

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use ROXYBOND™ safely and effectively. See full prescribing information for ROXYBOND.

ROXYBOND (oxycodone hydrochloride) tablets, for oral use, CII
Initial U.S. Approval: 1950

WARNING: ADDICTION, ABUSE, AND MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME; CYTOCHROME P450 3A4 INTERACTION; and RISKS FROM CONCOMITANT USE WITH BENZODIAZEPINES OR OTHER CNS DEPRESSANTS

See full prescribing information for complete boxed warning.

- ROXYBOND exposes users to risks of addiction, abuse, and misuse, which can lead to overdose and death. Assess patient's risk before prescribing and monitor regularly for these behaviors and conditions. (5.1)
- Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase. (5.2)
- Accidental ingestion of ROXYBOND, especially by children, can result in a fatal overdose of oxycodone. (5.2)
- Prolonged use of ROXYBOND during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated. If prolonged opioid use is required in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available. (5.3)
- Concomitant use with CYP3A4 inhibitors (or discontinuation of CYP3A4 inducers) can result in a fatal overdose of oxycodone from ROXYBOND. (5.4, 7, 12.3)
- Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing for use in patients for whom alternative treatment options are inadequate; limit dosages and durations to the minimum required; and follow patients for signs and symptoms of respiratory depression and sedation. (5.5, 7)

INDICATIONS AND USAGE

ROXYBOND is an opioid agonist indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. (1)

Limitations of Use (1)

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, reserve ROXYBOND for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or non-opioid combination products):

- Have not been tolerated, or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

DOSAGE AND ADMINISTRATION

- Use the lowest effective dosage for the shortest duration consistent with individual patient treatment goals. (2.1)
- Individualize dosing based on severity of pain, patient response, prior analgesic experience, and risk factors for addiction, abuse, and misuse. (2.1)
- Initiate dosing with a range of 5 to 15 mg every 4 to 6 hours as needed for pain. (2.2)

- For control of chronic pain, administer ROXYBOND on a regularly scheduled basis, at the lowest dosage level to achieve adequate analgesia. (2.2)
- Individually titrate ROXYBOND to a dose that provides adequate analgesia and minimizes adverse reactions. (2.3)
- Do not stop ROXYBOND abruptly in a physically dependent patient. (2.4)

DOSAGE FORMS AND STRENGTHS

Tablets: 5 mg, 15 mg, 30 mg (3)

CONTRAINDICATIONS

- Significant respiratory depression (4)
- Acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment (4)
- Known or suspected gastrointestinal obstruction, including paralytic ileus (4)
- Hypersensitivity to oxycodone (4)

WARNINGS AND PRECAUTIONS

- Life-Threatening Respiratory Depression in Patients with Chronic Pulmonary Disease or in Elderly, Cachectic, or Debilitated Patients: Monitor closely, particularly during initiation and titration. (5.6)
- Adrenal Insufficiency: If diagnosed, treat with physiologic replacement of corticosteroids, and wean patient off of the opioid. (5.7)
- Severe Hypotension: Monitor during dosage initiation and titration. Avoid use of ROXYBOND in patients with circulatory shock. (5.8)
- Risks of Use in Patients with Increased Intracranial Pressure, Brain Tumors, Head Injury, or Impaired Consciousness: Monitor for sedation and respiratory depression. Avoid use of ROXYBOND in patients with impaired consciousness or coma. (5.9)

ADVERSE REACTIONS

Most common adverse reactions ($\geq 3\%$): nausea, constipation, vomiting, headache, pruritus, insomnia, dizziness, asthenia, and somnolence. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Inspirin Delivery Sciences at 1-973-804-9300 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Serotonergic Drugs: Concomitant use may result in serotonin syndrome. Discontinue ROXYBOND if serotonin syndrome is suspected. (7)
- Mixed Agonist/Antagonist and Partial Agonist Opioid Analgesics: Avoid use with ROXYBOND because they may reduce analgesic effect of ROXYBOND or precipitate withdrawal symptoms. (7)
- Monoamine Oxidase Inhibitors (MAOIs): Can potentiate the effects of morphine. Avoid concomitant use in patients receiving MAOIs or within 14 days of stopping treatment with an MAOI. (7)

USE IN SPECIFIC POPULATIONS

- Pregnancy: May cause fetal harm. (8.1)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 4/2017

FULL PRESCRIBING INFORMATION: CONTENTS*

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FULL PRESCRIBING INFORMATION

WARNING: ADDICTION, ABUSE, AND MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME; CYTOCHROME P450 3A4 INTERACTION; and RISKS FROM CONCOMITANT USE WITH BENZODIAZEPINES OR OTHER CNS DEPRESSANTS

Addiction, Abuse, and Misuse

ROXYBOND exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk prior to prescribing ROXYBOND, and monitor all patients regularly for the development of these behaviors and conditions [see *Warnings and Precautions* (5.1)].

Life-Threatening Respiratory Depression

Serious, life-threatening, or fatal respiratory depression may occur with use of ROXYBOND. Monitor for respiratory depression, especially during initiation of ROXYBOND or following a dose increase. [see *Warnings and Precautions* (5.2)].

Accidental Ingestion

Accidental ingestion of even one dose of ROXYBOND, especially by children, can result in a fatal overdose of oxycodone [see *Warnings and Precautions* (5.2)].

Neonatal Opioid Withdrawal Syndrome

Prolonged use of ROXYBOND during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available [see *Warnings and Precautions* (5.3)].

Cytochrome P450 3A4 Interaction

The concomitant use of ROXYBOND with all cytochrome P450 3A4 inhibitors may result in an increase in oxycodone plasma concentrations, which could increase or prolong adverse reactions and may cause potentially fatal respiratory depression. In addition, discontinuation of a concomitantly used cytochrome P450 3A4 inducer may result in an increase in oxycodone plasma concentration. Monitor patients receiving ROXYBOND and any CYP3A4 inhibitor or inducer [see *Warnings and Precautions* (5.4), *Drug Interactions* (7), *Clinical Pharmacology* (12.3)].

Risks From Concomitant Use With Benzodiazepines Or Other CNS Depressants

Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death [see *Warnings and Precautions* (5.5), *Drug Interactions* (7)].

- Reserve concomitant prescribing of ROXYBOND and benzodiazepines or other CNS depressants for use in patients for whom alternative treatment options are inadequate.
- Limit dosages and durations to the minimum required.
- Follow patients for signs and symptoms of respiratory depression and sedation.

FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

ROXYBOND is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.

Limitations of Use

Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses [see *Warnings and Precautions (5.1)*], reserve ROXYBOND for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or opioid combination products):

- Have not been tolerated or are not expected to be tolerated,
- Have not provided adequate analgesia or are not expected to provide adequate analgesia.

2 DOSAGE AND ADMINISTRATION

2.1 Important Dosage and Administration Instructions

Use the lowest effective dosage for the shortest duration consistent with individual patient treatment goals [see *Warnings and Precautions (5)*].

Initiate the dosing regimen for each patient individually, taking into account the patient's severity of pain, patient response, prior analgesic treatment experience, and risk factors for addiction, abuse, and misuse [see *Warnings and Precautions (5.1)*].

Monitor patients closely for respiratory depression, especially within the first 24 to 72 hours of initiating therapy and following dosage increases with ROXYBOND and adjust the dosage accordingly [see *Warnings and Precautions (5.2)*].

2.2 Initial Dosage

Use of ROXYBOND as the First Opioid Analgesic

Initiate treatment with ROXYBOND in a dosing range of 5 to 15 mg every 4 to 6 hours as needed for pain. Titrate the dose based upon the individual patient's response to their initial dose of ROXYBOND. This dose can then be adjusted to an acceptable level of analgesia taking into account side effects experienced by the patient.

For control of severe chronic pain, consider dosing ROXYBOND on a regularly scheduled basis, every 4 to 6 hours, at the lowest dosage level that will achieve adequate analgesia.

Although it is not possible to list every condition that is important to the selection of the initial dose of ROXYBOND, attention should be given to: 1) the daily dose, potency, and characteristics of any prior opioid 2) the reliability of any relative potency estimate used to calculate the dose of oxycodone needed, 3) the degree of opioid tolerance, 4) the general condition and medical status of the patient, and 5) the balance between pain control and adverse experiences.

Conversion from Other Opioids to ROXYBOND

There is inter-patient variability in the potency of opioid drugs and opioid formulations. Therefore, a conservative approach is advised when determining the total daily dosage of ROXYBOND. It is safer to underestimate a patient's 24-hour ROXYBOND dosage than to overestimate the 24-hour ROXYBOND dosage and manage an adverse reaction due to overdose. If a patient has been receiving opioid-containing medications prior to taking ROXYBOND, the potency of the prior opioid relative to oxycodone should be factored into the selection of the total daily dose (TDD) of oxycodone.

In converting patients from other opioids to ROXYBOND, close observation and adjustment of dosage based upon the patient's response to ROXYBOND is imperative. Administration of supplemental analgesia for breakthrough or incident pain and titration of the TDD of ROXYBOND may be necessary, especially in patients who have disease states that are changing rapidly.

Conversion From Fixed-Ratio Opioid/Acetaminophen, Opioid/Aspirin, or Opioid/Nonsteroidal Combination Drugs

When converting patients from fixed ratio opioid/non-opioid drug regimens, a decision should be made whether or not to continue the non-opioid analgesic. If a decision is made to discontinue the use of non-opioid analgesic, it may be necessary to titrate the dose of ROXYBOND in response to the level of analgesia and adverse effects afforded by the dosing regimen. If the non-opioid regimen is continued as a separate single entity agent, the starting dose of ROXYBOND should be based upon the most recent dose of opioid as a baseline for further titration of oxycodone. Incremental increases should be gauged according to side effects to an acceptable level of analgesia.

