

SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Bupropion SUN 150 mg modified-release tablets.
Bupropion SUN 300 mg modified-release tablets.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains bupropion hydrochloride 150 mg or 300 mg.

Excipient with known effect

<Product name> 150 mg modified-release tablets

Each modified-release tablet contains 5 mg of lactose (as monohydrate).

<Product name> 300 mg modified-release tablets

Each modified-release tablet contains 9 mg of lactose (as monohydrate).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Modified- release tablet.

150 mg tablet: White to pale yellow, round, approximate 7.7 mm in diameter, coated tablets imprinted with 'T' in black ink on one side and plain on the other side

300 mg tablet: White to pale yellow, round, approximate 9.6 mm in diameter, coated tablets imprinted with 'T1' in black ink on one side and plain on the other side

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

<Product name> is indicated for the treatment of major depressive episodes.

4.2 Posology and method of administration

Posology

Adults

The recommended starting dose is 150 mg, given once daily. An optimal dose was not established in clinical studies. If no improvement is seen after 4 weeks treatment at 150 mg, the dose may be increased to 300 mg, given once daily. There should be an interval of at least 24 hours between successive doses.

The onset of action for bupropion has been noted 14 days after starting therapy. As with all antidepressants the full antidepressant effect of <Product name> may not be evident until after several weeks of treatment.

Patients with depression should be treated for a sufficient period of at least 6 months to ensure that they are free from symptoms.

Insomnia is a very common adverse event which is often transient. Insomnia may be reduced by avoiding dosing at bedtime (provided there is at least 24 hours between doses).

– **Switching patients from bupropion prolonged-release tablets:**

When patients are switching from the twice daily prolonged -release bupropion tablet to <Product name> tablets, the same total daily dose should be given when possible.

Pediatric population

<Product name> is not indicated for use in children or adolescents aged less than 18 years (see section 4.4). The safety and efficacy of <Product name> in patients under 18 years of age have not been established.

Elderly

Efficacy has been shown equivocally in older people. In a clinical trial, older people followed the same dose regimen as for the adults (see Use in Adults). Greater sensitivity in some older individuals cannot be ruled out.

Hepatic impairment

<Product name> should be used with caution in patients with hepatic impairment (see section 4.4). Because of increased variability in the pharmacokinetics in patients with mild to moderate impairment the recommended dose in these patients is 150 mg once a day.

Renal impairment

The recommended dose in these patients is 150 mg once a day, as bupropion and its active metabolites may accumulate in such patients to a greater extent than usual (see section 4.4).

Method of administration

<Product name> tablets should be swallowed whole. The tablets should not be cut, crushed or chewed as this may lead to an increased risk of adverse effects including seizures.

<Product name> tablets can be taken with or without food.

Discontinuing therapy

Although discontinuation reactions (measured as spontaneously reported events rather than on rating scales) were not observed in clinical studies with <Product name>, a tapering off period may be considered. Bupropion is a selective inhibitor of the neuronal re-uptake of catecholamines and a rebound effect or discontinuation reactions cannot be ruled out.

4.3 Contraindications

<Product name> is contraindicated in patients

- with hypersensitivity to bupropion or any of the excipients listed in section 6.1.
- taking any other medicinal product containing bupropion, as the incidence of seizures is dose dependent and to avoid overdosage.
- with a current seizure disorder or any history of seizures.
- with a known central nervous system tumour.
- who, at any time during treatment, are undergoing abrupt withdrawal from alcohol or any medicinal product known to be associated with a risk of seizures on withdrawal (in particular benzodiazepines and benzodiazepine-like agents).
- with severe hepatic cirrhosis.
- with a current or previous diagnosis of bulimia or anorexia nervosa.

Concomitant use of <Product name> and monoamine oxidase inhibitors (MAOIs) is contraindicated. At least 14 days should elapse between discontinuation of irreversible MAOIs and initiation of treatment with <Product name>. For reversible MAOIs, a 24 hour period is sufficient.

4.4 Special warnings and precautions for use

Seizures

The recommended dose of modified-release bupropion tablets should not be exceeded, since bupropion is associated with a dose-related risk of seizure. The overall incidence of seizure with modified-release bupropion tablets in clinical trials at doses up to 450 mg/day was approximately 0.1%.

There is an increased risk of seizures occurring with the use of <Product name> in the presence of predisposing risk factors which lower the seizure threshold. Therefore, <Product name> should be administered with caution to patients with one or more conditions predisposing to a lowered seizure threshold.

