

SUMMARY OF PRODUCT CHARACTERISTICS

1. TRADE NAME OF THE MEDICINAL PRODUCT

Phenobarbital Teva 15 mg Tablets.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 15 mg phenobarbital
For excipients, see 6.1.

3. PHARMACEUTICAL FORM

Tablets.
White, biconvex tablets marked "APS" over "0310" on one side and plain on the reverse.

4. CLINICAL PARTICULARS

4.1. Therapeutic Indications

Phenobarbital tablets are indicated for the management of all forms of epilepsy, except absence seizures.

4.2. Posology and Method of Administration

For oral administration.

Adults 60 - 180 mg at night.

Children 5 - 8 mg/kg daily.

Elderly Phenobarbital clearance diminishes in the elderly. Therefore, the dose of Phenobarbital is usually lower in elderly patients.

The dose of phenobarbital should be adjusted to meet the needs of individual patients. This usually requires plasma concentration of 15 to 40 micrograms/ml (65 to 170 micromoles/litre).

4.3. Contra-indications

Phenobarbital is contra-indicated in patients with

- known hypersensitivity to phenobarbital, other barbiturates or other ingredients in the tablet
- acute intermittent porphyria
- severe respiratory depression
- severe impairment of renal and hepatic function.

4.4. Special Warnings and Precautions for Use

Suicidal ideation and behaviour have been reported in patients treated with anti-epileptic agents in several indications. A meta-analysis of randomised placebo controlled trials of anti-epileptic drugs has also shown a small increased risk of suicidal ideation and behaviour. The mechanism of this risk is not known and the available data do not exclude the possibility of an increased risk for *Phenobarbital*.

Therefore, patients should be monitored for signs of suicidal ideation and behaviours and appropriate treatment should be considered. Patients (and caregivers of patients) should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge

Phenobarbital should be used with caution in the young, elderly, debilitated or senile patients and those with renal impairment, existing liver disease or respiratory depression (should be avoided if severe), pregnancy and breast-feeding and porphyria.

Prolonged use may result in dependence of the alcohol-barbiturate type and particular care should be taken in treating patients with a history of drug abuse or alcoholism.

Sudden withdrawal should be avoided as severe withdrawal syndrome (rebound insomnia, anxiety, tremor, dizziness, nausea, fits and delirium) may be precipitated.

Acute chronic pain – paradoxical excitement may be induced or important symptoms masked.

- Life-threatening cutaneous reactions Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported with the use of phenobarbital.

- Patients should be advised of the signs and symptoms and monitored closely for skin reactions. The highest risk for occurrence of SJS or TEN is within the first weeks of treatment. (Adoption to individual drug if such data are available)

- If symptoms or signs of SJS or TEN (e.g. progressive skin rash often with blisters or mucosal lesions) are present, phenobarbital treatment should be discontinued.

- The best results in managing SJS and TEN come from early diagnosis and immediate discontinuation of any suspect drug. Early withdrawal is associated with a better prognosis.

- If the patient has developed SJS or TEN with the use of Phenobarbital, phenobarbital must not be re-started in this patient at any time.

This medicine contains lactose. Patients with the rare hereditary problems of galactose intolerance, the lapp lactase deficiency or glucose – galactose malabsorption should not take this medicine.

4.5. Interactions with other Medicinal Products and other forms of Interaction

Effects on Phenobarbital

- Alcohol – concurrent administration with alcohol may lead to an additive CNS depressant effect. This is likely with concurrent administration with other CNS depressants.
- Antidepressants – including MAOIs, SSRIs and tricyclics may antagonise the antiepileptic activity of phenobarbital by lowering the convulsive threshold
- Antiepileptics - phenobarbital plasma concentrations increased by oxcarbazepine, phenytoin and sodium valproate. Vigabatrin possibly decreases phenobarbital plasma concentrations.
- Antipsychotics – concurrent use of chlorpromazine and thioridazine with phenobarbital can reduce the serum levels of either drug.
- Folic acid – if folic acid supplements are given to treat folate deficiency, which can be caused by the use of phenobarbital, the serum phenobarbital levels may fall, leading to decreased seizure control in some patients. (see section 4.6).
- Memantine – the effect of Phenobarbital is possibly reduced.
- Methylphenidate – plasma concentration of Phenobarbital is possibly increased.
- St John’s wort (*Hypericum perforatum*) – the effect of phenobarbital can be reduced by concomitant use of the herbal remedy St John’s wort.