Conversion from ROXYBOND to Extended-Release Oxycodone

The relative bioavailability of ROXYBOND compared to extended-release oxycodone products is unknown, so conversion to extended-release oxycodone must be accompanied by close observation for signs of excessive sedation and respiratory depression.

Conversion from Oxycodone Immediate-Release Tablets

Oxycodone pharmacokinetics are similar for ROXYBOND and oxycodone immediate-release tablets. Patients can be converted from oxycodone immediate-release to the same dose and dosing regimen of ROXYBOND.

2.3 Titration and Maintenance of Therapy

Individually titrate ROXYBOND to a dose that provides adequate analgesia and minimizes adverse reactions. Continually reevaluate patients receiving ROXYBOND to assess the maintenance of pain control and the relative incidence of adverse reactions, as well as monitoring for the development of addiction, abuse, or misuse [see *Warnings and Precautions (5.1)*]. Frequent communication is important among the prescriber, other members of the healthcare team, the patient, and the caregiver/family during periods of changing analgesic requirements, including initial titration.

If the level of pain increases after dosage stabilization, attempt to identify the source of increased pain before increasing the ROXYBOND dosage. If unacceptable opioid-related adverse reactions are observed, consider reducing the dosage. Adjust the dosage to obtain an appropriate balance between management of pain and opioid-related adverse reactions.

2.4 Discontinuation of ROXYBOND

When a patient who has been taking ROXYBOND regularly and may be physically-dependent no longer requires therapy with ROXYBOND, taper the dose gradually, by 25% to 50% every 2 to 4 days, while monitoring carefully for signs and symptoms of withdrawal. If the patient develops these signs or symptoms, raise the dose to the previous level and taper more slowly, either by increasing the interval between decreases, decreasing the amount of change in dose, or both. Do not abruptly discontinue ROXYBOND in a physically-dependent patient [*see Warnings and Precautions (5.1), Drug Abuse and Dependence (9.3)*].

3 DOSAGE FORMS AND STRENGTHS

ROXYBOND (oxycodone hydrochloride) tablets, 5 mg, 15 mg and 30 mg with the following characteristics:

Strength	Tablet Shape	Tablet Color	Ink-Print on Tablet Side 1	Ink-Print on Tablet Side 2
5 mg	Round coated tablets	White	IDT/O 5	None
15 mg		Green	IDT/O 15	None
30 mg		Blue	IDT/O 30	None

4 CONTRAINDICATIONS

ROXYBOND is contraindicated in patients with:

- Significant respiratory depression [*see Warnings and Precautions (5.2)*]
- Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment or hypercarbia [*see Warnings and Precautions (5.6)*]
- Known or suspected gastrointestinal obstruction, including paralytic ileus [*see Warnings and Precautions (5.10)*]
- Known hypersensitivity (e.g., anaphylaxis) to oxycodone [*see Adverse Reactions (6.2)*]

5 WARNINGS AND PRECAUTIONS

5.1 Addiction, Abuse, and Misuse

ROXYBOND contains oxycodone, a Schedule II controlled substance. As an opioid, ROXYBOND exposes users to the risks of addiction, abuse, and misuse [*see Drug Abuse and Dependence (9)*].

Although the risk of addiction in any individual is unknown, it can occur in patients appropriately prescribed ROXYBOND. Addiction can occur at recommended dosages, when taken as directed, and if the drug is misused or abused.

Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing ROXYBOND, and monitor all patients receiving ROXYBOND for the development of these behaviors and conditions. Risks are increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). The potential for these risks should not, however, prevent the proper management of pain in any given patient. Patients at increased risk may be prescribed opioids such as ROXYBOND, but use in such patients necessitates intensive counseling about the risks and proper use of ROXYBOND along with intensive monitoring for signs of addiction, abuse, and misuse.

Opioids are sought by drug abusers and people with addiction disorders and are subject to criminal diversion. Consider these risks when prescribing or dispensing ROXYBOND. Strategies to reduce these risks include prescribing the drug in the smallest appropriate quantity and advising the patient on the proper disposal of unused drugs [see *Patient Counseling Information (17)*]. Contact local state professional licensing board or state controlled substances authority for information on how to prevent and detect abuse or diversion of this product.

5.2 Life-Threatening Respiratory Depression

Serious, life-threatening, or fatal respiratory depression has been reported with the use of opioids, even when used as recommended. Respiratory depression, if not immediately recognized and treated, may lead to respiratory arrest and death. Management of respiratory depression may include close observation, supportive measures, and use of opioid antagonists, depending on the patient's clinical status [see *Overdosage (10)*]. Carbon dioxide (CO₂) retention from opioid-induced respiratory depression can exacerbate the sedating effects of opioids.

While serious, life-threatening, or fatal respiratory depression can occur at any time during the use of ROXYBOND, the risk is greatest during the initiation of therapy or following a dosage increase. Monitor patients closely for respiratory depression, especially within the first 24 to 72 hours of initiating therapy with and following dosage increases of ROXYBOND.

To reduce the risk of respiratory depression, proper dosing and titration of ROXYBOND are essential [see *Dosage and Administration (2)*]. Overestimating the ROXYBOND dosage when converting patients from another opioid product can result in fatal overdose with the first dose.

Accidental ingestion of even one dose of ROXYBOND, especially by children, can result in respiratory depression and death due to an overdose of oxycodone.

5.3 Neonatal Opioid Withdrawal Syndrome

Prolonged use of ROXYBOND during pregnancy can result in withdrawal in the neonate. Neonatal opioid withdrawal syndrome, unlike opioid withdrawal syndrome in adults, may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. Observe newborns for signs of neonatal opioid withdrawal

syndrome and manage accordingly. Advise pregnant women using opioids for a prolonged period of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available [*see Use in Specific Populations (8.1), Patient Counseling Information (17)*].

5.4 Risks of Concomitant Use or Discontinuation of Cytochrome P450 3A4 Inhibitors and Inducers

Concomitant use of ROXYBOND with a CYP3A4 inhibitor, such as macrolide antibiotics (e.g., erythromycin), azole-antifungal agents (e.g., ketoconazole), and protease inhibitors (e.g., ritonavir), may increase plasma concentrations of oxycodone and prolong opioid adverse reactions, which may cause potentially fatal respiratory depression [*see Warnings and Precautions (5.2)*], particularly when an inhibitor is added after a stable dose of ROXYBOND is achieved. Similarly, discontinuation of a CYP3A4 inducer, such as rifampin, carbamazepine, and phenytoin, in ROXYBOND-treated patients may increase oxycodone plasma concentrations and prolong opioid adverse reactions. When using ROXYBOND with CYP3A4 inhibitors or discontinuing CYP3A4 inducers in ROXYBOND-treated patients, monitor patients closely at frequent intervals and consider dosage reduction of ROXYBOND until stable drug effects are achieved [*see Drug Interactions (7)*].

Concomitant use of ROXYBOND with CYP3A4 inducers or discontinuation of a CYP3A4 inhibitor could decrease oxycodone plasma concentrations, decrease opioid efficacy or, possibly, lead to a withdrawal syndrome in a patient who had developed physical dependence to oxycodone. When using ROXYBOND with CYP3A4 inducers or discontinuing CYP3A4 inhibitors, monitor patients closely at frequent intervals and consider increasing the opioid dosage if needed to maintain adequate analgesia or if symptoms of opioid withdrawal occur [*see Drug Interactions (7)*].

5.5 Risks from Concomitant Use with Benzodiazepines or Other CNS Depressants

Profound sedation, respiratory depression, coma, and death may result from the concomitant use of ROXYBOND with benzodiazepines or other CNS depressants (e.g., non-benzodiazepine sedatives/hypnotics, anxiolytics, tranquilizers, muscle relaxants, general anesthetics, antipsychotics, other opioids, alcohol). Because of these risks, reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate.

Observational studies have demonstrated that concomitant use of opioid analgesics and benzodiazepines increases the risk of drug-related mortality compared to use of opioid analgesics alone. Because of similar pharmacological properties, it is reasonable to expect similar risk with the concomitant use of other CNS depressant drugs with opioid analgesics [*see Drug Interactions (7)*].

If the decision is made to prescribe a benzodiazepine or other CNS depressant concomitantly with an opioid analgesic, prescribe the lowest effective dosages and minimum durations of concomitant use. In patients already receiving an opioid analgesic, prescribe a lower initial dose of the benzodiazepine or other CNS depressant than indicated in the absence of an opioid, and titrate based on clinical response. If an opioid analgesic is initiated in a patient already taking a benzodiazepine or other CNS depressant, prescribe a lower initial dose of the opioid analgesic,

and titrate based on clinical response. Follow patients closely for signs and symptoms of respiratory depression and sedation.

Advise both patients and caregivers about the risks of respiratory depression and sedation when ROXYBOND is used with benzodiazepines or other CNS depressants (including alcohol and illicit drugs). Advise patients not to drive or operate dangerous machinery until the effects of concomitant use of the benzodiazepine or other CNS depressant have been determined. Screen patients for risk of substance use disorders, including opioid abuse and misuse, and warn them of the risk for overdose and death associated with the use of additional CNS depressants including alcohol and illicit drugs [see *Drug Interactions (7)*, *Patient Counseling Information (17)*].