All patients should be assessed for predisposing risk factors, which include

- Concomitant administration of other medicinal products known to lower the seizure threshold (e.g. antipsychotics, antidepressants, antimalarials, tramadol, theophylline, systemic steroids, quinolones and sedating antihistamines)
- Alcohol abuse (see also section 4.3)
- History of head trauma
- Diabetes treated with hypoglycaemics or insulin
- Use of stimulants or anorectic products

<Product name> should be discontinued and not recommenced in patients who experience a seizure while on treatment.

Interactions (see section 4.5)

Due to pharmacokinetic interactions, plasma levels of bupropion or its metabolites may be altered, which may increase the potential for undesirable effects (e.g. dry mouth, insomnia, seizures). Therefore, care should be taken when bupropion is given concomitantly with medicinal products which can induce or inhibit the metabolism of bupropion.

Bupropion inhibits metabolism by cytochrome P450 2D6. Caution is advised when medicinal products metabolised by this enzyme are administered concurrently.

In the literature it has been shown that medications that inhibit CYP2D6 may lead to reduced concentrations of endoxifen which is the active metabolite of tamoxifen. Therefore the use of bupropion, which is an inhibitor of CYP2D6, should whenever possible be avoided during tamoxifen treatment (see section 4.5).

Neuropsychiatry

Suicide/suicidal thoughts or clinical worsening

Depression is associated with an increased risk of suicidal thoughts, self harm and suicide (suicide-related events). This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery.

Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment.

A meta-analysis of placebo-controlled clinical trials of antidepressant drugs in adult patients with psychiatric disorders showed an increased risk of suicidal behaviour with antidepressants compared to

placebo in patients less than 25 years old.

Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present. It should be recognised that the onset of some neuropsychiatric symptoms could be related either to the underlying disease state or the drug therapy (see Neuropsychiatric symptoms including mania and bipolar disorder below; see section 4.8).

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medicinal product, in patients who experience the emergence of suicidal ideation/behaviour, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

Neuropsychiatric symptoms including mania and bipolar disorder

Neuropsychiatric symptoms have been reported (see section 4.8). In particular, psychotic and manic symptomatology has been observed, mainly in patients with a known history of psychiatric illness. Additionally, a major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone can increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Limited clinical data on use of bupropion in combination with mood stabilisers in patients with a history of bipolar disorder suggests a low rate of switch to mania. Prior to initiating treatment with an antidepressant, patients should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression.

Data in animals suggest a potential for abuse. However, studies on abuse liability in humans and extensive clinical experience show that bupropion has low abuse potential. Clinical experience with bupropion in patients receiving electroconvulsive therapy (ECT) is limited. Caution should be exercised in patients receiving ECT therapy concomitantly with bupropion treatment.

Hypersensitivity

<Product name> should be discontinued promptly if patients experience hypersensitivity reactions during treatment. Clinicians should be aware that symptoms may progress or recur following the discontinuation of <Product name> and should ensure symptomatic treatment is administered for an adequate length of time (at least one week). Symptoms typically include skin rash, pruritus, urticaria or chest pain, but more severe reactions may include angioedema, dyspnoea/bronchospasm, anaphylactic shock and erythema multiforme. Arthralgia, myalgia and fever have also been reported in association with rash and other symptoms suggestive of delayed hypersensitivity (see section 4.8). In most patients symptoms improved after stopping bupropion and initiating treatment with antihistamine or corticosteroids, and resolved over time.

Severe cutaneous adverse reactions (SCARs)

Severe cutaneous adverse reactions (SCARs) such as Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), acute generalised exanthematous pustulosis (AGEP), and drug reaction with eosinophilia and systemic symptoms (DRESS), which can be life-threatening or fatal, have been reported in association with bupropion treatment. Patients should be advised of the signs and symptoms and monitored closely for skin reactions. If signs and symptoms suggestive of these reactions appear, bupropion should be withdrawn immediately and an alternative treatment considered (as appropriate). If the patient has developed a serious reaction such as SJS, TEN, AGEP, or DRESS with the use of bupropion, the treatment must not be restarted in this patient at any time.

Cardiovascular disease

There is limited clinical experience of the use of bupropion to treat depression in patients with cardiovascular disease. Care should be exercised if it is used in these patients. However, bupropion was generally well tolerated in studies for smoking cessation in patients with ischaemic cardiovascular disease (see section 5.1)

Blood pressure

Bupropion has been shown not to induce significant increases in blood pressure in non-depressed patients with Stage I hypertension. However, in clinical practice, hypertension, which in some cases may be severe (see section 4.8) and require acute treatment, has been reported in patients receiving bupropion. This has been observed in patients with and without pre-existing hypertension.

