

**WARNING: ADDICTION, ABUSE, AND MISUSE; RISK EVALUATION AND MITIGATION STRATEGY (REMS); LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME; CYCLOCHROME P450 3A4 INTERACTION; HEPATOXICITY; and RISKS FROM CONCOMITANT USE WITH BENZODIAZEPINES OR OTHER CNS DEPRESSANTS**

**Addiction, Abuse, and Misuse**  
Oxycodone and acetaminophen tablets expose 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 oxycodone and acetaminophen tablets, and monitor all patients regularly for the development of these behaviors and conditions [see WARNINGS].

**Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)**  
To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse, the Food and Drug Administration (FDA) has required a REMS for these products [see WARNINGS]. Under the requirements of the REMS, drug companies with approved opioid analgesic products must make REMS-compliant education programs available to healthcare providers. Healthcare providers are strongly encouraged to:

- complete a REMS-compliant education program;
- counsel patients and/or their caregivers, with every prescription, on safe use, serious risks, storage, and disposal of these products;
- emphasize to patients and their caregivers the importance of reading the Medication Guide every time it is provided by their pharmacist; and
- consider other tools to improve patient, household, and community safety.

**Life-Threatening Respiratory Depression**  
Serious, life-threatening, or fatal respiratory depression may occur with use of oxycodone and acetaminophen tablets. Monitor for respiratory depression, especially during initiation of oxycodone and acetaminophen tablets or following a dose increase [see WARNINGS].

**Accidental Ingestion**  
Accidental ingestion of oxycodone and acetaminophen tablets, especially by children, can result in a fatal overdose of oxycodone and acetaminophen tablets [see WARNINGS].

**Neonatal Opioid Withdrawal Syndrome**  
Prolonged use of oxycodone and acetaminophen tablets 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].

**Cyclochrome P450 3A4 Interaction**  
The concomitant use of oxycodone and acetaminophen tablets with all cyclochrome 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 cyclochrome P450 3A4 inducer may result in an increase in oxycodone plasma concentration. Monitor patients receiving oxycodone and acetaminophen tablets and any CYP3A4 inhibitor or inducer [see CLINICAL PHARMACOLOGY, WARNINGS, PRECAUTIONS; Drug Interactions].

**Hepatoxicity**  
Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with the use of acetaminophen at doses that exceed 4000 mg per day, and often involve more than one acetaminophen-containing product.

**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, PRECAUTIONS; Drug Interactions].

• Reserve concomitant prescribing of oxycodone and acetaminophen tablets 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.

**DESCRIPTION**

Oxycodone hydrochloride and acetaminophen are available in tablets for oral administration.

Each Oxycodone and Acetaminophen Tablet, 2.5 mg/300 mg contains:

Oxycodone Hydrochloride USP ..... 2.5 mg\*  
(\* 2.5 mg Oxycodone Hydrochloride is equivalent to 2.2409 mg Oxycodone)  
Acetaminophen USP ..... 300 mg

Each Oxycodone and Acetaminophen Tablet, 5 mg/300 mg contains:

Oxycodone Hydrochloride USP ..... 5 mg\*  
(\* 5 mg Oxycodone Hydrochloride is equivalent to 4.4815 mg Oxycodone)  
Acetaminophen USP ..... 300 mg

Each Oxycodone and Acetaminophen Tablet, 7.5 mg/300 mg contains:

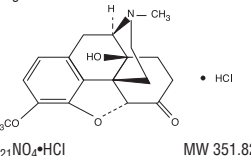
Oxycodone Hydrochloride USP ..... 7.5 mg\*  
(\* 7.5 mg Oxycodone Hydrochloride is equivalent to 6.7228 mg Oxycodone)  
Acetaminophen USP ..... 300 mg

Each Oxycodone and Acetaminophen Tablet, 10 mg/300 mg contains:

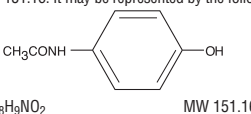
Oxycodone Hydrochloride USP ..... 10 mg\*  
(\* 10 mg Oxycodone Hydrochloride is equivalent to 8.9637 mg Oxycodone)  
Acetaminophen USP ..... 300 mg

**Inactive Ingredients**  
The tablets contain: colloidal silicon dioxide, croscarmellose sodium, crospovidone, microcrystalline cellulose, croscarmellose sodium, and stearic acid. In addition, the 2.5 mg/300 mg strength contains FD&C Blue #1 Aluminum Lake; the 5 mg/300 mg strength contains D&C Yellow #10; the 7.5 mg/300 mg strength contains FD&C Red #40 Aluminum Lake; the 10 mg/300 mg strength contains FD&C Yellow #6 Aluminum Lake.

Oxycodone and acetaminophen tablets contain oxycodone, 14-hydroxydihydrocodeinone, a semisynthetic opioid analgesic which occurs as a white to off-white fine crystalline powder. The molecular formula for oxycodone hydrochloride is C<sub>18</sub>H<sub>21</sub>NO<sub>4</sub>·HCl and the molecular weight is 351.82. It is derived from the opium alkaloid thebaine, and may be represented by the following structural formula:



Oxycodone and acetaminophen tablets contain acetaminophen, 4'-hydroxyacetanilide, a non-opiate, non-salicylate analgesic and antipyretic which occurs as a white, odorless, crystalline powder. The molecular formula for acetaminophen is C<sub>9</sub>H<sub>9</sub>NO<sub>2</sub> and the molecular weight is 151.16. It may be represented by the following structural formula:



**CLINICAL PHARMACOLOGY**  
**Mechanism of Action**  
Oxycodone is a full opioid agonist with relative selectivity for the mu-opioid receptor, although it can interact with 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.

The precise mechanism of the analgesic properties of acetaminophen is not established but is thought to involve central actions.