5.6 Life-Threatening Respiratory Depression in Patients with Chronic Pulmonary Disease or in Elderly, Cachectic, or Debilitated Patients

The use of ROXYBOND in patients with acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment is contraindicated.

Patients with Chronic Pulmonary Disease: ROXYBOND-treated patients with significant chronic obstructive pulmonary disease or cor pulmonale, and those with a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression are at increased risk of decreased respiratory drive including apnea, even at recommended dosages of ROXYBOND [see *Warnings and Precautions (5.2)*].

Elderly, Cachectic, or Debilitated Patients: Life-threatening respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients because they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients [see *Warnings and Precautions (5.2)*].

Monitor patients closely, particularly when initiating and titrating ROXYBOND and when ROXYBOND is given concomitantly with other drugs that depress respiration [see *Warnings and Precautions (5.2)*]. Alternatively, consider the use of non-opioid analgesics in these patients.

5.7 Adrenal Insufficiency

Cases of adrenal insufficiency have been reported with opioid use, more often following greater than one month of use. Presentation of adrenal insufficiency may include non-specific symptoms and signs including nausea, vomiting, anorexia, fatigue, weakness, dizziness, and low blood pressure. If adrenal insufficiency is suspected, confirm the diagnosis with diagnostic testing as soon as possible. If adrenal insufficiency is diagnosed, treat with physiologic replacement doses of corticosteroids. Wean the patient off of the opioid to allow adrenal function to recover and continue corticosteroid treatment until adrenal function recovers. Other opioids may be tried as some cases reported use of a different opioid without recurrence of adrenal insufficiency. The information available does not identify any particular opioids as being more likely to be associated with adrenal insufficiency.

5.8 Severe Hypotension

ROXYBOND may cause severe hypotension including orthostatic hypotension and syncope in ambulatory patients. There is increased risk in patients whose ability to maintain blood pressure has already been compromised by a reduced blood volume or concurrent administration of certain CNS depressant drugs (e.g., phenothiazines or general anesthetics) [*see Drug Interactions (7)*]. Monitor these patients for signs of hypotension after initiating or titrating the dosage of ROXYBOND. In patients with circulatory shock, use of ROXYBOND may cause vasodilation that can further reduce cardiac output and blood pressure. Avoid use of ROXYBOND in patients with circulatory shock.

5.9 Risks of Use in Patients with Increased Intracranial Pressure, Brain Tumors, Head Injury, or Impaired Consciousness

In patients who may be susceptible to the intracranial effects of CO₂ retention (e.g., those with evidence of increased intracranial pressure or brain tumors), ROXYBOND may reduce the respiratory drive, and the resultant CO₂ retention can further increase intracranial pressure. Monitor such patients for signs of sedation and respiratory depression, particularly when initiating therapy with ROXYBOND.

Opioids may obscure the clinical course in a patient with a head injury. Avoid the use of ROXYBOND in patients with impaired consciousness or coma.

5.10 Risks of Use in Patients with Gastrointestinal Conditions

ROXYBOND is contraindicated in patients with gastrointestinal obstruction, including paralytic ileus.

The oxycodone in ROXYBOND may cause spasm of the sphincter of Oddi. Opioids may cause increases in serum amylase. Monitor patients with biliary tract disease, including acute pancreatitis, for worsening symptoms.

5.11 Increased Risk of Seizures in Patients with Seizure Disorders

The oxycodone in ROXYBOND may increase the frequency of seizures in patients with seizure disorders, and may increase the risk of seizures occurring in other clinical settings associated with seizures. Monitor patients with a history of seizure disorders for worsened seizure control during ROXYBOND therapy.

5.12 Withdrawal

Avoid the use of mixed agonist/antagonist (e.g., pentazocine, nalbuphine, and butorphanol) or partial agonist (e.g., buprenorphine) analgesics in patients who are receiving a full opioid agonist analgesic, including ROXYBOND. In these patients, mixed agonist/antagonist and partial agonist analgesics may reduce the analgesic effect and/or precipitate withdrawal symptoms [*see Drug Interactions (7)*].

When discontinuing ROXYBOND in a physically-dependent patient, gradually taper the dosage [see *Dosage and Administration (2.4)*]. Do not abruptly discontinue ROXYBOND in these patients [see *Drug Abuse and Dependence (9.3)*].

5.13 Risks of Driving and Operating Machinery

ROXYBOND may impair the mental or physical abilities needed to perform potentially hazardous activities such as driving a car or operating machinery. Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of ROXYBOND and know how they will react to the medication [see *Patient Counseling Information (17)*].

6 ADVERSE REACTIONS

The following serious adverse reactions are described or are described in greater detail, in other sections:

- Addiction, Abuse, and Misuse [see *Warnings and Precautions (5.1)*]
- Life-Threatening Respiratory Depression [see *Warnings and Precautions (5.2)*]
- Neonatal Opioid Withdrawal Syndrome [see *Warnings and Precautions (5.3)*]
- Interactions with Benzodiazepines or Other CNS Depressants [see *Warnings and Precautions (5.5)*]
- Adrenal Insufficiency [see *Warnings and Precautions (5.7)*]
- Severe Hypotension [see *Warnings and Precautions (5.8)*]
- Gastrointestinal Adverse Reactions [see *Warnings and Precautions (5.10)*]
- Seizures [see *Warnings and Precautions (5.11)*]
- Withdrawal [see *Warnings and Precautions (5.12)*]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Oxycodone hydrochloride tablets have been evaluated in open label clinical trials in patients with cancer and nonmalignant pain. Oxycodone hydrochloride tablets are associated with adverse experiences similar to those seen with other opioids.

Serious adverse reactions that may be associated with ROXYBOND therapy include: respiratory depression, respiratory arrest, circulatory depression, cardiac arrest, hypotension, and/or shock.

The common adverse reactions seen on initiation of therapy with oxycodone hydrochloride tablets are dose related and are opioid-related adverse reactions. The most frequent of these included nausea, constipation, vomiting, headache, pruritus, insomnia, dizziness, asthenia, and

somnolence. The frequency of these reactions depended on several factors, including clinical setting, the patient's level of opioid tolerance, and host factors specific to the individual.

In all patients for whom dosing information was available (n=191) from the open-label and double-blind studies involving oxycodone hydrochloride tablets, the following adverse events were recorded in oxycodone hydrochloride treated patients with an incidence $\geq 3\%$. In descending order of frequency they were: nausea, constipation, vomiting, headache, pruritus, insomnia, dizziness, asthenia, and somnolence.

Other less frequently observed adverse reactions from opioid analgesics, including oxycodone hydrochloride tablets included:

Blood and lymphatic system disorders: anemia, leukopenia

Cardiac disorders: cardiac failure, palpitation, tachycardia

Gastrointestinal disorders: abdominal pain, dry mouth, diarrhea, dyspepsia, dysphagia, glossitis, nausea, vomiting

General disorders and administration site conditions: chills, edema, edema peripheral, pain, pyrexia

Immune system disorders: hypersensitivity

Infections and infestations: bronchitis, gingivitis, infection, pharyngitis, rhinitis, sepsis, sinusitis, urinary tract infection

Injury, poisoning, and procedural complications: injury

Metabolism and nutritional disorders: decreased appetite, gout, hyperglycemia

Musculoskeletal and connective tissue disorders: arthralgia, arthritis, back pain, bone pain, myalgia, neck pain, pathological fracture

Nervous system disorders: hypertonia, hypoesthesia, migraine, neuralgia, tremor, vasodilation

Psychiatric disorders: agitation, anxiety, confusional state, nervousness, personality disorder

Respiratory, thoracic, and mediastinal disorders: cough, dyspnea, epistaxis, laryngospasm, lung disorder

Skin and subcutaneous tissue disorders: photosensitivity reaction, rash, hyperhidrosis, urticaria

Vascular disorders: thrombophlebitis, hemorrhage, hypotension, vasodilation

6.2 Postmarketing Experience

The following adverse reactions have been identified during post approval use of oxycodone. Because these reactions are reported voluntarily from a population of uncertain size, it is not

always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

General disorders and administrative site disorders: drug withdrawal syndrome neonatal [*see Warnings and Precautions (5.3)*]

Respiratory, thoracic, and mediastinal disorders: pharyngeal edema

Serotonin syndrome: Cases of serotonin syndrome, a potentially life-threatening condition, have been reported during concomitant use of opioids with serotonergic drugs [*see Drug Interactions (7)*].

Adrenal insufficiency: Cases of adrenal insufficiency have been reported with opioid use, more often following greater than one month of use [*see Warnings and Precautions (5.7)*].

Anaphylaxis: Anaphylactic reaction has been reported with ingredients contained in ROXYBOND [*see Contraindications (4)*].

Androgen deficiency: Cases of androgen deficiency have occurred with chronic use of opioids [*see Clinical Pharmacology (12.2)*].

7 DRUG INTERACTIONS

Table 1 includes clinically significant drug interactions with ROXYBOND.

