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2 **EC-NAPROSYN[®] (naproxen delayed-release tablets)**
3 **NAPROSYN[®] (naproxen tablets)**
4 **ANAPROX[®]/ANAPROX[®] DS (naproxen sodium tablets)**
5 **NAPROSYN[®] (naproxen suspension)**

6 **R_x only**

Cardiovascular Risk

- NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk (see **WARNINGS**).
- Naproxen as NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS or NAPROSYN Suspension is contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery (see **WARNINGS**).

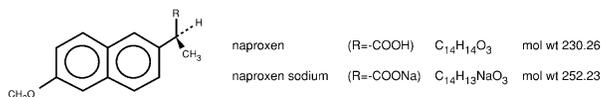
Gastrointestinal Risk

- NSAIDs cause an increased risk of serious gastrointestinal adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients are at greater risk for serious gastrointestinal events (see **WARNINGS**).

7 **DESCRIPTION**

8 Naproxen is a propionic acid derivative related to the arylacetic acid group of
9 nonsteroidal anti-inflammatory drugs.

10 The chemical names for naproxen and naproxen sodium are (S)-6-methoxy- α -
11 methyl-2-naphthaleneacetic acid and (S)-6-methoxy- α -methyl-2-
12 naphthaleneacetic acid, sodium salt, respectively. Naproxen and naproxen
13 sodium have the following structures, respectively:



15 Naproxen has a molecular weight of 230.26 and a molecular formula of
16 C₁₄H₁₄O₃. Naproxen sodium has a molecular weight of 252.23 and a
17 molecular formula of C₁₄H₁₃NaO₃.

18 Naproxen is an odorless, white to off-white crystalline substance. It is lipid-
19 soluble, practically insoluble in water at low pH and freely soluble in water at
20 high pH. The octanol/water partition coefficient of naproxen at pH 7.4 is 1.6

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21 to 1.8. Naproxen sodium is a white to creamy white, crystalline solid, freely
22 soluble in water at neutral pH.

23 NAPROSYN (naproxen tablets) is available as yellow tablets containing 250
24 mg of naproxen, pink tablets containing 375 mg of naproxen and yellow
25 tablets containing 500 mg of naproxen for oral administration. The inactive
26 ingredients are croscarmellose sodium, iron oxides, povidone and magnesium
27 stearate.

28 EC-NAPROSYN (naproxen delayed-release tablets) is available as enteric-
29 coated white tablets containing 375 mg of naproxen and 500 mg of naproxen
30 for oral administration. The inactive ingredients are croscarmellose sodium,
31 povidone and magnesium stearate. The enteric coating dispersion contains
32 methacrylic acid copolymer, talc, triethyl citrate, sodium hydroxide and
33 purified water. The dispersion may also contain simethicone emulsion. The
34 dissolution of this enteric-coated naproxen tablet is pH dependent with rapid
35 dissolution above pH 6. There is no dissolution below pH 4.

36 ANAPROX (naproxen sodium tablets) is available as blue tablets containing
37 275 mg of naproxen sodium and ANAPROX DS (naproxen sodium tablets) is
38 available as dark blue tablets containing 550 mg of naproxen sodium for oral
39 administration. The inactive ingredients are magnesium stearate,
40 microcrystalline cellulose, povidone and talc. The coating suspension for the
41 ANAPROX 275 mg tablet may contain hydroxypropyl methylcellulose 2910,
42 Opaspray K-1-4210A, polyethylene glycol 8000 or Opadry YS-1-4215. The
43 coating suspension for the ANAPROX DS 550 mg tablet may contain
44 hydroxypropyl methylcellulose 2910, Opaspray K-1-4227, polyethylene
45 glycol 8000 or Opadry YS-1-4216.

46 NAPROSYN (naproxen suspension) is available as a light orange-colored
47 opaque oral suspension containing 125 mg/5 mL of naproxen in a vehicle
48 containing sucrose, magnesium aluminum silicate, sorbitol solution and
49 sodium chloride (30 mg/5 mL, 1.5 mEq), methylparaben, fumaric acid, FD&C
50 Yellow No. 6, imitation pineapple flavor, imitation orange flavor and purified
51 water. The pH of the suspension ranges from 2.2 to 3.7.