A baseline blood pressure should be obtained at the start of treatment, with subsequent monitoring especially in patients with pre-existing hypertension. Consideration should be given to discontinuation of <Product name> if a clinically significant increase in blood pressure is observed.

Concomitant use of bupropion and a nicotine transdermal system may result in elevations of blood pressure.

Brugada syndrome

Bupropion may unmask Brugada syndrome, a rare hereditary disease of the cardiac sodium channel with characteristic ECG changes (ST segment elevation and T wave abnormalities in the right precordial leads), which may lead to cardiac arrest and/or sudden death. Caution is advised in patients with Brugada syndrome or risk factors such as a family history of cardiac arrest or sudden death.

Specific patient groups

Pediatric population - Treatment with antidepressants is associated with an increased risk of suicidal thinking and behaviour in children and adolescents with major depressive disorder and other psychiatric disorders.

Patients with hepatic impairment – Bupropion is extensively metabolised in the liver to active metabolites, which are further metabolised. No statistically significant differences in the pharmacokinetics of bupropion were observed in patients with mild to moderate hepatic cirrhosis compared with healthy volunteers, but bupropion plasma levels showed a higher variability between individual patients. Therefore <Product name> should be used with caution in patients with mild to moderate hepatic impairment (see section 4.2).

All patients with hepatic impairment should be monitored closely for possible undesirable effects (e.g. insomnia, dry mouth, seizures) that could indicate high drug or metabolite levels.

Patients with renal impairment– Bupropion is mainly excreted into the urine as its metabolites.

Therefore, in patients with renal impairment, bupropion and its active metabolites may accumulate to a greater extent than usual. The patient should be closely monitored for possible undesirable effects (e.g. insomnia, dry mouth, seizures) that could indicate high drug or metabolite levels (see section 4.2).

Older people – Efficacy has been shown equivocally in older people. In a clinical trial, older people followed the same dose regimen as for the adults (see sections 4.2 Use in Adults and 5.2). Greater sensitivity in some older individuals cannot be ruled out.

Interference with urine testing

Having an amphetamine-like chemical structure, bupropion interferes with the assay used in some rapid urine drug screens, which can result in false positive readings, particularly for amphetamines. A positive result should usually be confirmed with a more specific method.

Inappropriate routes of administration

<Product name> is intended for oral use only. The inhalation of crushed tablets or injection of dissolved bupropion has been reported, and may lead to a rapid release, faster absorption and a

potential overdose. Seizures and/or cases of death have been reported when bupropion has been administered intra-nasally or by parenteral injection.

Serotonin Syndrome

There have been post-marketing reports of serotonin syndrome, a potentially life-threatening condition, when <Product name> is co-administered with a serotonergic agent, such as Selective Serotonin Reuptake Inhibitors (SSRI) or Serotonin Norepinephrine Re-uptake Inhibitors (SNRIs) (see section 4.5). If concomitant treatment with other serotonergic agents is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases. Serotonin syndrome may include mental-status changes (e.g. agitation, hallucinations, coma), autonomic instability (e.g. tachycardia, labile blood pressure, hyperthermia), neuromuscular abnormalities (e.g. hyperreflexia, incoordination, rigidity), and/or gastrointestinal symptoms (e.g. nausea, vomiting, diarrhoea). If serotonin syndrome is suspected, a dose reduction or discontinuation of therapy should be considered depending on the severity of the symptoms.

Lactose

Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption, should not take this medicinal product.

4.5 Interaction with other medicinal products and other forms of interaction

Since monoamine oxidase A and B inhibitors also enhance the catecholaminergic pathways, by a different mechanism from bupropion, concomitant use of <Product name> and monoamine oxidase inhibitors (MAOIs) is contraindicated (see section 4.3) as there is an increased possibility of adverse reactions from their co-administration. At least 14 days should elapse between discontinuation of irreversible MAOIs and initiation of treatment with <Product name> For reversible MAOIs a 24 hour period is sufficient.

The effect of bupropion on other medicinal products

Although not metabolised by the CYP2D6 isoenzyme, bupropion and its main metabolite, hydroxybupropion inhibit the CYP2D6 pathway. Co-administration of bupropion and desipramine to healthy volunteers known to be extensive metabolisers of the CYP2D6 isoenzyme resulted in large (2- to 5-fold) increases in the C_{max} and AUC of desipramine. Inhibition of CYP2D6 was present for at least 7 days after the last dose of bupropion.

