

CZ:L96

PRESCRIBING INFORMATION

**COMPAZINE<sup>®</sup>**

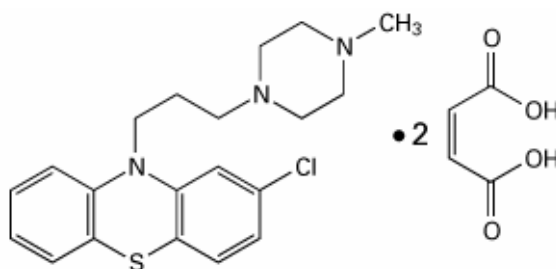
*brand of*

*prochlorperazine*

*antiemetic • antipsychotic • tranquilizer*

**DESCRIPTION**

Compazine (prochlorperazine) is a phenothiazine derivative, present in *Compazine* tablets and *Spansule* sustained release capsules as the maleate. Its chemical name is 2-chloro-10-[3-(4-methyl-1-piperazinyl)propyl]-10*H*-phenothiazine (*Z*)-2-butenedioate (1:2).



prochlorperazine maleate

*Compazine* vials and syrup contain prochlorperazine as the edisylate salt and *Compazine* suppositories contain prochlorperazine base. Empirical formulas (and molecular weights) are: prochlorperazine maleate— $C_{20}H_{24}ClN_3S \cdot 2C_4H_4O_4$  (606.10); prochlorperazine edisylate --  $C_{20}H_{24}ClN_3S \cdot C_2H_6O_6S_2$  (564.14); and prochlorperazine base— $C_{20}H_{24}ClN_3S$  (373.95).

**Tablets**—Each round, yellow-green, coated tablet contains prochlorperazine maleate equivalent to prochlorperazine as follows: 5 mg imprinted SKF and C66; 10 mg imprinted SKF and C67.

**5 mg and 10 mg Tablets**—Inactive ingredients consist of cellulose, lactose, magnesium stearate, polyethylene glycol, sodium croscarmellose, titanium dioxide, D&C Yellow No. 10, FD&C Blue No. 2, FD&C Yellow No. 6, FD&C Red No. 40, iron oxide, starch, stearic acid and trace amounts of other inactive ingredients, including aluminum lake dyes.

**Spansule<sup>®</sup> sustained release capsules**—Each *Compazine<sup>®</sup> Spansule* capsule is so prepared that an initial dose is released promptly and the remaining medication is released gradually over a prolonged period. Food slows absorption of prochlorperazine and decreases  $C_{max}$  by 23% and AUC by 13%.

Each capsule, with black cap and natural body, contains prochlorperazine maleate equivalent to prochlorperazine. The 10 mg capsule is imprinted 10 mg and 3344 on the black cap and is imprinted 10 mg and SB on the natural body. The 15 mg capsule is imprinted 15 mg and 3346 on the black cap and is imprinted 15 mg and SB on the natural body. Inactive ingredients consist of ammonio methacrylate co-polymer, D&C Green No. 5, D&C Yellow No. 10, FD&C Blue No. 1,

32 FD&C Blue No. 1 aluminum lake, FD&C Red No. 40, FD&C Yellow No. 6, gelatin,  
33 hydroxypropyl methylcellulose, propylene glycol, silicon dioxide, simethicone emulsion, sodium  
34 lauryl sulfate, sorbic acid, sugar spheres, talc, triethyl citrate, and trace amounts of other inactive  
35 ingredients.

36 **Vials**, 2 mL (5 mg/mL) and 10 mL (5 mg/mL)—Each mL contains, in aqueous solution, 5 mg  
37 prochlorperazine as the edisylate, 5 mg sodium biphosphate, 12 mg sodium tartrate, 0.9 mg  
38 sodium saccharin and 0.75% benzyl alcohol as preservative.

39 **Suppositories**—Each suppository contains 2½ mg, 5 mg or 25 mg of prochlorperazine; with  
40 glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids  
41 and hydrogenated palm kernel oil fatty acids.

42 **Syrup**—Each 5 mL (1 teaspoonful) of clear, yellow-orange, fruit-flavored liquid contains 5 mg  
43 of prochlorperazine as the edisylate. Inactive ingredients consist of FD&C Yellow No. 6, flavors,  
44 polyoxyethylene polyoxypropylene glycol, sodium benzoate, sodium citrate, sucrose and water.