**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.

Therapeutic doses of acetaminophen have negligible effects on the cardiovascular or respiratory systems; however, toxic doses may cause circulatory failure and rapid, shallow breathing.

**Effects on the Gastrointestinal Tract and Other Smooth Muscle**  
Oxycodone causes a reduction in motility associated with an increase in smooth muscle tone in the antrum of the 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 the Cardiovascular System**  
Oxycodone produces peripheral vasodilation which may result in orthostatic hypotension or syncope. Manifestations of histamine release and/or peripheral vasodilation 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]. 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 symptoms such as low libido, impotence, erectile dysfunction, amenorrhea, or infertility. The causal role of opioids in the 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].

**Effects on the Immune System**  
Opioids have been shown to have a variety of effects on components of the immune system. 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 opioid agonists. 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].

**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].

**Pharmacokinetics**  
**Absorption and Distribution**  
The mean absolute oral bioavailability of oxycodone in cancer patients was reported to be about 87%. Oxycodone has been shown to be 45% bound to human plasma proteins *in vitro*. The volume of distribution after intravenous administration is 211.9 ± 186.6 L.

Absorption of oxycodone is rapid and almost complete from the GI tract after oral administration. With overdose, absorption is complete in 4 hours. Acetaminophen is relatively uniformly distributed throughout most body fluids. Binding of the drug to plasma proteins is variable; only 20% to 50% may be bound at the concentrations encountered during acute intoxication.

**Metabolism and Elimination**  
**Oxycodone**  
In humans, oxycodone is extensively metabolized to noroxycodone by means of CYP3A-mediated N-demethylation, oxycodone by means of CYP2D6-mediated O-demethylation, and their glucuronides [see PRECAUTIONS; Drug Interactions].

**Acetaminophen**  
Acetaminophen is rapidly absorbed from the gastrointestinal tract and is distributed throughout most body tissues. A small fraction (10-25%) of acetaminophen is bound to plasma proteins. The plasma half-life is 1.25 to 3 hours, but may be increased by liver damage and following overdose. Elimination of acetaminophen is principally by liver metabolism (conjugation) and subsequent renal excretion of metabolites. Acetaminophen is primarily metabolized in the liver by first-order kinetics and involves three principal separate pathways: conjugation with glucuronide; conjugation with sulfate; and oxidation via the cyclochrome P450-dependent, mixed-function oxidase enzyme pathway to form a reactive intermediate metabolite, which conjugates with glutathione and is then further metabolized to form cysteine and mercapturic acid conjugates. The principal cyclochrome P450 isoenzyme involved appears to be CYP2E1, with CYP1A2 and CYP3A4 as additional pathways. Approximately 85% of an oral dose appears in the urine within 24 hours of administration, most as the glucuronide conjugate, with small amounts of other conjugates and unchanged drug. See OVERDOSAGE for toxicity information.

**INDICATIONS AND USAGE**  
Oxycodone and acetaminophen tablets are 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], reserve oxycodone and acetaminophen tablets for use in patients for whom alternative treatment options [e.g., non-opioid analgesics]

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

**CONTRAINDICATIONS**  
Oxycodone and acetaminophen tablets are contraindicated in patients with:

- Significant respiratory depression [see WARNINGS]
- Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment [see WARNINGS]
- Known or suspected gastrointestinal obstruction, including paralytic ileus [see WARNINGS]
- Hypersensitivity to oxycodone, acetaminophen, or any other component of the product (e.g., anaphylaxis) [see WARNINGS, ADVERSE REACTIONS]

**WARNINGS**  
**Addiction, Abuse, and Misuse**  
Oxycodone and acetaminophen tablets contain oxycodone, a Schedule II controlled substance. As an opioid, oxycodone and acetaminophen tablets expose users to the risks of addiction, abuse, and misuse [see DRUG ABUSE AND DEPENDENCE].

Although the risk of addiction in any individual is unknown, it can occur in patients appropriately prescribed oxycodone and acetaminophen tablets. Addiction can occur at recommended dosages and if the drug is misused or abused.

Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing oxycodone and acetaminophen tablets, and monitor all patients receiving oxycodone and acetaminophen tablets 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 oxycodone and acetaminophen tablets, but use in such patients necessitates intensive counseling about the risks and proper use of oxycodone and acetaminophen tablets along with intensive monitoring for signs of addiction, abuse, and misuse. Consider prescribing naloxone for the emergency treatment of opioid overdose [see WARNINGS, Life-Threatening Respiratory Depression, DOSAGE AND ADMINISTRATION; Patient Access to Naloxone for the Emergency Treatment of Opioid Overdose].

Opioids are sought by drug abusers and people with addiction disorders and are subject to criminal diversion. Consider these risks when prescribing or dispensing oxycodone and acetaminophen tablets. Strategies to reduce these risks include prescribing the drug in the smallest appropriate quantity and advising the patient on the proper disposal of unused drug [see PRECAUTIONS; Information for Patients/Caregivers]. 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.

**Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)**  
To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse, the Food and Drug Administration (FDA) has required a Risk Evaluation and Mitigation Strategy (REMS) for these products. Under the requirements of the REMS, drug companies with approved opioid analgesic products must make REMS-compliant education programs available to healthcare providers. Healthcare providers are strongly encouraged to do all of the following:

- Complete a REMS-compliant education program offered by an accredited provider of continuing education (CE) or another education program that includes all the elements of the FDA Education Blueprint for Health Care Providers Involved in the Management or Support of Patients with Pain.
- Discuss the safe use, serious risks, and proper storage and disposal of opioid analgesics with patients and/or their caregivers every time these medicines are prescribed. The Patient Counseling Guide (PCG) can be obtained at this link: [www.fda.gov/OpioidAnalgesicREMSPCG](http://www.fda.gov/OpioidAnalgesicREMSPCG).
- Emphasize to patients and their caregivers the importance of reading the Medication Guide that they will receive from their pharmacist every time an opioid analgesic is dispensed to them.
- Consider using other tools to improve patient, household, and community safety, such as patient-prescriber agreements that reinforce patient-prescriber responsibilities.