Concomitant therapy with medicinal products with narrow therapeutic indices that are predominantly metabolised by CYP2D6 should be initiated at the lower end of the dose range of the concomitant medicinal product. Such medicinal products include certain antidepressants (e.g. desipramine, imipramine), antipsychotics (e.g. risperidone, thioridazine), beta-blockers (e.g. metoprolol), serotonin selective reuptake inhibitors (SSRIs) and Type 1C antiarrhythmics (e.g. propafenone, flecainide). If <Product name> is added to the treatment regimen of a patient already receiving such a medicinal product, the need to decrease the dose of the original medicinal product should be considered. In these cases the expected benefit of treatment with <Product name> should be carefully compared with the potential risks.

There have been post-marketing reports of serotonin syndrome, a potentially life-threatening condition, when <Product name> is co-administered with a serotonergic agent, such as Selective Serotonin Reuptake Inhibitors (SSRI) or Serotonin Norepinephrine Re-uptake Inhibitors (SNRIs) (see section 4.4).

Drugs which require metabolic activation by CYP2D6 in order to be effective (e.g. tamoxifen), may have reduced efficacy when administered concomitantly with inhibitors of CYP2D6 such as bupropion (see section 4.4).

Although citalopram (a SSRI) is not primarily metabolised by CYP2D6, in one study, bupropion increased the C_{max} and AUC of citalopram by 30% and 40%, respectively. Co-administration of digoxin with bupropion may decrease digoxin levels. Digoxin AUC 0–24 h was decreased and renal clearance was increased in healthy volunteers, based on a cross-study comparison. Clinicians should be aware that digoxin levels may rise on discontinuation of bupropion and the patient should be monitored for possible digoxin toxicity.

The effect of other medicinal products on bupropion

Bupropion is metabolised to its major active metabolite hydroxybupropion primarily by the cytochrome P450 CYP2B6 (see section 5.2). Co-administration of medicinal products that may affect the metabolism of bupropion via CYP2B6 isoenzyme (e.g. CYP2B6 substrates: cyclophosphamide, ifosfamide, and CYP2B6 inhibitors: orphenadrine, ticlopidine, clopidogrel), may result in increased bupropion plasma levels and lower levels of active metabolite hydroxybupropion. The clinical consequences of the inhibition of the metabolism of bupropion via CYP2B6 enzyme and the consequent changes in the bupropion-hydroxybupropion ratio are currently unknown.

Since bupropion is extensively metabolised, caution is advised when bupropion is coadministered with medicinal products known to induce metabolism (e.g. carbamazepine, phenytoin, ritonavir, efavirenz) or inhibit metabolism (e.g. valproate), as these may affect its clinical efficacy and safety. In a series of studies in healthy volunteers, ritonavir (100 mg twice daily or 600 mg twice daily) or ritonavir 100 mg plus lopinavir 400 mg twice daily reduced the exposure of bupropion and its major metabolites in a dose dependent manner by approximately 20 to 80% (see section 5.2). Similarly, efavirenz 600 mg once daily for two weeks reduced the exposure of bupropion by approximately 55% in healthy volunteers. The clinical consequences of the reduced exposure are unclear, but may include decreased efficacy in the treatment of major depression. Patients receiving any of these drugs with bupropion may need increased doses of bupropion but the maximum recommended dose of bupropion should not be exceeded.

Other interaction information

Administration of <Product name> to patients receiving either levodopa or amantadine concurrently should be undertaken with caution. Limited clinical data suggest a higher incidence of undesirable effects (e.g. nausea, vomiting, and neuropsychiatric events – see section 4.8) in patients receiving bupropion concurrently with either levodopa or amantadine.

Although clinical data do not identify a pharmacokinetic interaction between bupropion and alcohol, there have been rare reports of adverse neuropsychiatric events or reduced alcohol tolerance in patients drinking alcohol during bupropion treatment. The consumption of alcohol during <Product name> treatment should be minimised or avoided.

There have been no pharmacokinetic studies with bupropion and co-administered benzodiazepines. Based on *in vitro* metabolic pathways, there is no basis for such an interaction. After coadministration of bupropion with diazepam in healthy volunteers, there was less sedation than when diazepam was administered alone.

There has been no systematic evaluation of the combination of bupropion with antidepressants (other than desipramine and citalopram), benzodiazepines (other than diazepam), or neuroleptics. There has also been limited clinical experience with St Johns Wort.