## 45 **INDICATIONS**

46 For control of severe nausea and vomiting.

47 For the treatment of schizophrenia.

48 Compazine (prochlorperazine) is effective for the short-term treatment of generalized  
49 non-psychotic anxiety. However, *Compazine* is not the first drug to be used in therapy for most  
50 patients with non-psychotic anxiety, because certain risks associated with its use are not shared  
51 by common alternative treatments (e.g., benzodiazepines).

52 When used in the treatment of non-psychotic anxiety, *Compazine* should not be administered at  
53 doses of more than 20 mg per day or for longer than 12 weeks, because the use of *Compazine* at  
54 higher doses or for longer intervals may cause persistent tardive dyskinesia that may prove  
55 irreversible (see WARNINGS).

56 The effectiveness of *Compazine* as treatment for non-psychotic anxiety was established in  
57 4-week clinical studies of outpatients with generalized anxiety disorder. This evidence does not  
58 predict that *Compazine* will be useful in patients with other non-psychotic conditions in which  
59 anxiety, or signs that mimic anxiety, are found (e.g., physical illness, organic mental conditions,  
60 agitated depression, character pathologies, etc.).

61 *Compazine* has not been shown effective in the management of behavioral complications in  
62 patients with mental retardation.

## 63 **CONTRAINDICATIONS**

64 Do not use in patients with known hypersensitivity to phenothiazines.

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

67 Do not use in pediatric surgery.

68 Do not use in pediatric patients under 2 years of age or under 20 lbs. Do not use in children for  
69 conditions for which dosage has not been established.

## 70 **WARNINGS**

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

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

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

87 There is no known treatment for established cases of tardive dyskinesia, although the syndrome  
88 may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic  
89 treatment itself, however, may suppress (or partially suppress) the signs and symptoms of the  
90 syndrome and thereby may possibly mask the underlying disease process.

91 The effect that symptomatic suppression has upon the long-term course of the syndrome is  
92 unknown.

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

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

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

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

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

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

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

125 An encephalopathic syndrome (characterized by weakness, lethargy, fever, tremulousness and  
126 confusion, extrapyramidal symptoms, leukocytosis, elevated serum enzymes, BUN and FBS) has  
127 occurred in a few patients treated with lithium plus an antipsychotic. In some instances, the  
128 syndrome was followed by irreversible brain damage. Because of a possible causal relationship  
129 between these events and the concomitant administration of lithium and antipsychotics, patients  
130 receiving such combined therapy should be monitored closely for early evidence of neurologic  
131 toxicity and treatment discontinued promptly if such signs appear. This encephalopathic  
132 syndrome may be similar to or the same as neuroleptic malignant syndrome (NMS).

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

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

140 Phenothiazines may intensify or prolong the action of central nervous system depressants (e.g.,  
141 alcohol, anesthetics, narcotics).

142 **Usage in Pregnancy:** Safety for the use of *Compazine* during pregnancy has not been  
143 established. Therefore, *Compazine* is not recommended for use in pregnant patients except in  
144 cases of severe nausea and vomiting that are so serious and intractable that, in the judgment of  
145 the physician, drug intervention is required and potential benefits outweigh possible hazards.

146 There have been reported instances of prolonged jaundice, extrapyramidal signs, hyperreflexia or  
147 hyporeflexia in newborn infants whose mothers received phenothiazines.

148 **Nursing Mothers:** There is evidence that phenothiazines are excreted in the breast milk of  
149 nursing mothers. Caution should be exercised when *Compazine* is administered to a nursing  
150 woman.

## 151 **PRECAUTIONS**

152 The antiemetic action of Compazine (prochlorperazine) may mask the signs and symptoms of  
153 overdosage of other drugs and may obscure the diagnosis and treatment of other conditions such  
154 as intestinal obstruction, brain tumor and Reye's syndrome (see WARNINGS).

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

157 Because hypotension may occur, large doses and parenteral administration should be used  
158 cautiously in patients with impaired cardiovascular systems. To minimize the occurrence of  
159 hypotension after injection, keep patient lying down and observe for at least ½ hour. If  
160 hypotension occurs after parenteral or oral dosing, place patient in head-low position with legs  
161 raised. If a vasoconstrictor is required, Levophed<sup>®\*</sup> and Neo-Synephrine<sup>®†</sup> are suitable. Other  
162 pressor agents, including epinephrine, should not be used because they may cause a paradoxical  
163 further lowering of blood pressure.