52 **CLINICAL PHARMACOLOGY**

53 **Pharmacodynamics**

54 Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) with analgesic
55 and antipyretic properties. The sodium salt of naproxen has been developed as
56 a more rapidly absorbed formulation of naproxen for use as an analgesic. The
57 mechanism of action of the naproxen anion, like that of other NSAIDs, is not
58 completely understood but may be related to prostaglandin synthetase
59 inhibition.

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60 **Pharmacokinetics**

61 Naproxen and naproxen sodium are rapidly and completely absorbed from the
62 gastrointestinal tract with an in vivo bioavailability of 95%. The different
63 dosage forms of NAPROSYN are bioequivalent in terms of extent of
64 absorption (AUC) and peak concentration (C_{max}); however, the products do
65 differ in their pattern of absorption. These differences between naproxen
66 products are related to both the chemical form of naproxen used and its
67 formulation. Even with the observed differences in pattern of absorption, the
68 elimination half-life of naproxen is unchanged across products ranging from
69 12 to 17 hours. Steady-state levels of naproxen are reached in 4 to 5 days, and
70 the degree of naproxen accumulation is consistent with this half-life. This
71 suggests that the differences in pattern of release play only a negligible role in
72 the attainment of steady-state plasma levels.

73 **Absorption**

74 *Immediate Release*

75 After administration of NAPROSYN tablets, peak plasma levels are attained
76 in 2 to 4 hours. After oral administration of ANAPROX, peak plasma levels
77 are attained in 1 to 2 hours. The difference in rates between the two products
78 is due to the increased aqueous solubility of the sodium salt of naproxen used
79 in ANAPROX. Peak plasma levels of naproxen given as NAPROSYN
80 Suspension are attained in 1 to 4 hours.

81 *Delayed Release*

82 EC-NAPROSYN is designed with a pH-sensitive coating to provide a barrier
83 to disintegration in the acidic environment of the stomach and to lose integrity
84 in the more neutral environment of the small intestine. The enteric polymer
85 coating selected for EC-NAPROSYN dissolves above pH 6. When EC-
86 NAPROSYN was given to fasted subjects, peak plasma levels were attained
87 about 4 to 6 hours following the first dose (range: 2 to 12 hours). An in vivo
88 study in man using radiolabeled EC-NAPROSYN tablets demonstrated that
89 EC-NAPROSYN dissolves primarily in the small intestine rather than in the
90 stomach, so the absorption of the drug is delayed until the stomach is emptied.

91 When EC-NAPROSYN and NAPROSYN were given to fasted subjects
92 (n=24) in a crossover study following 1 week of dosing, differences in time to
93 peak plasma levels (T_{max}) were observed, but there were no differences in total
94 absorption as measured by C_{max} and AUC:

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	EC-NAPROSYN* 500 mg bid	NAPROSYN* 500 mg bid
C _{max} (µg/mL)	94.9 (18%)	97.4 (13%)
T _{max} (hours)	4 (39%)	1.9 (61%)
AUC _{0-12 hr} (µg·hr/mL)	845 (20%)	767 (15%)

95 *Mean value (coefficient of variation)

96 *Antacid Effects*

97 When EC-NAPROSYN was given as a single dose with antacid (54 mEq
98 buffering capacity), the peak plasma levels of naproxen were unchanged, but
99 the time to peak was reduced (mean T_{max} fasted 5.6 hours, mean T_{max} with
100 antacid 5 hours), although not significantly.

101 *Food Effects*

102 When EC-NAPROSYN was given as a single dose with food, peak plasma
103 levels in most subjects were achieved in about 12 hours (range: 4 to 24 hours).
104 Residence time in the small intestine until disintegration was independent of
105 food intake. The presence of food prolonged the time the tablets remained in
106 the stomach, time to first detectable serum naproxen levels, and time to
107 maximal naproxen levels (T_{max}), but did not affect peak naproxen levels
108 (C_{max}).