Table 1. Clinically Significant Drug Interactions with ROXYBOND	
Inhibitors of CYP3A4 and CYP2D6	
<i>Clinical Impact:</i>	The concomitant use of ROXYBOND and CYP3A4 inhibitors can increase the plasma concentration of oxycodone, resulting in increased or prolonged opioid effects. These effects could be more pronounced with concomitant use of ROXYBOND and CYP2D6 and CYP3A4 inhibitors, particularly when an inhibitor is added after a stable dose of ROXYBOND is achieved [<i>see Warnings and Precautions (5.4)</i>]. After stopping a CYP3A4 inhibitor, as the effects of the inhibitor decline, the oxycodone plasma concentration will decrease [<i>see Clinical Pharmacology (12.3)</i>], resulting in decreased opioid efficacy or a withdrawal syndrome in patients who had developed physical dependence to oxycodone.
<i>Intervention:</i>	If concomitant use is necessary, consider dosage reduction of ROXYBOND until stable drug effects are achieved. Monitor patients for respiratory depression and sedation at frequent intervals. If a CYP3A4 inhibitor is discontinued, consider increasing the ROXYBOND dosage until stable drug effects are achieved. Monitor for signs of opioid withdrawal.
<i>Examples:</i>	Macrolide antibiotics (e.g., erythromycin), azole-antifungal agents (e.g., ketoconazole), protease inhibitors (e.g., ritonavir).

Table 1. Clinically Significant Drug Interactions with ROXYBOND	
CYP3A4 Inducers	
<i>Clinical Impact:</i>	The concomitant use of ROXYBOND and CYP3A4 inducers can decrease the plasma concentration of oxycodone [see <i>Clinical Pharmacology (12.3)</i>], resulting in decreased efficacy or onset of a withdrawal syndrome in patients who have developed physical dependence to oxycodone [see <i>Warnings and Precautions (5.12)</i>]. After stopping a CYP3A4 inducer, as the effects of the inducer decline, the oxycodone plasma concentration will increase [see <i>Clinical Pharmacology (12.3)</i>], which could increase or prolong both the therapeutic effects and adverse reactions, and may cause serious respiratory depression.
<i>Intervention:</i>	If concomitant use is necessary, consider increasing the ROXYBOND dosage until stable drug effects are achieved. Monitor for signs of opioid withdrawal. If a CYP3A4 inducer is discontinued, consider ROXYBOND dosage reduction and monitor for signs of respiratory depression.
<i>Examples:</i>	Rifampin, carbamazepine, phenytoin
Benzodiazepines and Other Central Nervous System (CNS) Depressants	
<i>Clinical Impact:</i>	Due to additive pharmacologic effect, the concomitant use of benzodiazepines or other CNS depressants, including alcohol, can increase the risk of hypotension, respiratory depression, profound sedation, coma, and death.
<i>Intervention:</i>	Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients closely for signs of respiratory depression and sedation [see <i>Warnings and Precautions (5.5)</i>].
<i>Examples:</i>	Benzodiazepines and other sedatives/hypnotics, anxiolytics, tranquilizers, muscle relaxants, general anesthetics, antipsychotics, other opioids, alcohol.
Serotonergic Drugs	
<i>Clinical Impact:</i>	The concomitant use of opioids with other drugs that affect the serotonergic neurotransmitter system has resulted in serotonin syndrome [see <i>Adverse Reactions (6.2)</i>].
<i>Intervention:</i>	If concomitant use is warranted, carefully observe the patient, particularly during treatment initiation and dose adjustment. Discontinue ROXYBOND if serotonin syndrome is suspected.
<i>Examples:</i>	Selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), triptans, 5-HT ₃ receptor antagonists, drugs that affect the serotonin neurotransmitter system (e.g., mirtazapine, trazodone, tramadol), monoamine oxidase (MAO) inhibitors (those intended to treat psychiatric

Table 1. Clinically Significant Drug Interactions with ROXYBOND	
	disorders and also others, such as linezolid and intravenous methylene blue).
Monoamine Oxidase Inhibitors (MAOIs)	
<i>Clinical Impact:</i>	MAOI interactions with opioids may manifest as serotonin syndrome or opioid toxicity (e.g., respiratory depression, coma) [see <i>Warnings and Precautions (5.2)</i>].
<i>Intervention:</i>	The use of ROXYBOND is not recommended for patients taking MAOIs or within 14 days of stopping such treatment. If urgent use of an opioid is necessary, use test doses and frequent titration of small doses to treat pain while closely monitoring blood pressure and signs and symptoms of CNS and respiratory depression.
<i>Examples:</i>	phenelzine, tranylcypromine, linezolid
Mixed Agonist/Antagonist Opioid Analgesics	
<i>Clinical Impact:</i>	May reduce the analgesic effect of ROXYBOND and/or may precipitate withdrawal symptoms.
<i>Intervention:</i>	Avoid concomitant use
<i>Examples:</i>	Butorphanol, nalbuphine, pentazocine, buprenorphine
Muscle Relaxants	
<i>Clinical Impact:</i>	Oxycodone may enhance the neuromuscular blocking action of skeletal muscle relaxants and produce an increased degree of respiratory depression.
<i>Intervention:</i>	Monitor patients for signs of respiratory depression that may be greater than otherwise expected and decrease the dosage of ROXYBOND and/or the muscle relaxant as necessary.
Diuretics	
<i>Clinical Impact:</i>	Opioids can reduce the efficacy of diuretics by inducing the release of antidiuretic hormone.
<i>Intervention:</i>	Monitor patients for signs of diminished diuresis and/or effects on blood pressure and increase the dosage of the diuretic as needed.
Anticholinergic Drugs	
<i>Clinical Impact:</i>	The concomitant risk of anticholinergic drugs may result in increased risk of urinary retention and/or severe constipation, which may lead to paralytic ileus.
<i>Intervention:</i>	Monitor patients for signs of urinary retention or reduced gastric motility when ROXYBOND is used concurrently with anticholinergic drugs.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Prolonged use of opioid analgesics during pregnancy may cause neonatal opioid withdrawal syndrome [*see Warnings and Precautions (5.3), Clinical Considerations*]. There are reports of respiratory depression when oxycodone is used during labor and delivery [*see Clinical Considerations*]. There are no available data with ROXYBOND in pregnant women to inform a drug-associated risk for adverse developmental outcomes. Animal reproduction studies with oral administrations of oxycodone HCl in rats and rabbits during the period of organogenesis, at doses 2.6 and 8.1 times, respectively, the human dose of 60 mg/day did not reveal evidence of teratogenicity or embryo-fetal toxicity. In several published studies, treatment of pregnant rats with oxycodone at clinically relevant doses and below, resulted in neurobehavioral effects in offspring [*see Data*]. Based on animal data, advise pregnant women of the potential risk to a fetus.

The estimated risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defects, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Clinical Considerations

Fetal/Neonatal Adverse Reactions

Prolonged use of opioid analgesics during pregnancy for medical or nonmedical purposes can result in physical dependence in the neonate and neonatal opioid withdrawal syndrome shortly after birth.

Neonatal opioid withdrawal syndrome presents as irritability, hyperactivity, and abnormal sleep pattern, high pitched cry, tremor, vomiting, diarrhea, and failure to gain weight. The onset, duration, and severity of neonatal opioid withdrawal syndrome vary based on the specific opioid used, duration of use, timing and amount of last maternal use, and rate of elimination of the drug by the newborn. Observe newborns for symptoms of neonatal opioid withdrawal syndrome and manage accordingly [*see Warnings and Precautions (5.3)*].

Labor or Delivery

Opioids cross the placenta and may produce respiratory depression and psycho-physiologic effects in neonates. An opioid antagonist such as naloxone, must be available for reversal of opioid-induced respiratory depression in the neonate. ROXYBOND is not recommended for use in pregnant women during or immediately prior to labor, when other analgesic techniques are more appropriate. Opioid analgesics, including ROXYBOND, can prolong labor through actions which temporarily reduce the strength, duration, and frequency of uterine contractions. However, this effect is not consistent and may be offset by an increased rate of cervical dilation,

which tends to shorten labor. Monitor neonates exposed to opioid analgesics during labor for signs of excess sedation and respiratory depression.

Data

Human Data

Limited published data from case-control and observational studies on oxycodone use during pregnancy are inconsistent in their findings. Although some studies reported an increased risk of congenital malformations, there was no consistent pattern of malformations noted. In addition, multiple similar studies reported no association. Methodological limitations of these studies, including small sample size, recall bias, lack of information regarding dose and timing of exposure and concomitant use of other medications, preclude a reliable evaluation of the potential risk of adverse fetal outcomes with the use of oxycodone in pregnancy.

Animal Data

In embryo-fetal development studies in rats and rabbits, pregnant animals received oral doses of oxycodone HCl administered during the period of organogenesis up to 16 mg/kg/day and up to 25 mg/kg/day, respectively. These studies revealed no evidence of teratogenicity or embryo-fetal toxicity due to oxycodone. The highest doses tested in rats and rabbits were equivalent to approximately 2.6 and 8.1 times an adult human dose of 60 mg/day, respectively, on a mg/m² basis. In published studies, offspring of pregnant rats administered oxycodone during gestation have been reported to exhibit neurobehavioral effects including altered stress responses, increased anxiety-like behavior (2 mg/kg/day IV from Gestation Day 8 to 21 and Postnatal Day 1, 3, and 5; 0.3-times an adult human dose of 60 mg/day, on a mg/m² basis) and altered learning and memory (15 mg/kg/day orally from breeding through parturition; 2.4 times an adult human dose of 60 mg/day, on a mg/m² basis).

8.2 Lactation

Risk Summary

Lactation studies have not been conducted with ROXYBOND. Published lactation studies report that oxycodone is present in human milk [*see Data*]. There are reports of central nervous system depression in infants who are breastfed by mothers taking oxycodone. There is no information on the effects of oxycodone on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for ROXYBOND and any potential adverse effects on the breastfed infant from ROXYBOND or from the underlying maternal condition.