164 Aspiration of vomitus has occurred in a few post-surgical patients who have received Compazine  
165 (prochlorperazine) as an antiemetic. Although no causal relationship has been established, this  
166 possibility should be borne in mind during surgical aftercare.

167 Deep sleep, from which patients can be aroused, and coma have been reported, usually with  
168 overdosage.

169 Antipsychotic drugs elevate prolactin levels; the elevation persists during chronic administration.  
170 Tissue culture experiments indicate that approximately one third of human breast cancers are  
171 prolactin-dependent *in vitro*, a factor of potential importance if the prescribing of these drugs is  
172 contemplated in a patient with a previously detected breast cancer. Although disturbances such

173 as galactorrhea, amenorrhea, gynecomastia and impotence have been reported, the clinical  
174 significance of elevated serum prolactin levels is unknown for most patients. An increase in  
175 mammary neoplasms has been found in rodents after chronic administration of antipsychotic  
176 drugs. Neither clinical nor epidemiologic studies conducted to date, however, have shown an  
177 association between chronic administration of these drugs and mammary tumorigenesis; the  
178 available evidence is considered too limited to be conclusive at this time.

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

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

183 Because phenothiazines may interfere with thermoregulatory mechanisms, use with caution in  
184 persons who will be exposed to extreme heat.

185 Phenothiazines can diminish the effect of oral anticoagulants.

186 Phenothiazines can produce alpha-adrenergic blockade.

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

189 Antihypertensive effects of guanethidine and related compounds may be counteracted when  
190 phenothiazines are used concomitantly.

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

193 Phenothiazines may lower the convulsive threshold; dosage adjustments of anticonvulsants may  
194 be necessary. Potentiation of anticonvulsant effects does not occur. However, it has been  
195 reported that phenothiazines may interfere with the metabolism of Dilantin<sup>®</sup> and thus precipitate  
196 *Dilantin* toxicity.

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

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

203 To lessen the likelihood of adverse reactions related to cumulative drug effect, patients with a  
204 history of long-term therapy with Compazine (prochlorperazine) and/or other antipsychotics  
205 should be evaluated periodically to decide whether the maintenance dosage could be lowered or  
206 drug therapy discontinued.

207 **Children with acute illnesses (e.g., chickenpox, CNS infections, measles, gastroenteritis) or**  
208 **dehydration seem to be much more susceptible to neuromuscular reactions, particularly**  
209 **dystonias, than are adults. In such patients, the drug should be used only under close**  
210 **supervision.**

211 Drugs which lower the seizure threshold, including phenothiazine derivatives, should not be used  
212 with Amipaque<sup>®§</sup>. As with other phenothiazine derivatives, Compazine (prochlorperazine)  
213 should be discontinued at least 48 hours before myelography, should not be resumed for at least  
214 24 hours postprocedure, and should not be used for the control of nausea and vomiting occurring  
215 either prior to myelography with *Amipaque*, or postprocedure.

216 **Geriatric Use:** Clinical studies of *Compazine* did not include sufficient numbers of subjects  
217 aged 65 and over to determine whether elderly subjects respond differently from younger  
218 subjects. Geriatric patients are more sensitive to the side effects of antipsychotics, including  
219 *Compazine*. These adverse events include hypotension, anticholinergic effects (such as urinary  
220 retention, constipation, and confusion), and neuromuscular reactions (such as parkinsonism and  
221 tardive dyskinesia) (see PRECAUTIONS and ADVERSE REACTIONS). Also, postmarketing  
222 safety experience suggests that the incidence of agranulocytosis may be higher in geriatric  
223 patients compared to younger individuals who received *Compazine*. In general, dose selection for  
224 an elderly patient should be cautious, usually starting at the low end of the dosing range,  
225 reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of  
226 concomitant disease or other drug therapy (see DOSAGE AND ADMINISTRATION).

## 227 **ADVERSE REACTIONS**

228 Drowsiness, dizziness, amenorrhea, blurred vision, skin reactions and hypotension may occur.  
229 Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic  
230 drugs (see WARNINGS).