Concomitant use of <Product name> and a nicotine transdermal system (NTS) may result in elevations of blood pressure.

4.6 Fertility, pregnancy and lactation

Pregnancy

Some epidemiological studies of pregnancy outcomes following maternal exposure to bupropion in the first trimester have reported an association with increased risk of certain congenital cardiovascular malformations specifically ventricular septal defects and left outflow tract heart defects. These findings are not consistent across studies. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity (see section 5.3). <Product name> should not be used during pregnancy unless the clinical condition of the woman requires treatment with bupropion and alternative treatments are not an option.

Breastfeeding

Bupropion and its metabolites are excreted in human breast milk. A decision on whether to abstain from breast-feeding or to abstain from therapy with <Product name> should be made taking into account the benefit of breast-feeding to the newborn/infant and the benefit of <Product name> therapy to the mother.

Fertility

There are no data on the effect of bupropion on human fertility. A reproductive study in rats revealed no evidence of impaired fertility (see section 5.3).

4.7 Effects on ability to drive and use machines

As with other CNS acting drugs bupropion may affect ability to perform tasks that require judgement or motor and cognitive skill. Patients should therefore exercise caution before driving or use of machinery until they are reasonably certain <Product name> does not adversely affect their performance.

4.8 Undesirable effects

The list below provides information on the undesirable effects identified from clinical experience, categorised by incidence and System Organ Class body system.

Undesirable effects are ranked under headings of frequency using the following convention; very common ($\geq 1/10$); common ($\geq 1/100$, $< 1/10$); uncommon ($\geq 1/1,000$, $< 1/100$); rare ($\geq 1/10,000$, $< 1/1,000$); very rare ($< 1/10,000$); not known (cannot be estimated from the available data).

Blood and lymphatic system disorders	Not known	Anaemia, leukopenia and thrombocytopenia
Immune system disorders*	Common	Hypersensitivity reactions such as urticaria
	Very Rare	More severe hypersensitivity reactions including angioedema, dyspnoea/bronchospasm and anaphylactic shock. Arthralgia, myalgia and fever have also been reported in association with rash and other symptoms suggestive of delayed hypersensitivity. These symptoms may resemble serum sickness.
Metabolism and nutrition disorders	Common	Anorexia
	Uncommon	Weight loss
	Very Rare	Blood glucose disturbances

	Not known	hyponatraemia
Psychiatric disorders	Very comm	Insomnia (see section 4.2)
	Common	Agitation, anxiety
	Uncommon	Depression (see section 4.4), confusion
	Very rare	Aggression, hostility, irritability, restlessness, hallucinations, abnormal dreams including nightmares, depersonalisation, delusions, paranoid ideation
	Not known	Suicidal ideation and suicidal behaviour***, psychosis, dysphemia, panic attack
Nervous system disorders	Very Comm	Headache
	Common	Tremor, dizziness, taste disorders
	Uncommon	Concentration disturbance
	Rare	Seizures (see below)**
	Very Rare	Dystonia, ataxia, Parkinsonism, incoordination, memory impairment, paraesthesia, syncope
	Not known	Serotonin syndrome****
Eye disorders	Common	Visual disturbance
Ear and labyrinth disorders	Common	Tinnitus
Cardiac disorders	Uncommon	Tachycardia
	Very Rare	Palpitations
Vascular disorders	Common	Increased blood pressure (sometimes severe), flushing
	Very Rare	Vasodilation, postural hypotension
Gastrointestinal disorders	Very Comm	Dry mouth, gastrointestinal disturbance including nausea and vomiting
	Common	Abdominal pain, constipation
Hepatobiliary disorders	Very Rare	Elevated liver enzymes, jaundice, hepatitis
Skin and subcutaneous tissue disorders*	Common	Rash, pruritus, sweating
	Very Rare	Erythema multiforme, Stevens Johnson syndrome, exacerbation of psoriasis
	Not known	Systemic lupus erythematosus syndrome aggravated, Cutaneous lupus erythematosus, acute generalised exanthematous pustulosis Toxic epidermal necrolysis Drug reaction with eosinophilia and systemic symptoms
Musculoskeletal and connective tissue disorders	Very Rare	Twitching
Renal and urinary disorders	Very Rare	Urinary frequency and/or retention, urinary incontinence
General disorders and administration site conditions	Common	Fever, chest pain, asthenia

* Hypersensitivity may manifest as skin reactions. See “Immune system disorders” and “Skin and subcutaneous tissue disorders”.