To obtain further information on the opioid analgesic REMS and for a list of accredited REMS CME/CE, call 800-503-0784, or log on to [www.opioidanalgesicsrem.com](http://www.opioidanalgesicsrem.com). The FDA Blueprint can be found at [www.fda.gov/OpioidAnalgesicREMSBlueprint](http://www.fda.gov/OpioidAnalgesicREMSBlueprint).

**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]. Carbon dioxide (CO<sub>2</sub>) 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 oxycodone and acetaminophen tablets, 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 oxycodone and acetaminophen tablets.

To reduce the risk of respiratory depression, proper dosing and titration of oxycodone and acetaminophen tablets are essential [see DOSAGE AND ADMINISTRATION]. Overestimating the oxycodone and acetaminophen tablets dosage when converting patients from another opioid product can result in a fatal overdose with the first dose.

Accidental ingestion of oxycodone and acetaminophen tablets, especially by children, can result in respiratory depression and death due to an overdose of oxycodone and acetaminophen tablets.

Educate patients and caregivers on how to recognize respiratory depression and emphasize the importance of calling 911 or getting emergency medical help right away in the event of a known or suspected overdose [see PRECAUTIONS; Information for Patients/Caregivers].

Opioids can cause sleep-related breathing disorders including central sleep apnea (CSA) and sleep-related hypoxemia. Opioid use increases the risk of CSA in a dose-dependent fashion. In patients who present with CSA, consider decreasing the opioid dosage using best practices for opioid taper [see DOSAGE AND ADMINISTRATION].

**Patient Access to Naloxone for the Emergency Treatment of Opioid Overdose**

Discuss the availability of naloxone for the emergency treatment of opioid overdose with the patient and caregiver and assess the potential need for access to naloxone, both when initiating and renewing treatment with oxycodone and acetaminophen tablets. Inform patients and caregivers about the various ways to obtain naloxone as permitted by individual state naloxone dispensing and prescribing requirements or guidelines (e.g., by prescription, directly from a pharmacist, or as part of a community-based program). Educate patients and caregivers on how to recognize respiratory depression and emphasize the importance of calling 911 or getting emergency medical help, even if naloxone is administered [see PRECAUTIONS; Information for Patients/Caregivers].

Consider prescribing naloxone, based on the patient's risk factors for overdose, such as concomitant use of other CNS depressants, a history of opioid use disorder, or prior opioid overdose. The presence of risk factors for overdose should not prevent the proper management of pain in any given patient. Also consider prescribing naloxone if the patient has household members (including children) or other close contacts at risk for accidental ingestion or overdose. If naloxone is prescribed, educate patients and caregivers on how to treat with naloxone [see WARNINGS; Addiction, Abuse, and Misuse, Risks from Concomitant Use with Benzodiazepines or Other CNS Depressants; PRECAUTIONS; Information for Patients/Caregivers].

**Neonatal Opioid Withdrawal Syndrome**  
Prolonged use of oxycodone and acetaminophen tablets 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 PRECAUTIONS; Information for Patients/Caregivers; Pregnancy].

**Risks of Concomitant Use or Discontinuation of Cyclochrome P450 3A4 Inhibitors and Inducers**  
Concomitant use of oxycodone and acetaminophen tablets 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 hydrochloride and prolong opioid adverse reactions, which may cause potentially fatal respiratory depression [see WARNINGS], particularly when an inhibitor is added after a stable dose of oxycodone and acetaminophen tablets is achieved. Similarly, discontinuation of a CYP3A4 inducer, such as rifampin, carbamazepine, and phenytoin, in oxycodone and acetaminophen tablets-treated patients may increase oxycodone plasma concentrations and prolong opioid adverse reactions. When using oxycodone and acetaminophen tablets with CYP3A4 inhibitors or discontinuing CYP3A4 inducers in oxycodone and acetaminophen tablets-treated patients, monitor patients closely at frequent intervals and consider dosage reduction of oxycodone and acetaminophen tablets until stable drug effects are achieved [see PRECAUTIONS; Drug Interactions].

Concomitant use of oxycodone and acetaminophen tablets with CYP3A4 inducers or discontinuation of a CYP3A4 inhibitor could decrease oxycodone hydrochloride plasma concentrations, decrease opioid efficacy or, possibly, lead to a withdrawal syndrome in a patient who had developed physical dependence to oxycodone hydrochloride. When using oxycodone and acetaminophen tablets 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 PRECAUTIONS; Drug Interactions].

**Risks from Concomitant Use with Benzodiazepines or Other CNS Depressants**  
Profound sedation, respiratory depression, coma, and death may result from the concomitant use of oxycodone and acetaminophen tablets 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 PRECAUTIONS; Drug Interactions].

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.

If concomitant use is warranted, consider prescribing naloxone for the emergency treatment of opioid overdose [see WARNINGS, Life-Threatening Respiratory Depression, DOSAGE AND ADMINISTRATION; Patient Access to Naloxone for the Emergency Treatment of Opioid Overdose].

Advise both patients and caregivers about the risks of respiratory depression and sedation when oxycodone and acetaminophen tablets are used with benzodiazepines or other CNS depressants (including alcohol and illicit drugs). Advise patients not to drive or operate heavy 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.

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

The use of oxycodone and acetaminophen tablets 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:** Oxycodone and acetaminophen tablets-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 oxycodone and acetaminophen tablets [see WARNINGS, Life-Threatening Respiratory Depression].