109 *Distribution*

110 Naproxen has a volume of distribution of 0.16 L/kg. At therapeutic levels
111 naproxen is greater than 99% albumin-bound. At doses of naproxen greater
112 than 500 mg/day there is less than proportional increase in plasma levels due
113 to an increase in clearance caused by saturation of plasma protein binding at
114 higher doses (average trough C_{ss} 36.5, 49.2 and 56.4 mg/L with 500, 1000 and
115 1500 mg daily doses of naproxen, respectively). The naproxen anion has been
116 found in the milk of lactating women at a concentration equivalent to
117 approximately 1% of maximum naproxen concentration in plasma (see
118 **PRECAUTIONS: Nursing Mothers**).

119 *Metabolism*

120 Naproxen is extensively metabolized in the liver to 6-0-desmethyl naproxen,
121 and both parent and metabolites do not induce metabolizing enzymes. Both
122 naproxen and 6-0-desmethyl naproxen are further metabolized to their
123 respective acylglucuronide conjugated metabolites.

124 *Excretion*

125 The clearance of naproxen is 0.13 mL/min/kg. Approximately 95% of the
126 naproxen from any dose is excreted in the urine, primarily as naproxen (<1%),
127 6-0-desmethyl naproxen (<1%) or their conjugates (66% to 92%). The plasma

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128 half-life of the naproxen anion in humans ranges from 12 to 17 hours. The
129 corresponding half-lives of both naproxen's metabolites and conjugates are
130 shorter than 12 hours, and their rates of excretion have been found to coincide
131 closely with the rate of naproxen disappearance from the plasma. Small
132 amounts, 3% or less of the administered dose, are excreted in the feces. In
133 patients with renal failure metabolites may accumulate (see **WARNINGS:**
134 **Renal Effects**).

135 Special Populations

136 *Pediatric Patients*

137 In pediatric patients aged 5 to 16 years with arthritis, plasma naproxen levels
138 following a 5 mg/kg single dose of naproxen suspension (see **DOSAGE AND**
139 **ADMINISTRATION**) were found to be similar to those found in normal
140 adults following a 500 mg dose. The terminal half-life appears to be similar in
141 pediatric and adult patients. Pharmacokinetic studies of naproxen were not
142 performed in pediatric patients younger than 5 years of age. Pharmacokinetic
143 parameters appear to be similar following administration of naproxen
144 suspension or tablets in pediatric patients. EC-NAPROSYN has not been
145 studied in subjects under the age of 18.

146 *Geriatric Patients*

147 Studies indicate that although total plasma concentration of naproxen is
148 unchanged, the unbound plasma fraction of naproxen is increased in the
149 elderly, although the unbound fraction is <1% of the total naproxen
150 concentration. Unbound trough naproxen concentrations in elderly subjects
151 have been reported to range from 0.12% to 0.19% of total naproxen
152 concentration, compared with 0.05% to 0.075% in younger subjects. The
153 clinical significance of this finding is unclear, although it is possible that the
154 increase in free naproxen concentration could be associated with an increase
155 in the rate of adverse events per a given dosage in some elderly patients.

156 *Race*

157 Pharmacokinetic differences due to race have not been studied.

158 *Hepatic Insufficiency*

159 Naproxen pharmacokinetics has not been determined in subjects with hepatic
160 insufficiency.

161 *Renal Insufficiency*

162 Naproxen pharmacokinetics has not been determined in subjects with renal
163 insufficiency. Given that naproxen, its metabolites and conjugates are
164 primarily excreted by the kidney, the potential exists for naproxen metabolites

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165 to accumulate in the presence of renal insufficiency. Elimination of naproxen
166 is decreased in patients with severe renal impairment. Naproxen-containing
167 products are not recommended for use in patients with moderate to severe and
168 severe renal impairment (creatinine clearance <30 mL/min) (see
169 **WARNINGS: Renal Effects**).

170 **CLINICAL STUDIES**

171 **General Information**

172 Naproxen has been studied in patients with rheumatoid arthritis, osteoarthritis,
173 juvenile arthritis, ankylosing spondylitis, tendonitis and bursitis, and acute
174 gout. Improvement in patients treated for rheumatoid arthritis was
175 demonstrated by a reduction in joint swelling, a reduction in duration of
176 morning stiffness, a reduction in disease activity as assessed by both the
177 investigator and patient, and by increased mobility as demonstrated by a
178 reduction in walking time. Generally, response to naproxen has not been
179 found to be dependent on age, sex, severity or duration of rheumatoid arthritis.

