add the desired dosage of Concentrate to 60 mL (2 fl oz) or more of diluent *just prior to administration*. This will insure palatability and stability. Vehicles suggested for dilution are: tomato or fruit juice, milk, simple syrup, orange syrup, carbonated beverages, coffee, tea or water. Semisolid foods (soups, puddings, etc.) may also be used. The Concentrate is light sensitive; it should be protected from light and dispensed in amber glass bottles. *Refrigeration is not required.*

OVERDOSAGE

(See also ADVERSE REACTIONS.)

SYMPTOMS—Primarily symptoms of central nervous system depression to the point of somnolence or coma. Hypotension and extrapyramidal symptoms.

Other possible manifestations include agitation and restlessness, convulsions, fever, autonomic reactions such as dry mouth and ileus, EKG changes and cardiac arrhythmias.

TREATMENT—It is important to determine other medications taken by the patient since multiple drug therapy is common in overdose situations. Treatment is essentially symptomatic and supportive. Early gastric lavage is helpful. Keep patient under observation and maintain an open airway, since involvement of the extrapyramidal mechanism may produce dysphagia and respiratory difficulty in severe overdose. **Do not attempt to induce emesis because a dystonic reaction of the head or neck may develop that could result in aspiration of vomitus.** Extrapyramidal symptoms may be treated with anti-parkinsonism drugs, barbiturates, or *Benadryl*. See prescribing information for these products. Care should be taken to avoid increasing respiratory depression.

If administration of a stimulant is desirable, amphetamine, dextroamphetamine, or caffeine with sodium benzoate is recommended. Stimulants that may cause convulsions (e.g., picrotoxin or pentylenetetrazol) should be avoided.

If hypotension occurs, the standard measures for managing circulatory shock should be initiated. If it is desirable to administer a vasoconstrictor, *Levophed* and *Neo-Synephrine* are most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Limited experience indicates that phenothiazines are *not* dialyzable.

HOW SUPPLIED

Tablets: 10 mg, in bottles of 100; 25 mg or 50 mg, in bottles of 100. For use in severe neuropsychiatric conditions, 100 mg and 200 mg, in bottles of 100.

NDC 0007-5073-20 10 mg 100's
NDC 0007-5074-20 25 mg 100's
NDC 0007-5076-20 50 mg 100's
NDC 0007-5077-20 100 mg 100's
NDC 0007-5079-20 200 mg 100's

Ampuls: 1 mL and 2 mL (25 mg/mL), in boxes of 10.

NDC 0007-5060-11 25 mg/mL in 1 mL Ampuls (box of 10)
NDC 0007-5061-11 25 mg/mL in 2 mL Ampuls (box of 10)

Multi-Dose Vials: 10 mL (25 mg/mL), in boxes of 1.

NDC 0007-5062-01 25 mg/mL in 10 mL Multi-Dose Vials (box of 1)

Syrup: 10 mg/5 mL, in 4 fl oz bottles.

NDC 0007-5072-44 10 mg/5 mL 4 fl oz

Suppositories: 25 mg or 100 mg, in boxes of 12.

NDC 0007-5070-03 25 mg (box of 12)
NDC 0007-5071-03 100 mg (box of 12)

All dosage forms except Syrup should be stored between 15° and 30°C (59° and 86°F). Syrup should be stored below 25°C (77°F).

* phenytoin, Parke-Davis.

†metrizamide, Sanofi Winthrop Pharmaceuticals.
‡norepinephrine bitartrate, Abbott Laboratories.
§phenylephrine hydrochloride, Abbott Laboratories.
||diphenhydramine hydrochloride, Parke-Davis.

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