**Elderly, Cachectic, or Debilitated Patients:** Life-threatening respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients than they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients [see WARNINGS, Life-Threatening Respiratory Depression].

Monitor such patients closely, particularly when initiating and titrating oxycodone and acetaminophen tablets and when oxycodone and acetaminophen tablets are given concomitantly with other drugs that depress respiratory [see WARNINGS, Life-Threatening Respiratory Depression]. Alternatively, consider the use of non-opioid analgesics in these patients.

**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. Warn 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.

**Severe Hypotension**  
Oxycodone and acetaminophen tablets 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 PRECAUTIONS; Drug Interactions]. Monitor these patients for signs of hypotension after initiating or titrating the dosage of oxycodone and acetaminophen tablets. In patients with circulatory shock oxycodone and acetaminophen tablets may cause vasodilatation that can further reduce cardiac output and blood pressure. Avoid the use of oxycodone and acetaminophen tablets with circulatory shock.

**Hepatotoxicity**  
Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with the use of acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen-containing product. The excessive intake of acetaminophen may be intentional to cause self-harm or unintentional as patients attempt to obtain more pain relief or unknowingly take other acetaminophen-containing products.

The risk of acute liver failure is higher in individuals with underlying liver disease and in individuals who ingest alcohol while taking acetaminophen.

Instruct patients to look for acetaminophen or APAP on package labels and not to use more than one product that contains acetaminophen. Instruct patients to seek medical attention immediately upon ingestion of more than 4000 milligrams of acetaminophen per day, even if they feel well.

**Serious Skin Reactions**  
Rarely, acetaminophen may cause serious skin reactions such as acute generalized exanthematous pustulosis (AGEP), Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. Patients should be informed about the signs of serious skin reactions, and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

**Hypersensitivity/Anaphylaxis**  
There have been post-marketing reports of hypersensitivity and anaphylaxis associated with use of acetaminophen. Clinical signs included swelling of the face, mouth, and throat, and respiratory distress, urticaria, rash, pruritus, and vomiting. There were infrequent reports of life-threatening anaphylaxis requiring emergency medical attention. Instruct patients to discontinue oxycodone and acetaminophen tablets immediately and seek medical care if they experience these symptoms. Do not prescribe oxycodone and acetaminophen tablets for patients with known hypersensitivity allergy [see PRECAUTIONS; Information for Patients/Caregivers].

**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 CO<sub>2</sub> retention (e.g., those with evidence of increased intracranial pressure or brain tumors), oxycodone and acetaminophen tablets may reduce respiratory drive, and the resultant CO<sub>2</sub> retention can further increase intracranial pressure. Monitor such patients for signs of sedation and respiratory depression, particularly when initiating therapy with oxycodone and acetaminophen tablets.

Opioids may also obscure the clinical course in a patient with a head injury. Avoid the use of oxycodone and acetaminophen tablets in patients with impaired consciousness or coma.

**Risks of Use in Patients with Gastrointestinal Conditions**  
Oxycodone and acetaminophen tablets are contraindicated in patients with known or suspected gastrointestinal obstruction, including paralytic ileus.

The administration of oxycodone and acetaminophen tablets, or other opioids may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

The oxycodone in oxycodone and acetaminophen tablets 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.

**Increased Risk of Seizures in Patients with Seizure Disorders**  
The oxycodone in oxycodone and acetaminophen tablets 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 oxycodone and acetaminophen tablets therapy.

**Withdrawal**  
Do not abruptly discontinue oxycodone and acetaminophen tablets in a patient physically dependent on opioids. When discontinuing oxycodone and acetaminophen tablets in a physically dependent patient, gradually taper the dosage. Rapid tapering of oxycodone and acetaminophen tablets in a patient physically dependent on opioids may lead to a withdrawal syndrome and return of pain [see DOSAGE AND ADMINISTRATION, DRUG ABUSE AND DEPENDENCE].

Additionally, avoid the use of mixed agonist/antagonist (e.g., pentazocine, nalbuphine, and buprenorphine) or partial agonist (e.g., buprenorphine) analgesics in patients who are receiving a full opioid agonist analgesic, including oxycodone and acetaminophen tablets. In these patients, mixed agonist/antagonist and partial agonist analgesics may reduce the analgesic effect and/or precipitate withdrawal symptoms [see PRECAUTIONS; Drug Interactions]. Risks of Driving and Operating Machinery

Oxycodone and acetaminophen tablets 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 oxycodone and acetaminophen tablets and know how they will react to the medication [see PRECAUTIONS; Information for Patients/Caregivers].

**PRECAUTIONS**  
**Information for Patients/Caregivers**  
Advise the patient to read the FDA-approved patient labeling (Medication Guide).

**Storage and Disposal**  
Because of the risks associated with accidental ingestion, misuse, and abuse, advise patients to store oxycodone and acetaminophen tablets securely, out of sight and reach of children, and in a location not accessible by others, including visitors to the home [see WARNINGS, DRUG ABUSE AND DEPENDENCE]. Inform patients that leaving oxycodone and acetaminophen tablets unsecured can pose a deadly risk to others in the home.

Advise patients and caregivers that when medicines are no longer needed, they should be disposed of promptly. Expired, unwanted, or unused oxycodone and acetaminophen tablets should be disposed of by flushing the unused medication down the toilet if a drug take-back option is not readily available. Inform patients that they can visit [www.fda.gov/drugdisposal](http://www.fda.gov/drugdisposal) for a complete list of medicines recommended for disposal by flushing, as well as additional information on disposal of unused medicines.

**Addition, Abuse, and Misuse**  
Inform patients that the use of oxycodone and acetaminophen tablets, even when taken as recommended, can result in addiction, abuse, and misuse, which can lead to overdose and death [see WARNINGS]. Instruct patients not to share oxycodone and acetaminophen tablets with others and to take steps to protect oxycodone and acetaminophen tablets from theft or misuse.