** The incidence of seizures is approximately 0.1% (1/1,000). The most common type of seizures is generalised tonic-clonic seizures, a seizure type which can result in some cases in post-ictal confusion or memory impairment (see section 4.4).

*** Cases of suicidal ideation and suicidal behaviour have been reported during bupropion therapy or early after treatment discontinuation (see section 4.4).

**** Serotonin syndrome may occur as a consequence of an interaction between bupropion and a serotonergic medicinal product such as Selective Serotonin Reuptake Inhibitors (SSRI) or Serotonin Norepinephrine Re-uptake Inhibitors (SNRI) (see section 4.4).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorization 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 national reporting system listed in [Appendix V](#).

4.9 Overdose

Acute ingestion of doses in excess of 10 times the maximum therapeutic dose has been reported. In addition to those events reported as Undesirable Effects, overdose has resulted in symptoms including drowsiness, loss of consciousness and/or electrocardiogram (ECG) changes such as conduction disturbances (including QRS prolongation), arrhythmias and tachycardia. QTc prolongation has also been reported but was generally seen in conjunction with QRS prolongation and increased heart rate.

Although most patients recovered without sequelae, deaths associated with bupropion have been reported rarely in patients ingesting large overdoses of the drug. Serotonin syndrome has also been reported.

Treatment: In the event of overdose, hospitalisation is advised. ECG and vital signs should be monitored.

Ensure an adequate airway, oxygenation and ventilation. The use of activated charcoal is recommended. No specific antidote for bupropion is known. Further management should be as clinically indicated.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other antidepressants, ATC code: N06 AX12.

Mechanism of action

Bupropion is a selective inhibitor of the neuronal re-uptake of catecholamines (noradrenaline and dopamine) with minimal effect on the re-uptake of indolamines (serotonin) and does not inhibit either monoamine oxidase. The mechanism of action of bupropion as an antidepressant is unknown.

However, it is presumed that this action is mediated by noradrenergic and/or dopaminergic mechanisms.

Clinical efficacy

The antidepressant activity of bupropion was studied in a clinical programme involving a total of 1155

bupropion modified-release tablets patients and 1868 bupropion modified-release tablets patients with Major Depressive Disorder (MDD). Seven of the studies examined the efficacy of bupropion modified-release tablets: 3 were conducted in the EU at doses up to 300 mg/day and 4 were conducted in the US over a flexible dose range of up to 450 mg/day. In addition, 9 studies in MDD with bupropion modified-release tablets are considered to be supportive based on the bioequivalence of bupropion modified-release (once daily) to the sustained release (twice daily) tablet.

Bupropion modified-release tablets demonstrated statistical superiority over placebo as measured by improvement in the Montgomery-Asberg Depression Rating Scale (MADRS) total score in 1 of 2 identical studies utilising doses in the range 150-300 mg. Response and remission rates were also statistically significantly higher with bupropion modified-release tablets compared to placebo. In a third study in elderly patients, statistical superiority over placebo was not achieved on the primary parameter, mean change from baseline in MADRS (Last Observation Carried Forward endpoint) although statistically significant effects were seen on a secondary (Observed Case) analysis.

Significant benefit was shown on the primary endpoint in 2 of 4 US studies with bupropion modified-release tablets (300-450 mg). Of the 2 positive studies, one was a placebo controlled study in patients with MDD and one was an active controlled study in patients with MDD.

In a relapse prevention study, patients responding to 8 weeks of acute treatment with open-label bupropion modified-release tablets (300 mg/day) were randomised to either bupropion modified-release tablets or placebo for a further 44 weeks. Bupropion modified-release tablets demonstrated a statistically significant superiority compared to placebo ($P < 0.05$) on the primary outcome measure. The incidence of maintenance of effect during the 44 week double blind follow-up period was 64% and 48% for bupropion modified-release and placebo, respectively.

Clinical safety

The prospectively observed proportion of cardiac birth defects in pregnancies with prenatal exposure to bupropion in the first trimester in the international Pregnancy Registry was 9/675 (1.3%). In a retrospective study there was no greater proportion of congenital malformations or cardiovascular malformations amongst more than a thousand first trimester exposures to bupropion compared with the use of other antidepressants.

In a retrospective analysis using data from the National Birth Defects Prevention Study, a statistically significant association was observed between the occurrence of a left outflow tract heart defect in the infant and self-reported maternal bupropion use in early pregnancy. No association was observed between maternal bupropion use and any other type of cardiac defect or with all categories of heart defects combined.