180 In patients with osteoarthritis, the therapeutic action of naproxen has been
181 shown by a reduction in joint pain or tenderness, an increase in range of
182 motion in knee joints, increased mobility as demonstrated by a reduction in
183 walking time, and improvement in capacity to perform activities of daily
184 living impaired by the disease.

185 In a clinical trial comparing standard formulations of naproxen 375 mg bid
186 (750 mg a day) vs 750 mg bid (1500 mg/day), 9 patients in the 750 mg group
187 terminated prematurely because of adverse events. Nineteen patients in the
188 1500 mg group terminated prematurely because of adverse events. Most of
189 these adverse events were gastrointestinal events.

190 In clinical studies in patients with rheumatoid arthritis, osteoarthritis, and
191 juvenile arthritis, naproxen has been shown to be comparable to aspirin and
192 indomethacin in controlling the aforementioned measures of disease activity,
193 but the frequency and severity of the milder gastrointestinal adverse effects
194 (nausea, dyspepsia, heartburn) and nervous system adverse effects (tinnitus,
195 dizziness, lightheadedness) were less in naproxen-treated patients than in
196 those treated with aspirin or indomethacin.

197 In patients with ankylosing spondylitis, naproxen has been shown to decrease
198 night pain, morning stiffness and pain at rest. In double-blind studies the drug
199 was shown to be as effective as aspirin, but with fewer side effects.

200 In patients with acute gout, a favorable response to naproxen was shown by
201 significant clearing of inflammatory changes (eg, decrease in swelling, heat)
202 within 24 to 48 hours, as well as by relief of pain and tenderness.

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203 Naproxen has been studied in patients with mild to moderate pain secondary
204 to postoperative, orthopedic, postpartum episiotomy and uterine contraction
205 pain and dysmenorrhea. Onset of pain relief can begin within 1 hour in
206 patients taking naproxen and within 30 minutes in patients taking naproxen
207 sodium. Analgesic effect was shown by such measures as reduction of pain
208 intensity scores, increase in pain relief scores, decrease in numbers of patients
209 requiring additional analgesic medication, and delay in time to remedication.
210 The analgesic effect has been found to last for up to 12 hours.

211 Naproxen may be used safely in combination with gold salts and/or
212 corticosteroids; however, in controlled clinical trials, when added to the
213 regimen of patients receiving corticosteroids, it did not appear to cause greater
214 improvement over that seen with corticosteroids alone. Whether naproxen has
215 a “steroid-sparing” effect has not been adequately studied. When added to the
216 regimen of patients receiving gold salts, naproxen did result in greater
217 improvement. Its use in combination with salicylates is not recommended
218 because there is evidence that aspirin increases the rate of excretion of
219 naproxen and data are inadequate to demonstrate that naproxen and aspirin
220 produce greater improvement over that achieved with aspirin alone. In
221 addition, as with other NSAIDs, the combination may result in higher
222 frequency of adverse events than demonstrated for either product alone.

223 In ⁵¹Cr blood loss and gastroscopy studies with normal volunteers, daily
224 administration of 1000 mg of naproxen as 1000 mg of NAPROSYN
225 (naproxen) or 1100 mg of ANAPROX (naproxen sodium) has been
226 demonstrated to cause statistically significantly less gastric bleeding and
227 erosion than 3250 mg of aspirin.

228 Three 6-week, double-blind, multicenter studies with EC-NAPROSYN
229 (naproxen) (375 or 500 mg bid, n=385) and NAPROSYN (375 or 500 mg bid,
230 n=279) were conducted comparing EC-NAPROSYN with NAPROSYN,
231 including 355 rheumatoid arthritis and osteoarthritis patients who had a recent
232 history of NSAID-related GI symptoms. These studies indicated that EC-
233 NAPROSYN and NAPROSYN showed no significant differences in efficacy
234 or safety and had similar prevalence of minor GI complaints. Individual
235 patients, however, may find one formulation preferable to the other.

236 Five hundred and fifty-three patients received EC-NAPROSYN during long-
237 term open-label trials (mean length of treatment was 159 days). The rates for
238 clinically-diagnosed peptic ulcers and GI bleeds were similar to what has been
239 historically reported for long-term NSAID use.