Clinical Considerations

Infants exposed to ROXYBOND through breast milk should be monitored for excess sedation and respiratory depression. Withdrawal symptoms can occur in breastfed infants when maternal administration of an opioid analgesic is stopped or when breast-feeding is stopped.

8.3 Females and Males of Reproductive Potential

Infertility

Chronic use of opioids may cause reduced fertility in females and males of reproductive potential. It is not known whether these effects on fertility are reversible [*see Adverse Reactions (6.2), Clinical Pharmacology (12.2), and Nonclinical Toxicology (13.1)*].

8.4 Pediatric Use

The safety and efficacy of ROXYBOND in pediatric patients have not been evaluated.

8.5 Geriatric Use

Of the total number of subjects in clinical studies of oxycodone hydrochloride, 20.8% (112/538) were 65 and over, while 7.2% (39/538) were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Elderly patients (aged 65 years or older) may have increased sensitivity to oxycodone. In general, use caution when selecting a dosage for an elderly patient, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function and of concomitant disease or other drug therapy.

Respiratory depression is the chief risk for elderly patients treated with opioids, and has occurred after large initial doses were administered to patients who were not opioid-tolerant or when opioids were co-administered with other agents that depress respiration. Titrate the dosage of ROXYBOND slowly in geriatric patients and monitor closely for signs of central nervous system and respiratory depression [*see Warnings and Precautions (5.6)*].

Oxycodone is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

8.6 Hepatic Impairment

Because oxycodone is extensively metabolized in the liver, its clearance may decrease in patients with hepatic impairment. Initiate therapy in these patients with a lower than usual dosage of ROXYBOND and titrate carefully. Monitor closely for adverse events such as respiratory depression, sedation, and hypotension [*see Clinical Pharmacology (12.3)*].

8.7 Renal Impairment

Because oxycodone is known to be substantially excreted by the kidney, its clearance may decrease in patients with renal impairment. Initiate therapy with a lower than usual dosage of

ROXYBOND and titrate carefully. Monitor closely for adverse events such as respiratory depression, sedation, and hypotension [*see Clinical Pharmacology (12.3)*].

9. DRUG ABUSE AND DEPENDENCE

9.1 Controlled Substance

ROXYBOND contains oxycodone, a Schedule II controlled substance.

9.2 Abuse

ROXYBOND contains oxycodone, a substance with a high potential for abuse similar to other opioids including fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxymorphone, and tapentadol. ROXYBOND can be abused and is subject to misuse, addiction, and criminal diversion [*see Warnings and Precautions (5.1)*].

All patients treated with opioids require careful monitoring for signs of abuse and addiction, because use of opioid analgesic products carries the risk of addiction even under appropriate medical use.

Prescription drug abuse is the intentional non-therapeutic use of a prescription drug, even once, for its rewarding psychological or physiological effects.

Drug addiction is a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and includes: a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal.

“Drug-seeking” behavior is very common in persons with substance use disorders. Drug-seeking tactics include emergency calls or visits near the end of office hours, refusal to undergo appropriate examination, testing, or referral, repeated “loss” of prescriptions, tampering with prescriptions, and reluctance to provide prior medical records or contact information for other treating healthcare provider(s). “Doctor shopping” (visiting multiple prescribers to obtain additional prescriptions) is common among drug abusers and people suffering from untreated addiction. Preoccupation with achieving adequate pain relief can be appropriate behavior in a patient with poor pain control.

Abuse and addiction are separate and distinct from physical dependence and tolerance. Healthcare providers should be aware that addiction may not be accompanied by concurrent tolerance and symptoms of physical dependence in all addicts. In addition, abuse of opioids can occur in the absence of true addiction.

ROXYBOND, like other opioids, can be diverted for non-medical use into illicit channels of distribution. Careful record-keeping of prescribing information, including quantity, frequency, and renewal requests, as required by state and federal law, is strongly advised.

Proper assessment of the patient, proper prescribing practices, periodic reevaluation of therapy, and proper dispensing and storage are appropriate measures that help to limit abuse of opioid drugs.

Risks Specific to Abuse of ROXYBOND

ROXYBOND is for oral use only. Abuse of ROXYBOND poses a risk of overdose and death. This risk is increased with concurrent abuse of ROXYBOND with alcohol and other central nervous system depressants.

Parenteral abuse of ROXYBOND can be expected to result in local tissue necrosis, infection, pulmonary granulomas, and increased risk of endocarditis and valvular heart injury. Injection of excipients included in the ROXYBOND formulation, intended to provide abuse-deterrent properties, may be associated with additional unknown serious risks. Parenteral drug abuse is commonly associated with transmission of infectious diseases such as hepatitis and HIV.

Abuse Deterrence Studies

ROXYBOND is formulated with inactive ingredients that make the tablet more difficult to manipulate for misuse and abuse even if the tablet is subjected to physical manipulation and/or chemical extraction. To evaluate the ability of the abuse-deterrent technology to reduce the potential for abuse of ROXYBOND, a series of in vitro laboratory manipulation, extraction, and syringeability studies were conducted. An in vivo intranasal clinical abuse potential study was also conducted.

In Vitro Testing

ROXYBOND has been tested in vitro using methods of manipulation that drug abusers commonly use for preparation of opioids for administration by various routes, including oral consumption, intranasal insufflation, and injection.

Abusers may manipulate prescription opioids in order to prepare the tablets for oral, intranasal, or intravenous administration. The laboratory test data demonstrated that, relative to oxycodone immediate-release tablets, ROXYBOND has increased resistance to cutting, crushing, grinding, or breaking using selected tools. In addition, the intact and manipulated tablets resisted extraction in selected household and laboratory solvents under various conditions, including selected pre-treatments. Relative to oxycodone immediate-release tablets, the formulation forms a viscous material that resists passage through a needle; it was also more difficult to prepare solutions suitable for intravenous injection.

Clinical Abuse Potential Studies

A randomized, double-blind, double-dummy, placebo-controlled, single-dose four-way crossover study in 29 non-dependent recreational opioid users with a history of intranasal drug abuse was

performed to determine the relative bioavailability and abuse potential of crushed intranasal ROXYBOND 30 mg tablets compared with crushed intranasal 30 mg oxycodone immediate-release tablets and intact orally administered ROXYBOND 30 mg tablets. Intact oral ROXYBOND tablets were included as a reference for evaluating abuse potential after manipulation and administration via an unintended route.

Drug liking was measured on a 100-mm bipolar visual analog scale (VAS) where 50 represents a neutral response of neither liking nor disliking, 0 represents maximum disliking, and 100 represents maximum liking. Response to whether the subject would be willing to take the study drug again was also measured on a bipolar 0 to 100 VAS where 50 represents a neutral response, 0 represents the strongest negative response (“definitely would not take drug again”) and 100 represents the strongest positive response (“definitely would take drug again”).

The pharmacokinetic profiles of oxycodone were also determined in this study (Table 2). When crushed and insufflated, ROXYBOND showed a lower peak oxycodone plasma concentration (C_{max} ~28% reduction) and a 35% longer time to peak plasma concentration (T_{max}) relative to crushed and insufflated oxycodone immediate-release tablets. Similar results were demonstrated when crushed and insufflated ROXYBOND was compared to intact oral ROXYBOND with a reduction in C_{max} and a longer time to T_{max} . Intact oral ROXYBOND resulted in a C_{max} of oxycodone similar to that of crushed and insufflated oxycodone immediate-release tablets, with a similar T_{max} .

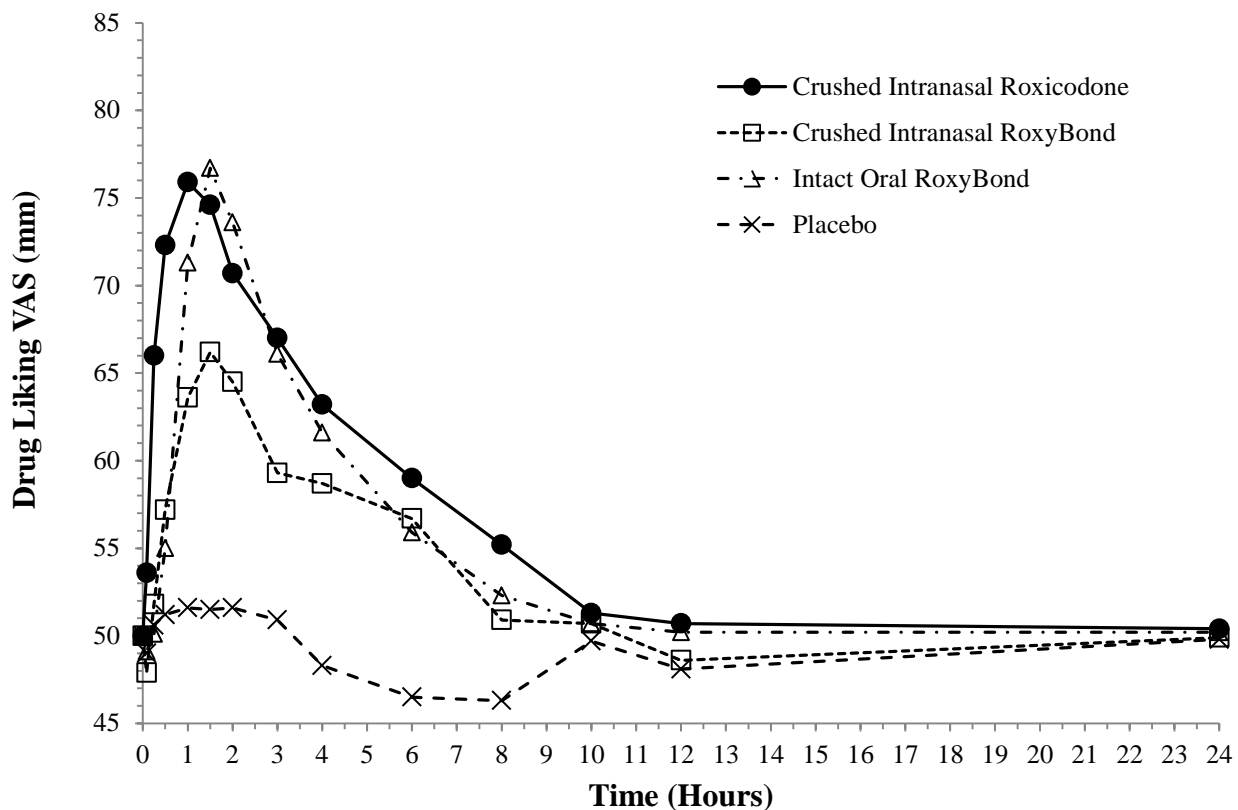
Treatment or Comparison	C_{max} (ng/mL) LS Mean	AUC _{0-t} (ng*hr/mL) LS Mean	T_{max} (hr) Median
Crushed, Insufflated oxycodone immediate-release tablets 30 mg	55.56	330.77	1.7
Crushed, Insufflated ROXYBOND 30 mg	40.04	309.21	2.3
Intact, oral ROXYBOND	56.97	265.38	1.3