231 Cholestatic jaundice has occurred. If fever with gripe-like symptoms occurs, appropriate liver  
232 studies should be conducted. If tests indicate an abnormality, stop treatment. There have been a  
233 few observations of fatty changes in the livers of patients who have died while receiving the  
234 drug. No causal relationship has been established.

235 Leukopenia and agranulocytosis have occurred. Warn patients to report the sudden appearance of  
236 sore throat or other signs of infection. If white blood cell and differential counts indicate  
237 leukocyte depression, stop treatment and start antibiotic and other suitable therapy.

## 238 **Neuromuscular (Extrapyramidal) Reactions**

239 These symptoms are seen in a significant number of hospitalized mental patients. They may be  
240 characterized by motor restlessness, be of the dystonic type, or they may resemble parkinsonism.

241 Depending on the severity of symptoms, dosage should be reduced or discontinued. If therapy is  
242 reinstated, it should be at a lower dosage. Should these symptoms occur in children or pregnant

243 patients, the drug should be stopped and not reinstated. In most cases barbiturates by suitable  
244 route of administration will suffice. (Or, injectable Benadryl<sup>®</sup> may be useful.) In more severe  
245 cases, the administration of an anti-parkinsonism agent, except levodopa (see *PDR*), usually  
246 produces rapid reversal of symptoms. Suitable supportive measures such as maintaining a clear  
247 airway and adequate hydration should be employed.

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

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

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

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

260 *In mild cases*, reassurance or a barbiturate is often sufficient. *In moderate cases*, barbiturates will  
261 usually bring rapid relief. *In more severe adult cases*, the administration of an anti-parkinsonism  
262 agent, except levodopa (see *PDR*), usually produces rapid reversal of symptoms. *In children*,  
263 reassurance and barbiturates will usually control symptoms. (Or, injectable *Benadryl* may be  
264 useful. Note: See *Benadryl* prescribing information for appropriate *children's* dosage.) If  
265 appropriate treatment with anti-parkinsonism agents or *Benadryl* fails to reverse the signs and  
266 symptoms, the diagnosis should be reevaluated.

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

275 **Tardive Dyskinesia:** As with all antipsychotic agents, tardive dyskinesia may appear in some  
276 patients on long-term therapy or may appear after drug therapy has been discontinued. The  
277 syndrome can also develop, although much less frequently, after relatively brief treatment  
278 periods at low doses. This syndrome appears in all age groups. Although its prevalence appears  
279 to be highest among elderly patients, especially elderly women, it is impossible to rely upon

280 prevalence estimates to predict at the inception of antipsychotic treatment which patients are  
281 likely to develop the syndrome. The symptoms are persistent and in some patients appear to be  
282 irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue,  
283 face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing  
284 movements). Sometimes these may be accompanied by involuntary movements of extremities. In  
285 rare instances, these involuntary movements of the extremities are the only manifestations of  
286 tardive dyskinesia. A variant of tardive dyskinesia, tardive dystonia, has also been described.

287 There is no known effective treatment for tardive dyskinesia; anti-parkinsonism agents do not  
288 alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be  
289 discontinued if these symptoms appear.

290 Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a  
291 different antipsychotic agent, the syndrome may be masked.

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

294 **Contact Dermatitis:** Avoid getting the Injection solution on hands or clothing because of the  
295 possibility of contact dermatitis.

296 **Adverse Reactions Reported with Compazine (prochlorperazine) or Other**  
297 **Phenothiazine Derivatives:** Adverse reactions with different phenothiazines vary in type,  
298 frequency and mechanism of occurrence, i.e., some are dose-related, while others involve  
299 individual patient sensitivity. Some adverse reactions may be more likely to occur, or occur with  
300 greater intensity, in patients with special medical problems, e.g., patients with mitral  
301 insufficiency or pheochromocytoma have experienced severe hypotension following  
302 recommended doses of certain phenothiazines.