**Life-Threatening Respiratory Depression**  
Inform patients of the risk of life-threatening respiratory depression, including information that the risk is greatest when starting oxycodone and acetaminophen tablets or when the dosage is increased, and that it can occur even at recommended dosages.

Educate patients and caregivers on how to recognize respiratory depression and emphasize the importance of calling 911 or getting emergency medical help right away in the event of a known or suspected overdose [see WARNINGS, Life-Threatening Respiratory Depression].

**Patient Access to Naloxone for the Emergency Treatment of Opioid Overdose**  
Discuss with the patient and caregiver the availability of naloxone for the emergency treatment of opioid overdose, both when initiating and renewing treatment with oxycodone and acetaminophen tablets. Inform patients and caregivers about the various ways to obtain naloxone as permitted by individual state naloxone dispensing and prescribing requirements or guidelines (e.g., by prescription, directly from a pharmacist, or as part of a community-based program) [see WARNINGS, Life-Threatening Respiratory Depression, DOSAGE AND ADMINISTRATION].

Educate patients and caregivers on how to recognize the signs and symptoms of an overdose.

Explain to patients and caregivers that naloxone's effects are temporary, and that they must call 911 or get emergency medical help right away in all cases of known or suspected opioid overdose, even if naloxone is administered [see OVERDOSAGE].

If naloxone is prescribed, also advise patients and caregivers:

- How to treat with naloxone in the event of an opioid overdose
- To tell family and friends about their naloxone and to keep it in a place where family and friends can access it in an emergency
- To read the Patient Information (or other educational material) that will come with their naloxone. Emphasize the importance of doing this before an opioid emergency happens, so the patient and caregiver will know what to do.

**Monoamine Oxidase Inhibitors (MAOIs)**

The concomitant use of opioids and MAOIs, such as phenelzine, tranylcypromine, linezolid, may manifest as serotonin syndrome or opioid toxicity (e.g., respiratory depression, coma) [see **WARNINGS**]. The use of oxycodone and acetaminophen tablets 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.

**Mixed Agonist/Antagonist and Partial Agonist Opioid Analgesics**

The concomitant use of opioids with other opioid analgesics, such as butorphanol, nalbuphine, pentazocine, may reduce the analgesic effect of oxycodone and acetaminophen tablets and/or precipitate withdrawal symptoms. Advise patient to avoid concomitant use of these drugs.

**Muscle Relaxants**

Oxycodone and acetaminophen tablets may enhance the neuromuscular-blocking action of skeletal muscle relaxants and produce an increase in the degree of respiratory depression.

If concomitant use is warranted, monitor patients for signs of respiratory depression that may be greater than otherwise expected and decrease the dosage of oxycodone and acetaminophen tablets and/or the muscle relaxant as necessary. Due to the risk of respiratory depression with concomitant use of skeletal muscle relaxants and opioids, consider prescribing naloxone for the emergency treatment of opioid overdose [see **WARNINGS**].

**Diuretics**

Opioids can reduce the efficacy of diuretics by inducing the release of antidiuretic hormone. If concomitant use is warranted, monitor patients for signs of diminished diuresis and/or effects on blood pressure and increase the dosage of the diuretic as needed.

**Anticholinergic Drugs**

The concomitant use of anticholinergic drugs may increase risk of urinary retention and/or severe constipation, which may lead to paralytic ileus.

If concomitant use is warranted, monitor patients for signs of urinary retention or reduced gastric motility when oxycodone and acetaminophen tablets are used concomitantly with anticholinergic drugs.

**Alcohol, Ethyl**

Hepatotoxicity has occurred in chronic alcoholics following various dose levels (moderate to excessive) of acetaminophen. **Oral Contraceptives**

Increase in glucuronidation resulting in increased plasma clearance and a decreased half-life of acetaminophen. **Charcoal (activated)**

Reduces acetaminophen absorption when administered as soon as possible after overdose.

**Beta Blockers (Propranolol)**

Propranolol appears to inhibit the enzyme systems responsible for the glucuronidation and oxidation of acetaminophen. Therefore, the pharmacologic effects of acetaminophen may be increased.

**Loop Diuretics**

The effects of the loop diuretic may be decreased because acetaminophen may decrease renal prostaglandin excretion and decrease plasma renin activity.

**Lamotrigine**

Serum lamotrigine concentrations may be reduced, producing a decrease in therapeutic effects.

**Probenecid**

Probenecid may increase the therapeutic effectiveness of acetaminophen slightly.

**Zidovudine**

The pharmacologic effects of zidovudine may be decreased because of enhanced non-hepatic or renal clearance of zidovudine.

**Drug/Laboratory Test Interactions**

Depending on the sensitivity/specificity and the test methodology, the individual components of oxycodone and acetaminophen tablets may cross-react with assays used in the preliminary detection of cocaine (primary urinary metabolite, benzoylecgonine) or marijuana (cannabinoids) in human urine. A more specific alternate chemical method must be used in order to obtain a confirmed analytical result. The preferred confirmatory method is gas chromatography/mass spectrometry (GC/MS). Moreover, clinical considerations and professional judgment should be applied to any drug-of-abuse test result, particularly when preliminary positive results are used. Acetaminophen may interfere with home blood glucose measurement systems; decreases of > 20% in mean glucose values may be noted. This effect appears to be drug, concentration and system dependent.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**

**Carcinogenesis**  
Long-term studies to evaluate the carcinogenic potential of the combination of oxycodone hydrochloride and acetaminophen have not been conducted.