240 **Geriatric Patients**

241 The hepatic and renal tolerability of long-term naproxen administration was
242 studied in two double-blind clinical trials involving 586 patients. Of the

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243 patients studied, 98 patients were age 65 and older and 10 of the 98 patients
244 were age 75 and older. Naproxen was administered at doses of 375 mg twice
245 daily or 750 mg twice daily for up to 6 months. Transient abnormalities of
246 laboratory tests assessing hepatic and renal function were noted in some
247 patients, although there were no differences noted in the occurrence of
248 abnormal values among different age groups.

249 **INDICATIONS AND USAGE**

250 Carefully consider the potential benefits and risks of NAPROSYN, EC-
251 NAPROSYN, ANAPROX, ANAPROX DS or NAPROSYN Suspension and
252 other treatment options before deciding to use NAPROSYN, EC-
253 NAPROSYN, ANAPROX, ANAPROX DS or NAPROSYN Suspension. Use
254 the lowest effective dose for the shortest duration consistent with individual
255 patient treatment goals (see **WARNINGS**).

256 Naproxen as NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS or
257 NAPROSYN Suspension is indicated:

- 258 • For the relief of the signs and symptoms of rheumatoid arthritis
- 259 • For the relief of the signs and symptoms of osteoarthritis
- 260 • For the relief of the signs and symptoms of ankylosing spondylitis
- 261 • For the relief of the signs and symptoms of juvenile arthritis

262 Naproxen as NAPROSYN Suspension is recommended for juvenile
263 rheumatoid arthritis in order to obtain the maximum dosage flexibility based
264 on the patient's weight.

265 Naproxen as NAPROSYN, ANAPROX, ANAPROX DS and NAPROSYN
266 Suspension is also indicated:

- 267 • For relief of the signs and symptoms of tendonitis
- 268 • For relief of the signs and symptoms of bursitis
- 269 • For relief of the signs and symptoms of acute gout
- 270 • For the management of pain
- 271 • For the management of primary dysmenorrhea

272 EC-NAPROSYN is not recommended for initial treatment of acute pain
273 because the absorption of naproxen is delayed compared to absorption from
274 other naproxen-containing products (see **CLINICAL PHARMACOLOGY**
275 and **DOSAGE AND ADMINISTRATION**).

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276 **CONTRAINDICATIONS**

277 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
278 NAPROSYN Suspension are contraindicated in patients with known
279 hypersensitivity to naproxen and naproxen sodium.

280 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
281 NAPROSYN Suspension should not be given to patients who have
282 experienced asthma, urticaria, or allergic-type reactions after taking aspirin or
283 other NSAIDs. Severe, rarely fatal, anaphylactic-like reactions to NSAIDs
284 have been reported in such patients (see **WARNINGS: Anaphylactoid**
285 **Reactions** and **PRECAUTIONS: Preexisting Asthma**).

286 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
287 NAPROSYN Suspension are contraindicated for the treatment of peri-
288 operative pain in the setting of coronary artery bypass graft (CABG) surgery
289 (see **WARNINGS**).

290 **WARNINGS**

291 **CARDIOVASCULAR EFFECTS**

292 **Cardiovascular Thrombotic Events**

293 Clinical trials of several COX-2 selective and nonselective NSAIDs of up to
294 three years duration have shown an increased risk of serious cardiovascular
295 (CV) thrombotic events, myocardial infarction, and stroke, which can be fatal.
296 All NSAIDs, both COX-2 selective and nonselective, may have a similar risk.
297 Patients with known CV disease or risk factors for CV disease may be at
298 greater risk. To minimize the potential risk for an adverse CV event in patients
299 treated with an NSAID, the lowest effective dose should be used for the
300 shortest duration possible. Physicians and patients should remain alert for the
301 development of such events, even in the absence of previous CV symptoms.
302 Patients should be informed about the signs and/or symptoms of serious CV
303 events and the steps to take if they occur.

304 There is no consistent evidence that concurrent use of aspirin mitigates the
305 increased risk of serious CV thrombotic events associated with NSAID use.
306 The concurrent use of aspirin and an NSAID does increase the risk of serious
307 GI events (see **Gastrointestinal Effects – Risk of Ulceration, Bleeding, and**
308 **Perforation**).