303 Not all of the following adverse reactions have been observed with every phenothiazine  
304 derivative, but they have been reported with 1 or more and should be borne in mind when drugs  
305 of this class are administered: extrapyramidal symptoms (opisthotonos, oculogyric crisis,  
306 hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) some of which have lasted months  
307 and even years—particularly in elderly patients with previous brain damage; grand mal and petit  
308 mal convulsions, particularly in patients with EEG abnormalities or history of such disorders;  
309 altered cerebrospinal fluid proteins; cerebral edema; intensification and prolongation of the  
310 action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates,  
311 alcohol), atropine, heat, organophosphorus insecticides; autonomic reactions (dryness of mouth,  
312 nasal congestion, headache, nausea, constipation, obstipation, adynamic ileus, ejaculatory  
313 disorders/impotence, priapism, atonic colon, urinary retention, miosis and mydriasis);  
314 reactivation of psychotic processes, catatonic-like states; hypotension (sometimes fatal); cardiac  
315 arrest; blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis,  
316 eosinophilia, hemolytic anemia, aplastic anemia); liver damage (jaundice, biliary stasis);  
317 endocrine disturbances (hyperglycemia, hypoglycemia, glycosuria, lactation, galactorrhea,

318 gynecomastia, menstrual irregularities, false-positive pregnancy tests); skin disorders  
319 (photosensitivity, itching, erythema, urticaria, eczema up to exfoliative dermatitis); other allergic  
320 reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral  
321 edema; reversed epinephrine effect; hyperpyrexia; mild fever after large I.M. doses; increased  
322 appetite; increased weight; a systemic lupus erythematosus-like syndrome; pigmentary  
323 retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial  
324 keratopathy, and lenticular and corneal deposits.

325 EKG changes—particularly nonspecific, usually reversible Q and T wave distortions—have been  
326 observed in some patients receiving phenothiazines.

327 Although phenothiazines cause neither psychic nor physical dependence, sudden discontinuance  
328 in long-term psychiatric patients may cause temporary symptoms, e.g., nausea and vomiting,  
329 dizziness, tremulousness.

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

### 333 **DOSAGE AND ADMINISTRATION**

334 **Notes on Injection: Stability**—This solution should be protected from light. This is a clear,  
335 colorless to pale yellow solution; a slight yellowish discoloration will not alter potency. If  
336 markedly discolored, solution should be discarded.

337 **Compatibility**—It is recommended that Compazine (prochlorperazine) Injection not be mixed  
338 with other agents in the syringe.

### 339 **DOSAGE AND ADMINISTRATION—ADULTS**

340 (For children's dosage and administration, see below.) Dosage should be increased more  
341 gradually in debilitated or emaciated patients.

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

347 **1. To Control Severe Nausea and Vomiting:** Adjust dosage to the response of the  
348 individual. Begin with the lowest recommended dosage.

349 **Oral Dosage—Tablets:** Usually one 5 mg or 10 mg tablet 3 or 4 times daily. Daily dosages above  
350 40 mg should be used only in resistant cases.

351 **Spansule capsules:** Initially, usually one 15 mg capsule on arising or one 10 mg capsule q12h.  
352 Daily doses above 40 mg should be used only in resistant cases.

353 **Rectal Dosage:** 25 mg twice daily.

354 **I.M. Dosage:** Initially 5 to 10 mg (1 to 2 mL) injected *deeply* into the upper outer quadrant of the  
355 buttock. If necessary, repeat every 3 or 4 hours. Total I.M. dosage should not exceed 40 mg per  
356 day.

357 **I.V. Dosage:** 2½ to 10 mg (½ to 2 mL) by slow I.V. injection or infusion at a rate not to exceed  
358 5 mg per minute. *Compazine* Injection may be administered either undiluted or diluted in  
359 isotonic solution. A single dose of the drug should not exceed 10 mg; total I.V. dosage should  
360 not exceed 40 mg per day. When administered I.V., do not use bolus injection. Hypotension is a  
361 possibility if the drug is given by I.V. injection or infusion.

362 **Subcutaneous administration is not advisable because of local irritation.**

363 **2. Adult Surgery (for severe nausea and vomiting):** Total parenteral dosage should not  
364 exceed 40 mg per day. Hypotension is a possibility if the drug is given by I.V. injection or  
365 infusion.

366 **I.M. Dosage:** 5 to 10 mg (1 to 2 mL) 1 to 2 hours before induction of anesthesia (repeat once in  
367 30 minutes, if necessary), or to control acute symptoms during and after surgery (repeat once if  
368 necessary).

369 **I.V. Dosage:** 5 to 10 mg (1 to 2 mL) as a slow I.V. injection or infusion 15 to 30 minutes before  
370 induction of anesthesia, or to control acute symptoms during or after surgery. Repeat once if  
371 necessary. *Compazine* (prochlorperazine) may be administered either undiluted or diluted in  
372 isotonic solution, but a single dose of the drug should not exceed 10 mg. The rate of  
373 administration should not exceed 5 mg per minute. When administered I.V., do not use bolus  
374 injection.