Long-term studies in mice and rats have been completed by the National Toxicology Program to evaluate the carcinogenic potential of acetaminophen. In 2-year feeding studies, F344/N rats and B6C3F1 mice were fed a diet containing acetaminophen up to 6000 ppm. Female rats demonstrated equivocal evidence of carcinogenic activity based on increased incidences of mononuclear cell leukemia at 0.8 times the maximum human daily dose (MHDD) of 4 grams/day, based on a body surface area comparison. In contrast, there was no evidence of carcinogenic activity in male rats that received up to 0.7 times or mice at up to 1.2-1.4 times the MHDD, based on a body surface area comparison.

**Mutagenesis**

The combination of oxycodone hydrochloride and acetaminophen has not been evaluated for mutagenicity. Oxycodone alone was negative in a bacterial reverse mutation assay (Ames), an *in vitro* chromosome aberration assay with human lymphocytes without metabolic activation and an *in vivo* mouse micronucleus assay. Oxycodone was clastogenic in the human lymphocyte chromosomal assay in the presence of metabolic activation and in the mouse lymphoma assay with or without metabolic activation.

In the published literature, acetaminophen has been reported to be clastogenic when administered at 1500 mg/kg/day to the rat model (3.6-times the MHDD, based on a body surface area comparison). In contrast, no clastogenicity was noted at a dose of 750 mg/kg/day (1.8-times the MHDD, based on a body surface area comparison), suggesting a threshold effect.

**Impairment of Fertility**

In studies conducted by the National Toxicology Program, fertility assessments with acetaminophen have been completed in Swiss CD-1 mice via a continuous breeding study. There were no effects on fertility parameters in mice consuming up to 1.7 times the MHDD of acetaminophen, based on a body surface area comparison. Although there was no effect on sperm motility or sperm density in the epididymis, there was a significant increase in the percentage of abnormal sperm in mice consuming 1.78 times the MHDD (based on a body surface comparison) and there was a reduction in the number of mating pairs producing a fifth litter at this dose, suggesting the potential for cumulative toxicity with chronic administration of acetaminophen near the upper limit of daily dosing.

Published studies in rodents report that oral acetaminophen treatment of male animals at doses that are 1.2 times the MHDD and greater (based on a body surface comparison) result in decreased testicular weights, reduced spermatogenesis, reduced fertility, and reduced implantation sites in females given the same doses. These effects appear to increase with the duration of treatment. The clinical significance of these findings is not known.

**Fertility**

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**].

**Pregnancy**

**Teratogenic Effects**

**Pregnancy Category C**  
Animal reproductive studies have not been conducted with oxycodone and acetaminophen tablets. It is also not known whether oxycodone and acetaminophen tablets can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Oxycodone and acetaminophen tablets should not be given to a pregnant woman unless in the judgment of the physician, the potential benefits outweigh the possible hazards.

**Nonteratogenic Effects**

**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**].

**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. Oxycodone and acetaminophen tablets are not recommended for use in pregnant women during or immediately prior to labor, when other analgesic techniques are more appropriate. Opioid analgesics, including oxycodone and acetaminophen tablets, 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.

**Nursing Mothers**

Ordinarily, nursing should not be undertaken while a patient is receiving oxycodone and acetaminophen tablets because of the possibility of sedation and/or respiratory depression in the infant. Oxycodone is excreted in breast milk in low concentrations, and there have been rare reports of somnolence and lethargy in babies of nursing mothers taking an oxycodone/acetaminophen product. Acetaminophen is also excreted in breast milk in low concentrations. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for oxycodone and acetaminophen tablets and any potential adverse effects on the breastfed infant from oxycodone and acetaminophen tablets or from the underlying maternal condition.

Infants exposed to oxycodone and acetaminophen tablets 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.

**Pediatric Use**

Safety and effectiveness of oxycodone and acetaminophen tablets in pediatric patients have not been established.

**Geriatric Use**

Elderly patients (aged 65 years or older) may have increased sensitivity to oxycodone and acetaminophen tablets. 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 oxycodone and acetaminophen tablets slowly in geriatric patients and monitor closely for signs of central nervous system and respiratory depression [see **WARNINGS**]. These drugs are 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.

**Hepatic Impairment**

In a pharmacokinetic study of oxycodone in patients with end-stage liver disease, oxycodone plasma clearance decreased and the elimination half-life increased.

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 oxycodone and acetaminophen tablets and titrate carefully. Monitor closely for adverse events such as respiratory depression, sedation, and hypotension [see **CLINICAL PHARMACOLOGY**].

**Renal Impairment**

In a study of patients with end stage renal impairment, mean elimination half-life was prolonged in uremic patients due to increased volume of distribution and reduced clearance. Oxycodone should be used with caution in patients with 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 oxycodone and acetaminophen tablets and titrate carefully. Monitor closely for adverse events such as respiratory depression, sedation, and hypotension [see **CLINICAL PHARMACOLOGY**].

**ADVERSE REACTIONS**

The following adverse reactions have been identified during post approval use of oxycodone and acetaminophen tablets. 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.

Serious adverse reactions that may be associated with oxycodone and acetaminophen use include respiratory depression, apnea, respiratory arrest, circulatory depression, hypotension, and shock [see **OVERDOSAGE**].

The most frequently observed non-serious adverse reactions include lightheadedness, dizziness, drowsiness or sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

Hypersensitivity reactions may include: Skin eruptions, urticarial, erythematous skin reactions. Hematologic reactions may include: thrombocytopenia, neutropenia, pancytopenia, hemolytic anemia. Rare cases of agranulocytosis have likewise been associated with acetaminophen use. In high doses, the most serious adverse effect is a dose-dependent, potentially fatal hepatic necrosis. Renal tubular necrosis and hypoglycemic coma also may occur.