Effects of phenobarbital on other medicines

Phenobarbital increases the rate of metabolism reducing serum concentrations of the following drugs:

- Anti-arrhythmics – disopyramide and quinidine loss of arrhythmia control is possible. Plasma levels of antiarrhythmics should be monitored, if phenobarbital is added or withdrawn. Changes in dosage may be necessary.

- Antibacterials – chloramphenicol, doxycycline, metronidazole and rifampicin. Avoid concomitant use of telithromycin during and for 2 weeks after Phenobarbital.
- Anticoagulants.
- Antidepressants – paroxetine, mianserin and tricyclic antidepressants.
- Antiepileptics – carbamazepine, lamotrigine, tiagabine, zonisamide, primidone and possibly ethosuxamide.
- Antifungals – the antifungal effects of griseofulvin can be reduced or even abolished by concurrent use. Phenobarbital possibly reduces plasma concentrations of itraconazole or posaconazole. Avoid concomitant use of voriconazole.
- Antipsychotics – phenobarbital possibly reduces concentration of aripiprazole.
- Antivirals – phenobarbital possibly reduces plasma levels of abacavir, amprenavir, darunavir, lopinavir, indinavir, nelfinavir, saquinavir.
- Anxiolytics and Hypnotics – clonazepam.
- Aprepitant – phenobarbital possibly reduces plasma concentration of aprepitant.
- Beta-blockers – metoprolol, timolol and possibly propranolol.
- Calcium channel blockers – phenobarbital causes reduced levels of felodipine, isradipine, diltiazem, verapamil, nimodipine and nifedipine and an increase in dosage may be required.
- Cardiac Glycosides – blood levels of digitoxin can be halved by concurrent use.
- Ciclosporin or tacrolimus.
- Corticosteroids.
- Cytotoxics – phenobarbital possibly reduces the plasma levels of etoposide or irinotecan.
- Diuretics – concomitant use with eplerenone should be avoided.
- Haloperidol- serum levels are approximately halved by concurrent use with phenobarbital.
- Hormone Antagonists – gestrinone and possibly toremifene.
- Methadone – levels can be reduced by concurrent use of phenobarbital and withdrawal symptoms have been reported in patients maintained on methadone when phenobarbital has been added. Increases in the methadone dosage may be necessary.
- Montelukast.
- Oestrogens – reduced contraceptive effect.
- Progestogens – reduced contraceptive effect.

- Sodium oxybate – enhanced effects, avoid concomitant use.
- Theophylline – may require an increase in theophylline dose.
- Thyroid hormones - Phenobarbital has been shown to accelerate the metabolism of levothyroxine and liothyronine. Prescribers should be alert for changes in thyroid status if barbiturates are added or withdrawn from patients being treated for hypothyroidism.
- Tibolone
- Tropisetron
- Vitamins – barbiturates possibly increase requirements for vitamin D

Phenobarbital may interfere with some laboratory tests including metyrapone test, phenolamine tests and serum bilirubin estimation.

4.6. Pregnancy and Lactation

Phenobarbital therapy in epileptic pregnant women presents a risk to the foetus in terms of major and minor congenital defects such as congenital craniofacial, digital abnormalities and, less commonly, cleft lip and palate. The risk of teratogenic effects developing appears to be greater if more than one antiepileptic drug is administered. The risk to the mother however is greater if phenobarbital is withheld and seizure control is lost. The risk: benefit balance, in this case, favours continued use of the drug during pregnancy at the lowest possible level to control seizures.