375 **3. In Adult Psychiatric Disorders:** Adjust dosage to the response of the individual and  
376 according to the severity of the condition. Begin with the lowest recommended dose. Although  
377 response ordinarily is seen within a day or 2, longer treatment is usually required before maximal  
378 improvement is seen.

379 **Oral Dosage:** *Non-Psychotic Anxiety*—Usual dosage is 5 mg 3 or 4 times daily; by *Spansule*  
380 capsule, usually one 15 mg capsule on arising or one 10 mg capsule q12h. Do not administer in  
381 doses of more than 20 mg per day or for longer than 12 weeks.

382 *Psychotic Disorders including Schizophrenia*—*In relatively mild conditions*, as seen in private  
383 psychiatric practice or in outpatient clinics, dosage is 5 or 10 mg 3 or 4 times daily.

384 *In moderate to severe conditions*, for hospitalized or adequately supervised patients, usual  
385 starting dosage is 10 mg 3 or 4 times daily. Increase dosage gradually until symptoms are  
386 controlled or side effects become bothersome. When dosage is increased by small increments  
387 every 2 or 3 days, side effects either do not occur or are easily controlled. Some patients respond  
388 satisfactorily on 50 to 75 mg daily.

389 *In more severe disturbances*, optimum dosage is usually 100 to 150 mg daily.

390 **I.M. Dosage:** For immediate control of adult schizophrenic patients with severe  
391 symptomatology, inject an initial dose of 10 to 20 mg (2 to 4 mL) *deeply* into the upper outer  
392 quadrant of the buttock. Many patients respond shortly after the first injection. If necessary,  
393 however, repeat the initial dose every 2 to 4 hours (or, in resistant cases, every hour) to gain  
394 control of the patient. More than three or four doses are seldom necessary. After control is  
395 achieved, switch patient to an oral form of the drug at the same dosage level or higher. If, in rare  
396 cases, parenteral therapy is needed for a prolonged period, give 10 to 20 mg (2 to 4 mL) every 4  
397 to 6 hours. Pain and irritation at the site of injection have seldom occurred.

398 **Subcutaneous administration is not advisable because of local irritation.**

### 399 **DOSAGE AND ADMINISTRATION—CHILDREN**

400 **Do not use in pediatric surgery.**

401 Children seem more prone to develop extrapyramidal reactions, even on moderate doses.  
402 Therefore, use lowest effective dosage. Tell parents not to exceed prescribed dosage, since the  
403 possibility of adverse reactions increases as dosage rises.

404 Occasionally the patient may react to the drug with signs of restlessness and excitement; if this  
405 occurs, do not administer additional doses. Take particular precaution in administering the drug  
406 to children with acute illnesses or dehydration (see under Dystonias).

407 When writing a prescription for the 2½ mg size suppository, write “2½,” not “2.5”; this will help  
408 avoid confusion with the 25 mg adult size.

409 **1. Severe Nausea and Vomiting in Children:** Compazine (prochlorperazine) should not be  
410 used in pediatric patients under 20 pounds in weight or 2 years of age. It should not be used in  
411 conditions for which children’s dosages have not been established. Dosage and frequency of  
412 administration should be adjusted according to the severity of the symptoms and the response of  
413 the patient. The duration of activity following intramuscular administration may last up to  
414 12 hours. Subsequent doses may be given by the same route if necessary.

415 **Oral or Rectal Dosage:** More than 1 day’s therapy is seldom necessary.

Weight	Usual Dosage	Not to Exceed
under 20 lbs	not recommended	
20 to 29 lbs	2½ mg 1 or 2 times a day	7.5 mg per day
30 to 39 lbs	2½ mg 2 or 3 times a day	10 mg per day
40 to 85 lbs	2½ mg 3 times a day or 5 mg 2 times a day	15 mg per day

416 **I.M. Dosage:** Calculate each dose on the basis of 0.06 mg of the drug per lb of body weight; give  
417 by deep I.M. injection. Control is usually obtained with one dose.