AUC_{0-t} = Area under the plasma concentration vs time curve from 0 to last measurable concentration.

Compared to crushed intranasal oxycodone immediate-release tablets, intranasal administration of crushed ROXYBOND was associated with statistically significantly lower drug liking (E_{max}) and take drug again (E_{max}) scores, as summarized in Table 3. Similar reductions in drug liking and willingness to take the drug again were reported for crushed intranasal ROXYBOND relative to intact oral ROXYBOND. These data are consistent with the slowing of the intended immediate-release properties of ROXYBOND when manipulated then insufflated compared to taking ROXYBOND orally intact. No statistically significant differences in E_{max} of Drug Liking or Take Drug Again were observed between crushed intranasal oxycodone immediate-release tablets and intact oral ROXYBOND.

Table 3. Summary of Maximum Drug Liking (E_{max}), and Take Drug Again (E_{max}), Following Administration of ROXYBOND, Oxycodone Immediate-release Tablets, and Placebo in Recreational Opioid Users (N=29)					
VAS		Crushed Intranasal ROXYBOND 30 mg	Crushed Intranasal Oxycodone immediate-release tablets 30 mg	Intact Oral ROXYBOND 30 mg	Placebo
Drug Liking (E_{max})	Mean (SD)	71.1 (12.01)	82.9 (11.55)	81.5 (11.49)	53.4 (6.34)
	Median (Range)	71 (50 to 100)	82 (50 to 100)	82.00 (56 to 100)	51.0 (50 to 77)
Take Drug Again (E_{max})	Mean (SD)	62.2 (24.51)	82.1 (16.44)	77.3 (18.11)	41.9 (20.09)
	Median (Range)	62.0 (3 to 99)	86.0 (37 to 100)	81.0 (13 to 100)	50.0 (0.0 to 78)

Figure 1. Mean Drug Liking VAS Scores Over Time (N=29)



The majority of subjects (86%; n=25) experienced some reduction in E_{max} of Drug Liking VAS with crushed intranasal ROXYBOND compared with crushed intranasal oxycodone immediate-

release tablets, whereas 59% (n=17) experienced at least a 30% reduction in E_{\max} of drug liking and 21% (n=6) experienced at least a 50% reduction in E_{\max} of drug liking.

Summary

The in vitro data demonstrate that ROXYBOND has physicochemical properties expected to make abuse via injection difficult. The data from the clinical study, along with support from in vitro data, also indicate that ROXYBOND has physicochemical properties that are expected to reduce abuse by the intranasal route of administration. However, abuse by the intranasal, oral, and intravenous route is still possible.

Additional data, including epidemiological data, when available, may provide further information on the impact of the current formulation of ROXYBOND on the abuse liability of the drug. Accordingly, this section may be updated in the future as appropriate.

9.3 Dependence

Both tolerance and physical dependence can develop during chronic opioid therapy. Tolerance is the need for increasing doses of opioids to maintain a defined effect such as analgesia (in the absence of disease progression or other external factors). Tolerance may occur to both the desired and undesired effects of drugs and may develop at different rates for different effects.

Physical dependence results in withdrawal symptoms after abrupt discontinuation or significant dosage reduction of a drug. Withdrawal also may be precipitated through the administration of drugs with opioid antagonist activity (e.g., naloxone, nalmefene), mixed agonist/antagonist analgesics (e.g., pentazocine, butorphanol, nalbuphine), or partial agonists (e.g., buprenorphine). Physical dependence may not occur to a clinically significant degree until after several days to weeks of continued opioid usage.

ROXYBOND should not be abruptly discontinued in a physically-dependent patient [*see Dosage and Administration (2.4)*]. If ROXYBOND is abruptly discontinued in a physically-dependent patient, a withdrawal syndrome may occur. Some or all of the following can characterize this syndrome: restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, myalgia, and mydriasis. Other symptoms also may develop, including irritability, anxiety, backache, joint pain, weakness, abdominal cramps, insomnia, nausea, anorexia, vomiting, diarrhea, or increased blood pressure, respiratory rate, or heart rate.

Infants born to mothers physically dependent on opioids will also be physically dependent and may exhibit respiratory difficulties and withdrawal signs [*see Use in Specific Populations (8.1)*].

10 OVERDOSAGE

Clinical Presentation

Acute overdose with ROXYBOND can be manifested by respiratory depression, somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, constricted pupils, and, in some cases, pulmonary edema, bradycardia, hypotension, partial or complete

airway obstruction, atypical snoring, and death. Marked mydriasis rather than miosis may be seen with hypoxia in overdose situations [see *Clinical Pharmacology (12.2)*].

Treatment of Overdose

In case of overdose, priorities are the re-establishment of a patent and protected airway and institution of assisted or controlled ventilation, if needed. Employ other supportive measures (including oxygen and vasopressors) in the management of circulatory shock and pulmonary edema as indicated. Cardiac arrest or arrhythmias will require advance life-support techniques.

The opioid antagonists, naloxone or nalmefene, are specific antidotes to respiratory depression resulting from opioid overdose. For clinically significant respiratory or circulatory depression secondary to oxycodone overdose, administer an opioid antagonist. Opioid antagonists should not be administered in the absence of clinically significant respiratory or circulatory depression secondary to oxycodone overdose.

Because the duration of opioid reversal is expected to be less than the duration of action of oxycodone in ROXYBOND, carefully monitor the patient until spontaneous respiration is reliably reestablished. If the response to an opioid antagonist is suboptimal or only brief in nature, administer additional antagonist as directed by the product's prescribing information.

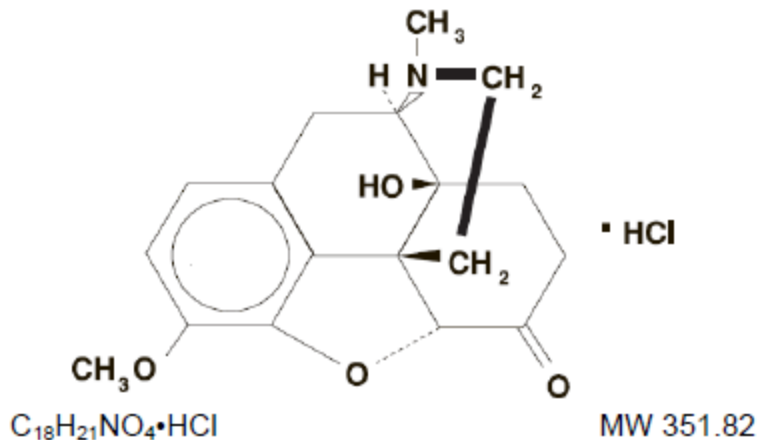
In an individual physically dependent on opioids, administration of the recommended usual dosage of the antagonist will precipitate an acute withdrawal syndrome. The severity of the withdrawal symptoms experienced will depend on the degree of physical dependence and the dose of the antagonist administered. If a decision is made to treat serious respiratory depression in the physically dependent patient, administration of the antagonist should be initiated with care and by titration with smaller than usual doses of the antagonist.

11 DESCRIPTION

ROXYBOND (oxycodone hydrochloride) tablets for oral administration are available in 5 mg, 15 mg, and 30 mg strengths, each containing an equivalent of 4.5 mg, 13.5 mg, and 27 mg of oxycodone free base, respectively.

Oxycodone hydrochloride is an opioid agonist. It is a white, odorless crystalline powder derived from the opium alkaloid, thebaine. Oxycodone hydrochloride dissolves in water (1 g in 6 to 7 mL) and is considered slightly soluble in alcohol (octanol water partition coefficient is 0.7).