Patients taking phenobarbital should be adequately supplemented with folic acid before conception and during pregnancy (see section 4.5). Folic supplementation during pregnancy can help to counteract the risk of neural tube defects.

Phenobarbital readily crosses the placenta following oral administration and is distributed throughout foetal tissue, the highest concentrations being found in the placenta, foetal liver and brain. Adverse effects on neurobehavioral development have also been reported.

Haemorrhage at birth and addiction are also a risk. Prophylactic treatment with vitamin K¹ for the mother before delivery (as well as the neonate) is recommended, the neonate should be monitored for signs of bleeding.

Phenobarbital is excreted into breast milk and there is a small risk of neonatal sedation. Breast-feeding is therefore not advisable.

4.7. Effects on Ability to Drive and Use Machines

Phenobarbital may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving or operating machines. If affected, patients should not drive or operate machinery.

4.8. Undesirable Effects

Antiepileptic hypersensitivity syndrome may occur. Symptoms include fever, rash, lymphadenopathy and hepatitis.

Blood and the lymphatic system disorders: megaloblastic anaemia (due to folate deficiency), agranulocytosis, thrombocytopenia.

Metabolism and nutritional disorders: osteomalacia, rickets.

Psychiatric disorders: paradoxical reaction (unusual excitement), hallucinations, restlessness and confusion in the elderly, mental depression, memory and cognitive impairment, drowsiness, lethargy.

Nervous system disorders: hyperactivity, behavioural disturbances in children, ataxia, nystagmus.

Cardiac disorders: hypotension.

Respiratory disorders: respiratory depression.

Hepato-biliary: hepatitis, cholestasis.

Skin and subcutaneous tissue disorders: allergic skin reactions (maculopapular morbilliform or scarlatiniform rashes), other skin reactions such as exfoliative dermatitis, erythema multiforme. Severe cutaneous adverse reactions (SCARs): Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported (see section 4.4) very rarely.

Musculoskeletal, connective tissue and bone disorders:

Frequency not known: Dupuytren's contracture, frozen shoulder, arthralgia. There have been reports of decreased bone mineral density, osteopenia, osteoporosis and fractures in patients on long-term therapy with Phenobarbital. The mechanism by which Phenobarbital affects bone metabolism has not been identified.

Reproductive system and breast disorders

Frequency not known: Peyronie's disease

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation 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 Yellow Card Scheme at: www.mhra.gov.uk/yellowcard.

4.9. Overdose

Toxicity varies between patients; tolerance will develop with chronic use. Features of poisoning are to be expected after ingestion of 1g in adults.

Features:

Drowsiness, dysarthria, ataxia, nystagmus and disinhibition. There may also be coma, cardiovascular collapse, cardiac arrest, hypotonia, hyporeflexia, hypothermia, hypotension and respiratory depression. Barbiturates decrease gut motility, which may lead to slow onset and worsening of symptoms or cyclical improvement and worsening of symptoms.

The duration and depth of cerebral depression varies with the dose and tolerance of the patient.

Management

If within 4 hours of ingestion, gastric aspiration or lavage may be of benefit in adults. Consider activated charcoal (50g for an adult, 10-15g for a child under 5 years) if more than 10mg/kg body weight of phenobarbital has been ingested within 1 hour, provided the airway can be protected.

The prime objective of treatment is to maintain vital functions while the majority of the drug is metabolised by hepatic enzymes. Given normal renal function, forced alkaline diuresis (maintaining the urinary pH at approximately 8 by intravenous infusion) may enhance the excretion of the drug from the kidneys. Repeat dose activated charcoal is the best method of enhancing elimination of phenobarbital in symptomatic patients. In severe hypotension dopamine or dobutamine can be used. Treat rhabdomyolysis with urinary alkalinisation. Haemodialysis or haemofiltration may be required for cases of acute renal or severe hyperkalaemia.