418 **2. In Children with schizophrenia:**

419 **Oral or Rectal Dosage:** For children 2 to 12 years, starting dosage is 2½ mg 2 or 3 times daily.  
420 Do not give more than 10 mg the first day. Then increase dosage according to patient's response.

421 FOR AGES 2 to 5, total daily dosage usually does not exceed 20 mg.

422 FOR AGES 6 to 12, total daily dosage usually does not exceed 25 mg.

423 **I.M. Dosage:** For ages under 12, calculate each dose on the basis of 0.06 mg of Compazine  
424 (prochlorperazine) per lb of body weight; give by deep I.M. injection. Control is usually obtained  
425 with one dose. After control is achieved, switch the patient to an oral form of the drug at the  
426 same dosage level or higher.

427 **OVERDOSAGE**

428 (See also ADVERSE REACTIONS.)

429 SYMPTOMS—Primarily involvement of the extrapyramidal mechanism producing some of the  
430 dystonic reactions described above.

431 Symptoms of central nervous system depression to the point of somnolence or coma. Agitation  
432 and restlessness may also occur. Other possible manifestations include convulsions, EKG  
433 changes and cardiac arrhythmias, fever and autonomic reactions such as hypotension, dry mouth  
434 and ileus.

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

444 If administration of a stimulant is desirable, amphetamine, dextroamphetamine or caffeine with  
445 sodium benzoate is recommended.

446 Stimulants that may cause convulsions (e.g., picrotoxin or pentylenetetrazol) should be avoided.

447 If hypotension occurs, the standard measures for managing circulatory shock should be initiated.  
448 If it is desirable to administer a vasoconstrictor, *Levophed* and *Neo-Synephrine* are most suitable.  
449 Other pressor agents, including epinephrine, are not recommended because phenothiazine

450 derivatives may reverse the usual elevating action of these agents and cause a further lowering of  
451 blood pressure.

452 Limited experience indicates that phenothiazines are *not* dialyzable.

453 *Special note on Spansule capsules*—Since much of the *Spansule* capsule medication is coated for  
454 gradual release, therapy directed at reversing the effects of the ingested drug and at supporting  
455 the patient should be continued for as long as overdosage symptoms remain. Saline cathartics are  
456 useful for hastening evacuation of pellets that have not already released medication.

#### 457 **HOW SUPPLIED**

458 **Tablets**—5 and 10 mg, in bottles of 100; in Single Unit Packages of 100 (intended for  
459 institutional use only).

460 5 mg 100's: NDC 0007-3366-20

461 5 mg SUP 100's: NDC 0007-3366-21

462 10 mg 100's: NDC 0007-3367-20

463 10 mg SUP 100's: NDC 0007-3367-21

464 **Spansule capsules**—10 and 15 mg, in bottles of 50.

465 10 mg 50's: NDC 0007-3344-15

466 15 mg 50's: NDC 0007-3346-15

467 **Vials**—2 mL (5 mg/mL), in boxes of 25 and 10 mL (5 mg/mL), in boxes of 1.

468 2 mL (5 mg/mL), in boxes of 25: NDC 0007-3352-16

469 10 mL (5 mg/mL), in boxes of 1: NDC 0007-3343-01

470 **Suppositories**—2½ mg (for young children), 5 mg (for older children) and 25 mg (for adults),  
471 in boxes of 12.

472 2½ mg, in boxes of 12: NDC 0007-3360-03

473 5 mg, in boxes of 12: NDC 0007-3361-03

474 25 mg, in boxes of 12: NDC 0007-3362-03

475 **Syrup**—5 mg/5 mL (1 teaspoonful) in 4 fl oz bottles.

476 5 mg/5 mL, 4 fl oz: NDC 0007-3363-44

477

478 Store Compazine (prochlorperazine) vials below 30°C (86°F). Do not freeze. Other dosage forms  
479 can be stored between 15° and 30°C (59° and 86°F). Protect from light.

480 \* norepinephrine bitartrate, Abbott Laboratories.

481 † phenylephrine hydrochloride, Abbott Laboratories.

482 \* phenytoin, Parke-Davis.

483 § metrizamide, Sanofi Pharmaceuticals.

484 †† diphenhydramine hydrochloride, Parke-Davis.

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488 Compazine<sup>®</sup> *Spansule* capsules are manufactured by **International Processing Corporation**,  
489 Winchester, KY 40391



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492 Research Triangle Park, NC 27709

493 CZ:L96