A further analysis of data from the Slone Epidemiology Center Birth Defects Study found no statistically significant increase of left outflow tract heart defects with maternal bupropion use. However, a statistically significant association was observed for ventricular septal defects following the use of bupropion alone during the first trimester.

In a study in healthy volunteers, no clinically significant effect of modified-release bupropion tablets (450 mg/day) compared with placebo was observed on QTcF interval after 14 days of dosing to steady state.

5.2 Pharmacokinetic properties

Absorption

After oral administration of 300 mg bupropion hydrochloride once daily as the modified-release tablet to healthy volunteers, maximum plasma concentrations (C_{max}) of approximately 160 ng/ml are observed at approximately 5 hours. At steady state, the C_{max} and AUC values of hydroxybupropion are approximately 3 and 14 times that of bupropion, respectively. The C_{max} of threohydrobupropion at

steady state is similar to that of bupropion and the AUC is approximately 5 times higher while the plasma concentrations of erythrohydrobupropion are comparable to those of bupropion. Peak plasma

levels of hydroxybupropion are reached at 7 hours while those for threohydrobupropion and erythrohydrobupropion are reached at 8 hours. The AUC and C_{max} values of bupropion and its active metabolites hydroxybupropion and threohydrobupropion increase dose proportionally over a dose range of 50-200 mg following single doses and over a dose range of 300-450 mg/day following chronic dosing.

The absolute bioavailability of bupropion is not known; urinary excretion data, however, show that at least 87% of the dose of bupropion is absorbed.

The absorption of bupropion modified-release tablets is not significantly influenced when taken concurrently with food.

Distribution

Bupropion is widely distributed with an apparent volume of distribution of approximately 2000 L. Bupropion, hydroxybupropion and threohydrobupropion bind moderately to plasma proteins (84%, 77% and 42%, respectively).

Bupropion and its active metabolites are excreted in human breast milk. Animal studies show that bupropion and its active metabolites pass the blood-brain barrier and the placenta. Positron Emission Tomography studies in healthy volunteers demonstrate that bupropion penetrates the CNS and binds to the striatal dopamine reuptake transporter (approximately 25% at 150 mg twice daily).

Biotransformation

Bupropion is extensively metabolised in humans. Three pharmacologically active metabolites have been identified in plasma: hydroxybupropion and the amino-alcohol isomers, threohydrobupropion and erythrohydrobupropion. These may have clinical importance, as their plasma concentrations are as high or higher than those of bupropion. The active metabolites are further metabolised to inactive metabolites (some of which have not been fully characterised but may include conjugates) and excreted in the urine.

In vitro studies indicate that bupropion is metabolised to its major active metabolite hydroxybupropion primarily by the CYP2B6, while CYP1A2, 2A6, 2C9, 3A4 and 2E1 are less involved. In contrast, formation of threohydrobupropion involves carbonyl reduction but does not involve cytochrome P450 isoenzymes (see section 4.5).

The inhibition potential of threohydrobupropion and erythrohydrobupropion towards cytochrome P450 has not been studied.

Bupropion and hydroxybupropion are both inhibitors of the CYP2D6 isoenzyme with K_i values of 21 and 13.3 μ M, respectively (see section 4.5).

Bupropion has been shown to induce its own metabolism in animals following sub-chronic administration. In humans, there is no evidence of enzyme induction of bupropion or hydroxybupropion in volunteers or patients receiving recommended doses of bupropion hydrochloride for 10 to 45 days.

Elimination

Following oral administration of 200 mg of 14 C-bupropion in humans, 87% and 10% of the radioactive dose were recovered in the urine and faeces, respectively. The fraction of the dose of bupropion excreted unchanged was only 0.5%, a finding consistent with the extensive metabolism of bupropion. Less than 10% of this 14 C dose was accounted for in the urine as active metabolites.

The mean apparent clearance following oral administration of bupropion hydrochloride is approximately 200 L/hr and the mean elimination half-life of bupropion is approximately 20 hours.

The elimination half-life of hydroxybupropion is approximately 20 hours. The elimination half-lives for threohydrobupropion and erythrohydrobupropion are longer (37 and 33 hours, respectively) and steady-state AUC values are 8 and 1.6 times higher than that of bupropion, respectively. Steady-state for bupropion and its metabolites is reached within 8 days.

The insoluble shell of the modified-release tablet may remain intact during gastrointestinal transit and be eliminated in the faeces.

Special patient population:

Renal impairment

The elimination of bupropion and its active major metabolites may be reduced in patients with impaired renal function. Limited data in patients with end-stage renal failure or moderate to severely impaired renal function indicate that exposure to bupropion and/or its metabolites was increased (see section 4.4).