309 Two large, controlled, clinical trials of a COX-2 selective NSAID for the
310 treatment of pain in the first 10-14 days following CABG surgery found an
311 increased incidence of myocardial infarction and stroke (see
312 **CONTRAINDICATIONS**).

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313 **Hypertension**

314 NSAIDs, including NAPROSYN, EC-NAPROSYN, ANAPROX,
315 ANAPROX DS and NAPROSYN Suspension, can lead to onset of new
316 hypertension or worsening of pre-existing hypertension, either of which may
317 contribute to the increased incidence of CV events. Patients taking thiazides or
318 loop diuretics may have impaired response to these therapies when taking
319 NSAIDs. NSAIDs, including NAPROSYN, EC-NAPROSYN, ANAPROX,
320 ANAPROX DS and NAPROSYN Suspension, should be used with caution in
321 patients with hypertension. Blood pressure (BP) should be monitored closely
322 during the initiation of NSAID treatment and throughout the course of
323 therapy.

324 **Congestive Heart Failure and Edema**

325 Fluid retention, edema, and peripheral edema have been observed in some
326 patients taking NSAIDs. NAPROSYN, EC-NAPROSYN, ANAPROX,
327 ANAPROX DS and NAPROSYN Suspension should be used with caution in
328 patients with fluid retention, hypertension, or heart failure. Since each
329 ANAPROX or ANAPROX DS tablet contains 25 mg or 50 mg of sodium
330 (about 1 mEq per each 250 mg of naproxen), and each teaspoonful of
331 NAPROSYN Suspension contains 39 mg (about 1.5 mEq per each 125 mg of
332 naproxen) of sodium, this should be considered in patients whose overall
333 intake of sodium must be severely restricted.

334 **Gastrointestinal Effects – Risk of Ulceration, Bleeding, and**
335 **Perforation**

336 NSAIDs, including NAPROSYN, EC-NAPROSYN, ANAPROX,
337 ANAPROX DS and NAPROSYN Suspension, can cause serious
338 gastrointestinal (GI) adverse events including inflammation, bleeding,
339 ulceration, and perforation of the stomach, small intestine, or large intestine,
340 which can be fatal.

341 These serious adverse events can occur at any time, with or without warning
342 symptoms, in patients treated with NSAIDs. Only one in five patients, who
343 develop a serious upper GI adverse event on NSAID therapy, is symptomatic.
344 Upper GI ulcers, gross bleeding, or perforation caused by NSAIDs occur in
345 approximately 1% of patients treated for 3-6 months, and in about 2-4% of
346 patients treated for one year. These trends continue with longer duration of
347 use, increasing the likelihood of developing a serious GI event at some time
348 during the course of therapy. However, even short-term therapy is not without
349 risk. The utility of periodic laboratory monitoring has not been demonstrated,
350 nor has it been adequately assessed. Only 1 in 5 patients who develop a
351 serious upper GI adverse event on NSAID therapy is symptomatic.

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352 NSAIDs should be prescribed with extreme caution in those with a prior
353 history of ulcer disease or gastrointestinal bleeding. Patients with a prior
354 history of peptic ulcer disease and/or gastrointestinal bleeding who use
355 NSAIDs have a greater than 10-fold increased risk for developing a GI bleed
356 compared to patients with neither of these risk factors. Other factors that
357 increase the risk for GI bleeding in patients treated with NSAIDs include
358 concomitant use of oral corticosteroids or anticoagulants, longer duration of
359 NSAID therapy, smoking, use of alcohol, older age, and poor general health
360 status. Most spontaneous reports of fatal GI events are in elderly or debilitated
361 patients and therefore, special care should be taken in treating this population.
362 To minimize the potential risk for an adverse GI event in patients treated with
363 an NSAID, the lowest effective dose should be used for the shortest possible
364 duration. Patients and physicians should remain alert for signs and symptoms
365 of GI ulceration and bleeding during NSAID therapy and promptly initiate
366 additional evaluation and treatment if a serious GI adverse event is suspected.
367 This should include discontinuation of the NSAID until a serious GI adverse
368 event is ruled out. For high risk patients, alternate therapies that do not
369 involve NSAIDs should be considered.