Other adverse reactions obtained from postmarketing experiences with oxycodone and acetaminophen are listed by organ system and in decreasing order of severity and/or frequency as follows:

**Body as a Whole:** Anaphylactoid reaction, allergic reaction, malaise, asthenia, fatigue, chest pain, fever, hypothermia, thirst, headache, increased sweating, accidental overdose, non-accidental overdose

**Cardiovascular:** Hypertension, hypotension, tachycardia, orthostatic hypotension, bradycardia, palpitations, dysrhythmias

**Central and Peripheral Nervous System:** Stupor, tremor, paraesthesia, hypoaesthesia, lethargy, seizures, anxiety, mental impairment, agitation, cerebral edema, confusion, dizziness

**Fluid and Electrolyte:** Dehydration, hyperkalemia, metabolic acidosis, respiratory alkalosis

**Gastrointestinal:** Dyspepsia, taste disturbances, abdominal pain, abdominal distention, sweating increased, diarrhea, dry mouth, flatulence, gastrointestinal disorder, nausea, vomiting, pancreatitis, intestinal obstruction, ileus

**Hepatic:** Transient elevations of hepatic enzymes, increase in bilirubin, hepatitis, hepatic failure, jaundice, hepatocytotoxicity, hepatic disorder

**Hearing and Vestibular:** Hearing loss, tinnitus

**Hematologic:** Thrombocytopenia

**Hypersensitivity:** Acute anaphylaxis, angioedema, asthma, bronchospasm, laryngeal edema, urticaria, anaphylactoid reaction

**Metabolic and Nutritional:** Hypoglycemia, hyperglycemia, acidosis, alkalosis

**Musculoskeletal:** Myalgia, rhabdomyolysis

**Ocular:** Miosis, visual disturbances, red eye

**Psychiatric:** Drug dependence, drug abuse, insomnia, confusion, anxiety, agitation, depressed level of consciousness, nervousness, hallucination, somnolence, depression, suicide

**Respiratory System:** Bronchospasm, dyspnea, hyperpnea, pulmonary edema, tachypnea, aspiration, hypoventilation, laryngeal edema

**Skin and Appendages:** Erythema, urticaria, rash, flushing

**Urogenital:** Interstitial nephritis, papillary necrosis, proteinuria, renal insufficiency and failure, urinary retention

- Serotonin syndrome:** Cases of serotonin syndrome, a potentially life-threatening condition, have been reported during concomitant use of opioids with serotonergic drugs.
- Adrenal insufficiency:** Cases of adrenal insufficiency have been reported with opioid use, more often following greater than one month of use.
- Anaphylaxis:** Anaphylaxis has been reported with ingredients contained in oxycodone and acetaminophen tablets.
- Androgen deficiency:** Cases of androgen deficiency have occurred with chronic use of opioids [see **CLINICAL PHARMACOLOGY**].

**DRUG ABUSE AND DEPENDENCE**

**Controlled Substance**

Oxycodone and acetaminophen tablets contain oxycodone, a Schedule II controlled substance.

**Abuse**

Oxycodone and acetaminophen tablets contain oxycodone, a substance with a high potential for abuse similar to other opioids including fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, and tapentadol. Oxycodone and acetaminophen tablets can be abused and is subject to misuse, addiction, and criminal diversion [see **WARNINGS**].

All patients treated with opioids require careful monitoring for signs of abuse and addiction, since 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 health care providers(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. Health care 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.

Oxycodone and acetaminophen tablets, 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 re-evaluation of therapy, and proper dispensing and storage are appropriate measures that help to limit abuse of opioid drugs.

**Risks Specific to Abuse of Oxycodone and Acetaminophen Tablets**

Oxycodone and acetaminophen tablets are for oral use only. Abuse of oxycodone and acetaminophen tablets poses a risk of overdose and death. The risk is increased with concurrent abuse of oxycodone and acetaminophen tablets with alcohol and other central nervous system depressants.

Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Parenteral drug abuse is commonly associated with transmission of infectious diseases such as hepatitis and HIV.

**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 is a physiological state in which the body adapts to the drug after a period of regular exposure, resulting in withdrawal symptoms after abrupt discontinuation or a 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.

Do not abruptly discontinue oxycodone and acetaminophen tablets in a patient physically dependent on opioids. Rapid tapering of oxycodone and acetaminophen tablets in a patient physically dependent on opioids may lead to serious withdrawal symptoms, uncontrolled pain, and suicide. Rapid discontinuation has also been associated with attempts to find other sources of opioid analgesics, which may be confused with drug-seeking for abuse.

When discontinuing oxycodone and acetaminophen tablets, gradually taper the dosage using a patient-specific pain management plan to taper the dose of the opioid gradually. For patients on oxycodone and acetaminophen tablets who are physically opioid-dependent, initiate the taper by a small enough increment (e.g., no greater than 10% to 25% of the total daily dose) to avoid withdrawal symptoms, and proceed with dose-lowering at an interval of every 2 to 4 weeks. Patients who have been taking opioids for brief periods of time may tolerate a more rapid taper. It may be necessary to provide the patient with lower dosage strengths to accomplish a successful taper. Reassess the patient frequently to manage pain and withdrawal symptoms, should they emerge. Common withdrawal symptoms include restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, myalgia, and mydriasis. Other signs and 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. If withdrawal symptoms arise, it may be necessary to pause the taper for a period of time or raise the dose of the opioid analgesic to the previous dose, and then proceed with a slower taper. In addition, monitor patients for any changes in mood, emergence of suicidal thoughts, or use of other substances.

When managing patients taking opioid analgesics, particularly those who have been treated for a long duration and/or with high doses for chronic pain, ensure that a multimodal approach to pain management, including mental health support (if needed), is in place prior to initiating an opioid analgesic taper. A multimodal approach to pain management may optimize the treatment of chronic pain, as well as assist with the successful tapering of the opioid analgesic [see **WARNINGS; Withdrawal, DRUG ABUSE AND DEPENDENCE**].

