OXYCODONE AND ACETAMINOPHEN TABLETS, USP
7.5 mg/325 mg and 7.5 mg/650 mg

In case of respiratory depression, a reversal agent such as naloxone hydrochloride may be utilized.

In respiratory depression, naloxone hydrochloride may be administered by intravenous, intramuscular, subcutaneous, or intranasal route, depending on clinical judgment. Naloxone is usually given 1 to 2 mg by intravenous route. If the patient responds, further increments of 1 to 2 mg may be administered every 3 to 5 minutes until clinical efficacy is achieved or evidence of histamine release occurs (e.g., hypotension, flushing, tachycardia, etc.).

Serious skin reactions, including toxic epidermal necrolysis and erythema multiforme, may occur in patients with serious skin reactions such as Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), and erythema multiforme may be seen with oxycodone given in conjunction with other agents. Therapeutic effects of oxycodone are independent of dose, and patients should be treated with the lowest effective dose to avoid the risk of overdose. If a skin reaction occurs, oxycodone should be discontinued and appropriate treatment instituted.

In patients who are known to be tolerant to other opioids, oxycodone may be given without restriction.

A high portion of oxycodone is N-dealkylated to noroxycodone during first-pass metabolism. Oxycodone is metabolized primarily in the liver by the cytochrome P450 family of enzymes, particularly CYP2D6 and CYP3A4. The principal metabolites of oxycodone are noroxycodone, N-desmethyl oxycodone, and N-desmethyl oxycodone. The principal metabolites of acetaminophen are glucuronide and sulfate conjugates. The major metabolite of acetaminophen is N-acetyl-p-benzoquinoneimine (NAPQI).

Oxycodone is a semisynthetic opioid analgesic whose principal therapeutic action is analgesia. Oxycodone is a pure opioid agonist at the mu-opioid receptor, with a higher affinity for the mu-1 receptor than the mu-2 or mu-3 receptor.

The systemic availability of oxycodone in adults is approximately 50% to 70% following an oral dose, with a half-life of 3.5 to 4 hours.

Oxycodone is eliminated primarily by metabolism in the liver and excretion in the urine. About 15% of the dose is excreted unchanged in the urine, and about 10% is excreted in the feces. Oxycodone is extensively metabolized in the liver. The major metabolites of oxycodone, noroxycodone, and N-desmethyl oxycodone, are conjugated with glucuronic acid and/or glucuronide conjugates.

Oxycodone is contraindicated in any situation where opioids are contraindicated, including patients with known hypersensitivity to any component of this product. It is also contraindicated in patients with a history of addiction or misuse of opioids.

Oxycodone is a schedule II controlled substance and is subject to abuse and diversion. Patients who are prescribed oxycodone should be monitored for evidence of misuse or abuse.

Oxycodone should be administered with caution to patients with impaired liver function, and a lower initial dose should be used in these patients.

Oxycodone is a potent opioid agonist with a relatively long duration of action, and should be administered with caution to patients with impaired renal function.

Oxycodone should be used with caution in elderly patients, and a lower initial dose should be used in these patients.

Oxycodone may cause respiratory depression, and should be used with caution in patients with respiratory compromise.

Oxycodone should be used with caution in patients with a history of addiction, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of misuse or abuse of opioids, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced respiratory depression, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced sedation, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced constipation, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced nausea and vomiting, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced flushing, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced pruritus, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced diaphoresis, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced dorsal pruritus, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced miosis, and a lower initial dose should be used in these patients.

Oxycodone should be used with caution in patients with a history of opioid-induced conjunctival injection, and a lower initial dose should be used in these patients.

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Drug Interactions with Oxycodone

Drug interactions involving coadministration of acetaminophen tablets with oxycodone tablets may result in decreased oxycodone plasma clearance and increased acetaminophen plasma clearance, leading to increased plasma concentration of oxycodone and decreased plasma concentration of acetaminophen. The clinical significance of this interaction is unknown. However, this increase may be of clinical importance, and therefore use of coadministration of these drugs should be carefully monitored. In the presence of hepatic impairment, the pharmacokinetics of oxycodone may be altered and the therapeutic effects of oxycodone may be diminished. Multiple hepatic enzyme systems are involved in the metabolism of oxycodone, and coadministration of drugs that inhibit these enzyme systems may result in increased oxycodone plasma concentration and increased plasma concentration of acetaminophen. Therefore, use of coadministration of these drugs should be carefully monitored.

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