370 **Renal Effects**

371 Long-term administration of NSAIDs has resulted in renal papillary necrosis
372 and other renal injury. Renal toxicity has also been seen in patients in whom
373 renal prostaglandins have a compensatory role in the maintenance of renal
374 perfusion. In these patients, administration of a nonsteroidal
375 anti-inflammatory drug may cause a dose-dependent reduction in
376 prostaglandin formation and, secondarily, in renal blood flow, which may
377 precipitate overt renal decompensation. Patients at greatest risk of this
378 reaction are those with impaired renal function, hypovolemia, heart failure,
379 liver dysfunction, salt depletion, those taking diuretics and ACE inhibitors,
380 and the elderly. Discontinuation of nonsteroidal anti-inflammatory drug
381 therapy is usually followed by recovery to the pretreatment state (see
382 **WARNINGS: Advanced Renal Disease**).

383 **Advanced Renal Disease**

384 No information is available from controlled clinical studies regarding the use
385 of NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS or
386 NAPROSYN Suspension in patients with advanced renal disease. Therefore,
387 treatment with NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS
388 and NAPROSYN Suspension is not recommended in these patients with
389 advanced renal disease. If NAPROSYN, EC-NAPROSYN, ANAPROX,
390 ANAPROX DS or NAPROSYN Suspension therapy must be initiated, close
391 monitoring of the patient's renal function is advisable.

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392 **Anaphylactoid Reactions**

393 As with other NSAIDs, anaphylactoid reactions may occur in patients without
394 known prior exposure to either NAPROSYN, EC-NAPROSYN, ANAPROX,
395 ANAPROX DS or NAPROSYN Suspension. NAPROSYN, EC-
396 NAPROSYN, ANAPROX, ANAPROX DS and NAPROSYN Suspension
397 should not be given to patients with the aspirin triad. This symptom complex
398 typically occurs in asthmatic patients who experience rhinitis with or without
399 nasal polyps, or who exhibit severe, potentially fatal bronchospasm after
400 taking aspirin or other NSAIDs (see **CONTRAINDICATIONS** and
401 **PRECAUTIONS: Preexisting Asthma**). Emergency help should be sought
402 in cases where an anaphylactoid reaction occurs.

403 **Skin Reactions**

404 NSAIDs, including NAPROSYN, EC-NAPROSYN, ANAPROX,
405 ANAPROX DS and NAPROSYN Suspension, can cause serious skin adverse
406 events such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and
407 toxic epidermal necrolysis (TEN), which can be fatal. These serious events
408 may occur without warning. Patients should be informed about the signs and
409 symptoms of serious skin manifestations and use of the drug should be
410 discontinued at the first appearance of skin rash or any other sign of
411 hypersensitivity.

412 **Pregnancy**

413 In late pregnancy, as with other NSAIDs, NAPROSYN, EC-NAPROSYN,
414 ANAPROX, ANAPROX DS and NAPROSYN Suspension should be avoided
415 because it may cause premature closure of the ductus arteriosus.

416 **PRECAUTIONS**

417 **General**

418 **Naproxen-containing products such as NAPROSYN, EC-NAPROSYN,**
419 **ANAPROX, ANAPROX DS, NAPROSYN SUSPENSION, ALEVE®, and**
420 **other naproxen products should not be used concomitantly since they all**
421 **circulate in the plasma as the naproxen anion.**

422 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
423 NAPROSYN Suspension cannot be expected to substitute for corticosteroids
424 or to treat corticosteroid insufficiency. Abrupt discontinuation of
425 corticosteroids may lead to disease exacerbation. Patients on prolonged
426 corticosteroid therapy should have their therapy tapered slowly if a decision is
427 made to discontinue corticosteroids and the patient should be observed closely
428 for any evidence of adverse effects, including adrenal insufficiency and
429 exacerbation of symptoms of arthritis.

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430 Patients with initial hemoglobin values of 10 g or less who are to receive long-
431 term therapy should have hemoglobin values determined periodically.

432 The pharmacological activity of NAPROSYN, EC-NAPROSYN,
433 ANAPROX, ANAPROX DS and NAPROSYN Suspension in reducing fever
434 and inflammation may diminish the utility of these diagnostic signs in
435 detecting complications of presumed noninfectious, noninflammatory painful
436 conditions.