**HOW SUPPLIED**

Oxycodone and Acetaminophen Tablets, USP are supplied as:

**2.5 mg/300 mg**  
Light blue, round-shaped, convex face tablets, debossed "680" on one side and "F B" on the other side, in bottles of 30 tablets NDC 72887-193-03.

**5 mg/300 mg**  
Yellow, capsule-shaped, convex face tablets, debossed "681" on one side and "A" score "P" on the other side, in bottles of 30 tablets NDC 72887-681-03.

**7.5 mg/300 mg**  
Red, capsule-shaped, flat face, beveled edge tablets, debossed "682" on one side and "AP" on the other side, in bottles of 30 tablets NDC 72887-682-03.

**10 mg/300 mg**  
Orange, oval-shaped, convex face tablets, debossed "683" on one side and "AP" on the other side, in bottles of 30 tablets NDC 72887-683-03.

**Storage**  
Store at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature]. Protect from moisture. Dispense in a tight, light-resistant container as defined in the USP with a child-resistant closure (as required).

Store oxycodone and acetaminophen tablets securely and dispose of properly [see **PRECAUTIONS; Information for Patients/Caregivers**].

Distributed by:  
**FH2 Pharma LLC**  
Delray Beach, FL 33444

Rev. 04/2021  
Code 1142800

Initial Dosage  
Initiating Treatment with Oxycodone and Acetaminophen Tablets  
The usual adult dosage is as follows. The total daily dose of acetaminophen should not exceed 4 grams.

Strength	Usual Adult Dosage	Maximal Daily Dose
2.5 mg/300 mg	1 or 2 tablets every 6 hours	12 Tablets
5 mg/300 mg	1 tablet every 6 hours as needed for pain	12 Tablets
7.5 mg/300 mg	1 tablet every 6 hours as needed for pain	8 Tablets
10 mg/300 mg	1 tablet every 6 hours as needed for pain	6 Tablets

Conversion from Oxycodone and Acetaminophen Tablets to Extended-Release Oxycodone  
The relative bioavailability of oxycodone and acetaminophen tablets compared to extended-release oxycodone is unknown, so conversion to extended-release oxycodone must be accompanied by close observation for signs of excessive sedation and respiratory depression.

**Titration and Maintenance of Therapy**  
Individually titrate oxycodone and acetaminophen tablets to a dose that provides adequate analgesia and minimizes adverse reactions. Continually reevaluate patients receiving oxycodone and acetaminophen tablets 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**]. 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 oxycodone and acetaminophen tablets 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.

**Safe Reduction or Discontinuation of Oxycodone and Acetaminophen Tablets**  
Do not abruptly discontinue oxycodone and acetaminophen tablets in patients who may be physically dependent on opioids. Rapid discontinuation of opioid analgesics in patients who are physically dependent on opioids has resulted in serious withdrawal symptoms, uncontrolled pain, and suicide. Rapid discontinuation has also been associated with attempts to find other sources of opioid analgesics, which may be confused with drug-seeking for abuse. Patients may also attempt to treat their pain or withdrawal symptoms with illicit opioids, such as heroin, and other substances.

When a decision has been made to decrease the dose or discontinue therapy in an opioid-dependent patient taking oxycodone and acetaminophen tablets, there are a variety of factors that should be considered, including the dose of oxycodone and acetaminophen tablets the patient has been taking, the duration of treatment, the type of pain being treated, and the physical and psychological attributes of the patient. It is important to ensure ongoing care of the patient and to agree on an appropriate tapering schedule and follow-up plan so that patient and provider goals and expectations are clear and realistic. When opioid analgesics are being discontinued due to a suspected substance use disorder, evaluate and treat the patient, or refer for evaluation and treatment of the substance use disorder. Treatment should include evidence-based approaches, such as medication assisted treatment of opioid use disorder. Complex patients with co-morbid pain and substance use disorders may benefit from referral to a specialist.

There are no standard opioid tapering schedules that are suitable for all patients. Good clinical practice dictates a patient-specific plan to taper the dose of the opioid gradually. For patients on oxycodone and acetaminophen tablets who are physically opioid-dependent, initiate the taper by a small enough increment (e.g., no greater than 10% to 25% of the total daily dose) to avoid withdrawal symptoms, and proceed with dose-lowering at an interval of every 2 to 4 weeks. Patients who have been taking opioids for brief periods of time may tolerate a more rapid taper. It may be necessary to provide the patient with lower dosage strengths to accomplish a successful taper. Reassess the patient frequently to manage pain and withdrawal symptoms, should they emerge. Common withdrawal symptoms include restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, myalgia, and mydriasis. Other signs and 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. If withdrawal symptoms arise, it may be necessary to pause the taper for a period of time or raise the dose of the opioid analgesic to the previous dose, and then proceed with a slower taper. In addition, monitor patients for any changes in mood, emergence of suicidal thoughts, or use of other substances.

When managing patients taking opioid analgesics, particularly those who have been treated for a long duration and/or with high doses for chronic pain, ensure that a multimodal approach to pain management, including mental health support (if needed), is in place prior to initiating an opioid analgesic taper. A multimodal approach to pain management may optimize the treatment of chronic pain, as well as assist with the successful tapering of the opioid analgesic [see **WARNINGS; Withdrawal, DRUG ABUSE AND DEPENDENCE**].

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Orange, oval-shaped, convex face tablets, debossed "683" on one side and "AP" on the other side, in bottles of 30 tablets NDC 72887-683-03.

**Storage**  
Store at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature]. Protect from moisture. Dispense in a tight, light-resistant container as defined in the USP with a child-resistant closure (as required).

Store oxycodone and acetaminophen tablets securely and dispose of properly [see **PRECAUTIONS; Information for Patients/Caregivers**].

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