Charcoal haemoperfusion is the treatment of choice for the small minority of patients with very severe barbiturate poisoning who fail to improve, or who deteriorate despite good supportive care.

5. PHARMACOLOGICAL PROPERTIES

5.1. Pharmacodynamic Properties

ATC Code: N03A A02 (antiepileptics, barbiturates and derivatives).

Phenobarbital is a long-acting barbiturate, which because of its depressant effect on the motor cortex, is used in the treatment of epilepsy. Phenobarbital has a widespread depressant action on cerebral function.

It has selective anticonvulsant activity and, used in hypnotic doses, it alters the stages of sleep in a dose dependent manner.

It has sedative effects and has some protective action against all varieties of human partial and generalised epilepsy, with the exception of absence

seizures. Phenobarbital is also effective in preventing seizures in the corresponding experimental animal models of epilepsy.

In different studies phenobarbital appears to have had inconsistent effects in suppressing experimental epileptic foci, and epileptic after-discharges, but it inhibits synaptic transmission, at least in the spinal cord. The drug's probable biochemical mechanism of action is through prolonging the opening time of Cl⁻ ion channels in postsynaptic neuronal membranes. This effect causes membrane hyperpolarisation and thus impairs nerve impulse propagation. Phenobarbital also decreases intraneuronal Na⁺ concentrations, and inhibits Ca²⁺ influx into depolarised synaptosomes. It raises brain serotonin levels, and inhibits noradrenaline (norepinephrine) reuptake into synaptosomes. These additional biochemical actions may contribute towards the anticonvulsant effects of the drug.

5.2. Pharmacokinetic Properties

Absorption

Phenobarbital is readily absorbed from the gastrointestinal tract, although it is relatively lipid – insoluble; peak concentrations are reached in about 2 hours after oral administration. Oral absorption of phenobarbital is complete.

Distribution

Peak concentration in plasma occurs several hours after a single dose. 40 - 60% bound to plasma protein and similarly in brain tissue. Phenobarbital crosses the placental barrier and is distributed into breast milk.

Metabolism

The plasma half-life is about 75 to 120 hours in adults but is greatly prolonged in neonates, and shorter (about 21 to 75 hours) in children. The half-life is increased in the elderly and in neonates and is prolonged by renal and hepatic disorders. There is a considerable interindividual variation in Phenobarbital kinetics. Phenobarbital is only partly metabolised in the liver.

Elimination

About 25% of the dose is excreted in the urine unchanged at normal urinary pH, the remainder is inactivated by the liver.

5.3. Preclinical Safety Data

Preclinical information has not been included because the safety profile of phenobarbital has been established after many years of clinical use. Please refer to section 4.

6. PHARMACEUTICAL PARTICULARS

6.1. List of Excipients

Lactose Monohydrate
Maize Starch
Sodium Starch Glycolate (Type A)
Magnesium Stearate (E572)
Dextrin.

6.2. Incompatibilities

Not applicable.

6.3. Shelf Life

HDPE or polypropylene container: 60 months.
Blister: 36 months.

6.4. Special Precautions for Storage

No special precautions for storage.

6.5. Nature and Contents of Container

HDPE or polypropylene containers with caps or child resistant closures in packs of 1000 and 5000 tablets.

PVDC/PVC/aluminium blister strips in packs of 7, 10, 14, 21, 28, 30, 56, 60, 84, 90, 100, 110, 112, 120, 150, 160 and 168.

Not all pack sizes may be marketed.

6.6. Instruction for Use/Handling

Not applicable.

7. MARKETING AUTHORISATION HOLDER

TEVA UK Limited,

Brampton Road, Hampden Park
Eastbourne, East Sussex, BN22 9AG

8. MARKETING AUTHORISATION NUMBER

PL 00289/5133R

**9. DATE OF FIRST AUTHORISATION/RENEWAL OF
AUTHORISATION**

15.12.2004

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18/01/2018

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