Hepatic impairment

The pharmacokinetics of bupropion and its active metabolites were not statistically significantly different in patients with mild to moderate cirrhosis when compared to healthy volunteers, although more variability was observed between individual patients (see section 4.4). For patients with severe hepatic cirrhosis, the bupropion C_{max} and AUC were substantially increased (mean difference approximately 70% and 3-fold, respectively) and more variable when compared to the values in healthy volunteers; the mean half-life was also longer (by approximately 40%). For hydroxybupropion, the mean C_{max} was lower (by approximately 70%), the mean AUC tended to be higher (by approximately 30%), the median T_{max} was later (by approximately 20 hrs), and the mean half-lives were longer (by approximately 4-fold) than in healthy volunteers. For threohydrobupropion and erythrohydrobupropion, the mean C_{max} tended to be lower (by approximately 30%), the mean AUC tended to be higher (by approximately 50%), the median T_{max} was later (by approximately 20 hrs), and the mean half-life was longer (by approximately 2-fold) than in healthy volunteers (see section 4.3).

Elderly

Pharmacokinetic studies in the elderly have shown variable results. A single dose study showed that the pharmacokinetics of bupropion and its metabolites in the elderly do not differ from those in the younger adults. Another pharmacokinetic study, single and multiple dose, has suggested that accumulation of bupropion and its metabolites may occur to a greater extent in the elderly. Clinical experience has not identified differences in tolerability between older and younger patients, but greater sensitivity in older patients cannot be ruled out (see section 4.4).

In-vitro release of bupropion with alcohol

In-vitro tests showed that at high alcohol concentrations (up to 40%), bupropion is released more rapidly from the modified-release formulation (up to 20% dissolved at 2 hours) (see section 4.5).

5.3 Preclinical safety data

Reproduction toxicity studies conducted in rats at exposures similar to those obtained at the maximum recommended human dose (based on systemic data on exposure) revealed no adverse effects on fertility, pregnancy and foetal development. Reproduction toxicity studies conducted in rabbits treated with doses up to 7 times the maximum recommended human dose based on a mg/m² basis (no systemic data on exposures are available) only revealed a slight increase in skeletal variations (increased incidence of common anatomical variation of an accessory thoracic rib and delayed

ossification of phalanges). Moreover at maternally toxic doses, a decrease of rabbits foetal weight was reported.

In animal experiments bupropion doses several times higher than therapeutic doses in humans caused, amongst others, the following dose-related symptoms: ataxia and convulsions in rats, general weakness, trembling and emesis in dogs and increased lethality in both species. Due to enzyme induction in animals but not in humans, systemic exposures in animals were similar to the systemic exposures seen in humans at the maximum recommended dose.

Liver changes are seen in animal studies but these reflect the action of a hepatic enzyme inducer. At recommended doses in humans, bupropion does not induce its own metabolism. This suggests that the hepatic findings in laboratory animals have only limited importance in the evaluation and risk assessment of bupropion.

Genotoxicity data indicate that bupropion is a weak bacterial mutagen, but not a mammalian mutagen, and therefore is of no concern as a human genotoxic agent. Mouse and rat studies confirm the absence of carcinogenicity in these species.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core:

Hydroxypropylcellulose
Glycerol Dibehenate
Stearic Acid

Tablet coating:

First coating:

Hypromellose

Second Coating:

Ethylcellulose
Povidone K90
Lactose Monohydrate
Triethyl Citrate

Third coating:

Methacrylic Acid-Ethyl Acrylate Copolymer (1:1) Dispersion 30 %
Triethyl Citrate
Macrogol 6000
Silica, colloidal hydrated

Printing ink:

Shellac, black iron oxide (E 172), propylene glycol

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years.

6.4 Special precautions for storage

This medicinal product does not require any special temperature storage conditions.

Store in the original package in order to protect from moisture and light.

6.5 Nature and contents of container

White opaque high-density polyethylene (HDPE) bottles, including 2 in 1 desiccant canister(s) 1 g containing activated silica gel & activated carbon (60:40) and closed with a polypropylene child-resistant closure that include an induction seal liner.

150 mg: 30, 60, 90 tablets.

300 mg: 30, 60, 90 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements for disposal.

7. MARKETING AUTHORISATION HOLDER

[To be completed nationally]

8. MARKETING AUTHORISATION NUMBER(S)

[To be completed nationally]

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

[To be completed nationally]

10. DATE OF REVISION OF THE TEXT

2026-02-05