Chemically, oxycodone hydrochloride is 4, 5 α -epoxy-14-hydroxy-3-methoxy-17-methylmorphinan-6-one hydrochloride and has the following structural formula:



Each ROXYBOND tablet contains the following inactive ingredients common to all strengths: alginic acid, ammonium hydroxide, colloidal silicon dioxide, dibutyl sebacate, dimethylaminoethyl methacrylate copolymer, ethyl acrylate and methyl methacrylate copolymer dispersion, ethylcellulose, hypromellose, iron oxide black, isopropyl alcohol, lactose monohydrate, magnesium stearate, mannitol, microcrystalline cellulose, n-butyl alcohol, polyethylene glycol, polysorbate 80, polyvinyl alcohol, propylene glycol, shellac in ethanol, sodium alginate, talc, titanium dioxide, and xanthan gum.

The 15 mg ROXYBOND tablets also contain: FD&C Blue No. 2 and iron oxide yellow.

The 30 mg ROXYBOND tablets also contain: FD&C Blue No. 2.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Oxycodone is a full opioid agonist and is relatively selective for the mu-opioid receptor, although it can bind to other opioid receptors at higher doses. The principal therapeutic action of oxycodone is analgesia. Like all full opioid agonists, there is no ceiling effect for analgesia with oxycodone. Clinically, dosage is titrated to provide adequate analgesia and may be limited by adverse reactions, including respiratory and CNS depression.

The precise mechanism of the analgesic action is unknown. However, specific CNS opioid receptors for endogenous compounds with opioid-like activity have been identified throughout the brain and spinal cord and are thought to play a role in the analgesic effects of this drug.

12.2 Pharmacodynamics

Effects on the Central Nervous System

Oxycodone produces respiratory depression by direct action on brain stem respiratory centers. The respiratory depression involves a reduction in the responsiveness of the brain stem respiratory centers to both increases in carbon dioxide tension and electrical stimulation.

Oxycodone causes miosis, even in total darkness. Pinpoint pupils are a sign of opioid overdose but are not pathognomonic (e.g., pontine lesions of hemorrhagic or ischemic origins may produce similar findings). Marked mydriasis rather than miosis may be seen due to hypoxia in overdose situations.

Effects on Gastrointestinal Tract and Other Smooth Muscle

Oxycodone causes a reduction in motility associated with an increase in smooth muscle tone in the antrum, stomach, and duodenum. Digestion of food in the small intestine is delayed and propulsive contractions are decreased. Propulsive peristaltic waves in the colon are decreased, while tone may be increased to the point of spasm, resulting in constipation. Other opioid-induced effects may include a reduction in biliary and pancreatic secretions, spasm of sphincter of Oddi, and transient elevations in serum amylase.

Effects on Cardiovascular System

Oxycodone produces peripheral vasodilatation, which may result in orthostatic hypotension or syncope. Manifestations of histamine release and/or peripheral vasodilatation may include pruritus, flushing, red eyes, sweating, and/or orthostatic hypotension.

Effects on the Endocrine System

Opioids inhibit the secretion of adrenocorticotropic hormone (ACTH), cortisol, and luteinizing hormone (LH) in humans [see *Adverse Reactions (6.2)*]. They also stimulate prolactin, growth hormone (GH) secretion, and pancreatic secretion of insulin and glucagon.

Chronic use of opioids may influence the hypothalamic-pituitary-gonadal axis, leading to androgen deficiency that may manifest as low libido, impotence, erectile dysfunction, amenorrhea, or infertility. The causal role of opioids in the clinical syndrome of hypogonadism is unknown because the various medical, physical, lifestyle, and psychological stressors that may influence gonadal hormone levels have not been adequately controlled for in studies conducted to date [see *Adverse Reactions (6.2)*].

Effects on the Immune System

Opioids have been shown to have a variety of effects on components of the immune system in in vitro and animal models. The clinical significance of these findings is unknown. Overall, the effects of opioids appear to be modestly immunosuppressive.

Concentration–Efficacy Relationships

The minimum effective analgesic concentration will vary widely among patients, especially among patients who have been previously treated with potent agonist opioids. The minimum effective analgesic concentration of oxycodone for any individual patient may increase over time due to an increase in pain, the development of a new pain syndrome, and/or the development of analgesic tolerance [see *Dosage and Administration (2.1, 2.3)*].

Concentration–Adverse Reaction Relationships

There is a relationship between increasing oxycodone plasma concentration and increasing frequency of dose-related opioid adverse reactions such as nausea, vomiting, CNS effects, and respiratory depression. In opioid-tolerant patients, the situation may be altered by the development of tolerance to opioid-related adverse reactions [see *Dosage and Administration* (2.1, 2.2, 2.3)].

12.3 Pharmacokinetics

The activity of ROXYBOND tablets is primarily due to the parent drug oxycodone. ROXYBOND tablets are designed to provide immediate-release of oxycodone.

Oxycodone pharmacokinetics are similar for ROXYBOND and oxycodone immediate-release tablets. In the fasted state, the extent of absorption (AUC) is equivalent, the rate of absorption (C_{max}) is similar, and median T_{max} is slightly longer (1.0 to 1.8 h).

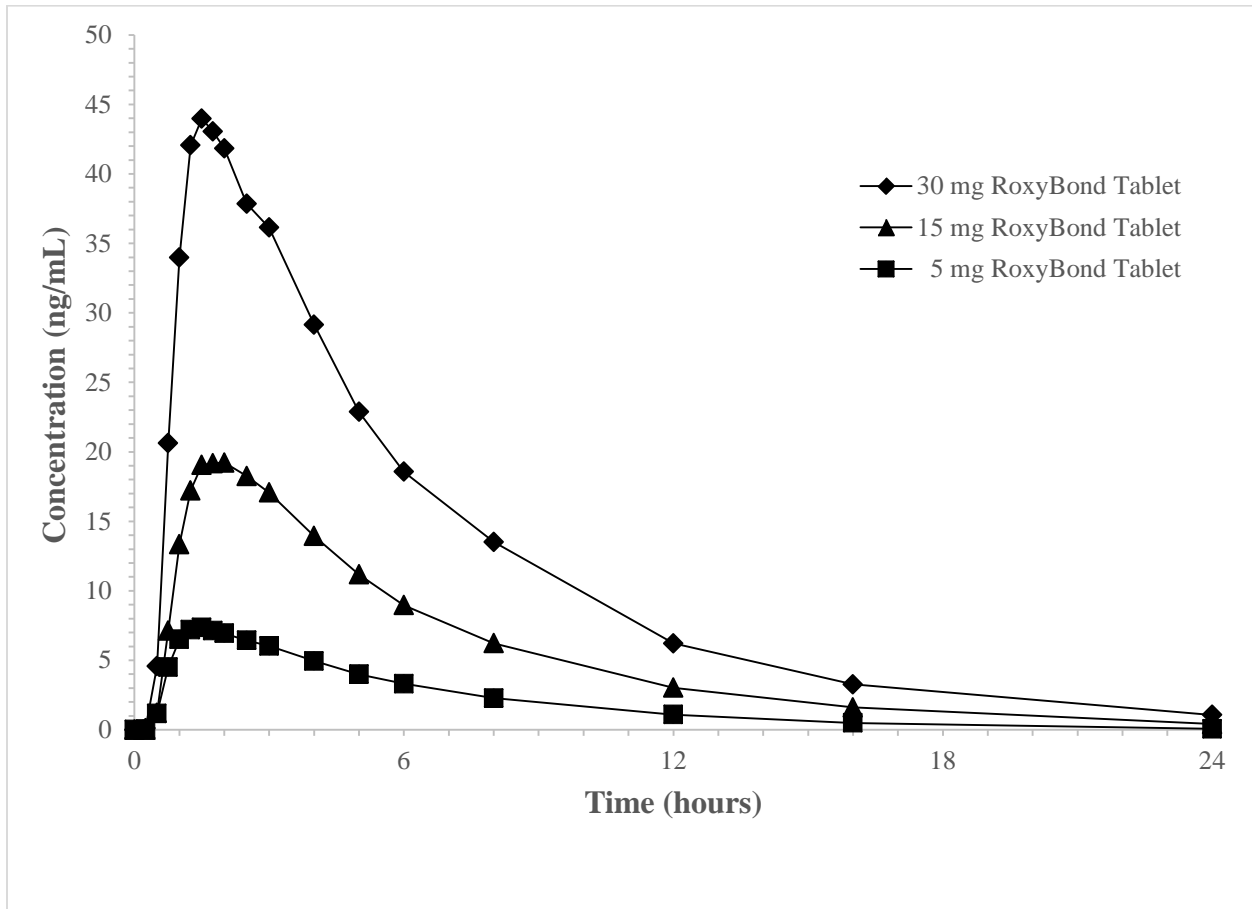
Table 4. Pharmacokinetic Parameters (Mean ± SD)					
Dose\Parameters	AUC_{0-t} (ng·hr/mL)	AUC_{0-inf} (ng·hr/mL)	C_{max} (ng/mL)	T_{max} (hr)	Half-Life (hr)
Single Dose Pharmacokinetics Study					
ROXYBOND 5 mg tab (fasted)	45.5±15.4	49.0±16.1	8.3±2.1	1.5 ^a (0.7 to 5.0)	3.9±1.2
ROXYBOND 15 mg tab (fasted)	127.5±38.1	131.6±39.0	22.0±5.8	1.7 ^a (1.0 to 12.0)	4.1±0.8
ROXYBOND 30 mg tab (fasted)	277.0±89.6	285.8±94.1	48.5±15.9	1.5 ^a (1.0 to 8.0)	4.3±1.0
Single Dose Food-Effect Study					
ROXYBOND 30 mg tab (fasted)	287.4±65.8	292.7±67.4	57.8±18.0	1.8 ^a (0.8 to 5.0)	3.8±0.7
ROXYBOND 30 mg tab (fed)	354.2±82.5	361.9±86.7	68.0±20.1	2.0 ^a (1.0 to 6.1)	3.9±0.6

^a Median (range)

Absorption

About 60% to 87% of an oral dose of oxycodone reaches the systemic circulation in comparison to a parenteral dose. This high oral bioavailability (compared to other oral opioids) is due to lower presystemic and/or first-pass metabolism of oxycodone. Dose proportionality of oxycodone has been established using the ROXYBOND 5 mg, 15 mg, and 30 mg tablets based on maximum plasma concentration (C_{max}) and extent of absorption (AUC) (Figure 2). It takes approximately 18 to 24 hours to reach steady-state plasma concentrations of oxycodone with oxycodone hydrochloride.

Figure 2. Mean Oxycodone Pharmacokinetic Profiles of 5-, 15-, 30-mg ROXYBOND Tablets (n=51)



Food Effect

A single-dose food effect study was conducted in normal volunteers using the 30-mg tablet. The concurrent intake of a high fat meal was shown to enhance the extent (23% increase in AUC), and the rate (18% increase in C_{max}) of oxycodone absorption from the 30-mg tablet (Table 4). In addition, food caused a slight delay in T_{max} (1.8 to 2 hours). Similar effects of food are expected with the 5-mg and 15-mg tablets.

Distribution

Following intravenous administration, the volume of distribution (V_{ss}) for oxycodone was 2.6 L/kg. Plasma protein binding of oxycodone at 37°C and a pH of 7.4 was about 45%. Oxycodone has been found in breast milk [see *Use in Specific Populations* (8.2)].

Elimination

Metabolism

A high proportion of oxycodone is N-dealkylated to noroxycodone during first-pass metabolism, and is catalyzed by CYP3A4. Oxymorphone is formed by the O-demethylation of oxycodone. The metabolism of oxycodone to oxymorphone is catalyzed by CYP2D6 [see *Drug Interactions (7)*]. Free and conjugated noroxycodone, free and conjugated oxycodone, and oxymorphone are excreted in human urine following a single oral dose of oxycodone. The major circulating metabolite is noroxycodone with an AUC ratio of 0.6 relative to that of oxycodone. Oxymorphone is present in the plasma only in low concentrations. The analgesic activity profile of other metabolites is not known at present.

Excretion

Oxycodone and its metabolites are excreted primarily via the kidney. The amounts measured in the urine have been reported as follows: free oxycodone up to 19%; conjugated oxycodone up to 50%; free oxymorphone 0%; conjugated oxymorphone \leq 14%; both free and conjugated noroxycodone have been found in the urine but not quantified. The total plasma clearance was 0.8 L/min for adults. Apparent elimination half-life of oxycodone following the administration of ROXYBOND was 3.8 to 4.3 hours.

Specific Populations

Age: Geriatric Patients

Population pharmacokinetic studies conducted with oxycodone hydrochloride, indicated that the plasma concentrations of oxycodone did not appear to be increased in patients over the age of 65.

Hepatic Impairment

In a clinical trial supporting the development of oxycodone hydrochloride tablets, too few patients with decreased hepatic function were evaluated to study these potential differences. However, because oxycodone is extensively metabolized in the liver, its clearance may decrease in hepatic impaired patients [see *Use in Specific Populations (8.6)*].

Renal Impairment

This drug is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function [see *Use in Specific Populations (8.7)*].

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Long-term studies have not been performed in animals to evaluate the carcinogenic potential of oxycodone.

Mutagenesis

Oxycodone hydrochloride was genotoxic in an in vitro mouse lymphoma assay in the presence of metabolic activation. There was no evidence of genotoxic potential in an in vitro bacterial reverse mutation assay (*Salmonella typhimurium* and *Escherichia coli*) or in an assay for chromosomal aberrations (*in vivo* mouse bone marrow micronucleus assay).

Impairment of Fertility

Studies in animals to evaluate the potential impact of oxycodone on fertility have not been conducted.

16 HOW SUPPLIED/STORAGE AND HANDLING

ROXYBOND (oxycodone hydrochloride) tablets are supplied as 5 mg, 15 mg, and 30 mg strength round and color coated tablets with ink-prints on one side. The tablets are packaged in 100 tablet opaque HDPE bottles.

NDC	Strength	Tablet Shape	Tablet Color	Ink-Print on Tablet Side 1	Ink-Print on Tablet Side 2
69296-005-01	5 mg	Round coated tablets	White	IDT/O 5	None
69296-006-01	15 mg		Green	IDT/O 15	None
69296-007-01	30 mg		Blue	IDT/O 30	None

Dispense in a tight, light-resistant container, with a child-resistant closure. Protect from moisture.

Store at controlled room temperature, 20°C to 25°C (68°F to 77°F), with excursions to 15°C to 30°C (59°F to 86°F).

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide).

Addiction, Abuse, and Misuse

Inform patients that the use of ROXYBOND, even when taken as recommended, can result in addiction, abuse, and misuse, which can lead to overdose and death [*see Warnings and Precautions (5.1)*]. Instruct patients not to share ROXYBOND with others and to take steps to protect ROXYBOND from theft and misuse.

Life-Threatening Respiratory Depression

Inform patients of the risk of life-threatening respiratory depression, including information that the risk is greatest when starting ROXYBOND or when the dosage is increased, and that it can occur even at recommended dosages [*see Warnings and Precautions (5.2)*]. Advise patients how to recognize respiratory depression and to seek medical attention if breathing difficulties develop.

Accidental Ingestion

Inform patients that accidental ingestion, especially by children, may result in respiratory depression or death [*see Warnings and Precautions (5.2)*]. Instruct patients to take steps to store ROXYBOND securely and to dispose of unused ROXYBOND by flushing the tablets down the toilet or disposing of in accordance with local state guidelines and/or regulations.

Interactions with Benzodiazepines and Other CNS Depressants

Inform patients and caregivers that potentially fatal additive effects may occur if ROXYBOND is used with benzodiazepines or other CNS depressants, including alcohol, and not to use these concomitantly unless supervised by a healthcare provider [*see Warnings and Precautions (5.5), Drug Interactions (7)*].

Serotonin Syndrome

Inform patients that opioids could cause a rare but potentially life-threatening condition resulting from concomitant administration of serotonergic drugs. Warn patients of the symptoms of serotonin syndrome and to seek medical attention right away if symptoms develop. Instruct patients to inform their healthcare providers if they are taking, or plan to take serotonergic medication [*see Drug Interactions (7)*].

MAOI Interaction

Inform patients to avoid taking ROXYBOND while using any drugs that inhibit monoamine oxidase. Patients should not start MAOIs while taking ROXYBOND [*see Drug Interactions (7)*].

Adrenal Insufficiency

Inform patients that opioids could cause adrenal insufficiency, a potentially life-threatening condition. Adrenal insufficiency may present with non-specific symptoms and signs such as nausea, vomiting, anorexia, fatigue, weakness, dizziness and low blood pressure. Advise patients to seek medical attention if they experience a constellation of these symptoms [*see Warnings and Precautions (5.7)*].

Important Administration Instructions

Instruct patients how to properly take ROXYBOND. Patients should be advised not to adjust the dose of ROXYBOND without consulting the prescribing healthcare provider [*see Dosage and Administration (2), Warnings and Precautions (5.12)*].

Hypotension

Inform patients that ROXYBOND may cause orthostatic hypotension and syncope. Instruct patients how to recognize symptoms of low blood pressure and how to reduce the risk of serious

consequences should hypotension occur (e.g., sit or lie down, carefully rise from sitting or lying position) [*see Warnings and Precautions (5.8)*].

Anaphylaxis

Inform patients that anaphylaxis has been reported with ingredients contained in ROXYBOND. Advise patients how to recognize such a reaction and when to seek medical attention [*see Contraindications (4), Adverse Reactions (6.2)*].

Pregnancy

Neonatal Opioid Withdrawal Syndrome

Inform female patients of reproductive potential that prolonged use of ROXYBOND during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated [*see Warnings and Precautions (5.3), Use in Specific Populations (8.1)*].

Embryo-Fetal Toxicity

Inform female patients of reproductive potential that ROXYBOND can cause fetal harm and to inform their healthcare provider of a known or suspected pregnancy [*see Use in Specific Populations (8.1)*].

Lactation

Advise nursing mothers to monitor infants for increased sleepiness (more than usual), breathing difficulties, or limpness. Instruct nursing mothers to seek immediate medical care if they notice these signs [*see Use in Specific Populations (8.2)*].

Infertility

Inform patients that chronic use of opioids may cause reduced fertility. It is not known whether these effects on fertility are reversible [*see Use in Specific Populations (8.3)*].

Driving or Operating Machinery

Inform patients that ROXYBOND may impair the ability to perform potentially hazardous activities such as driving a car or operating dangerous machinery. Advise patients not to perform such tasks until they know how they will react to the medication [*see Warnings and Precautions (5.13)*].

Constipation

Advise patients of the potential for severe constipation, including management instructions and when to seek medical attention [*see Adverse Reactions (6), Clinical Pharmacology (12.1)*].

Disposal of Unused ROXYBOND

Advise patients to keep ROXYBOND in a secure place out of reach of children. Advise patients to dispose of unused ROXYBOND by flushing the tablets down the toilet or disposing in accordance with local state guidelines and/or regulations.

Manufactured by:

**Cerovene for Inspirion Delivery Sciences LLC
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To request medical information or to report suspected adverse reactions, contact Inspirion Delivery Sciences Medical Affairs at 1-973-804-9300.

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