437 Because of adverse eye findings in animal studies with drugs of this class, it is
438 recommended that ophthalmic studies be carried out if any change or
439 disturbance in vision occurs.

440 **Hepatic Effects**

441 Borderline elevations of one or more liver tests may occur in up to 15% of
442 patients taking NSAIDs including NAPROSYN, EC-NAPROSYN,
443 ANAPROX, ANAPROX DS and NAPROSYN Suspension. Hepatic
444 abnormalities may be the result of hypersensitivity rather than direct toxicity.
445 These laboratory abnormalities may progress, may remain essentially
446 unchanged, or may be transient with continued therapy. The SGPT (ALT) test
447 is probably the most sensitive indicator of liver dysfunction. Notable
448 elevations of ALT or AST (approximately three or more times the upper limit
449 of normal) have been reported in approximately 1% of patients in clinical
450 trials with NSAIDs. In addition, rare cases of severe hepatic reactions,
451 including jaundice and fatal fulminant hepatitis, liver necrosis and hepatic
452 failure, some of them with fatal outcomes have been reported.

453 A patient with symptoms and/or signs suggesting liver dysfunction, or in
454 whom an abnormal liver test has occurred, should be evaluated for evidence
455 of the development of more severe hepatic reaction while on therapy with
456 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS or
457 NAPROSYN Suspension.

458 If clinical signs and symptoms consistent with liver disease develop, or if
459 systemic manifestations occur (eg, eosinophilia, rash, etc.), NAPROSYN, EC-
460 NAPROSYN, ANAPROX, ANAPROX DS or NAPROSYN Suspension
461 should be discontinued.

462 Chronic alcoholic liver disease and probably other diseases with decreased or
463 abnormal plasma proteins (albumin) reduce the total plasma concentration of
464 naproxen, but the plasma concentration of unbound naproxen is increased.
465 Caution is advised when high doses are required and some adjustment of
466 dosage may be required in these patients. It is prudent to use the lowest
467 effective dose.

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468 **Hematological Effects**

469 Anemia is sometimes seen in patients receiving NSAIDs, including
470 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
471 NAPROSYN Suspension. This may be due to fluid retention, occult or gross
472 GI blood loss, or an incompletely described effect upon erythropoiesis.
473 Patients on long-term treatment with NSAIDs, including NAPROSYN, EC-
474 NAPROSYN, ANAPROX, ANAPROX DS and NAPROSYN Suspension,
475 should have their hemoglobin or hematocrit checked if they exhibit any signs
476 or symptoms of anemia.

477 NSAIDs inhibit platelet aggregation and have been shown to prolong bleeding
478 time in some patients. Unlike aspirin, their effect on platelet function is
479 quantitatively less, of shorter duration, and reversible. Patients receiving either
480 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS or
481 NAPROSYN Suspension who may be adversely affected by alterations in
482 platelet function, such as those with coagulation disorders or patients
483 receiving anticoagulants, should be carefully monitored.

484 **Preexisting Asthma**

485 Patients with asthma may have aspirin-sensitive asthma. The use of aspirin in
486 patients with aspirin-sensitive asthma has been associated with severe
487 bronchospasm, which can be fatal. Since cross reactivity, including
488 bronchospasm, between aspirin and other nonsteroidal anti-inflammatory
489 drugs has been reported in such aspirin-sensitive patients, NAPROSYN, EC-
490 NAPROSYN, ANAPROX, ANAPROX DS and NAPROSYN Suspension
491 should not be administered to patients with this form of aspirin sensitivity and
492 should be used with caution in patients with preexisting asthma.

493 **Information for Patients**

494 **Patients should be informed of the following information before initiating**
495 **therapy with an NSAID and periodically during the course of ongoing**
496 **therapy. Patients should also be encouraged to read the NSAID**
497 **Medication Guide that accompanies each prescription dispensed.**

- 498 1. NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
499 NAPROSYN Suspension, like other NSAIDs, may cause serious CV side
500 effects, such as MI or stroke, which may result in hospitalization and even
501 death. Although serious CV events can occur without warning symptoms,
502 patients should be alert for the signs and symptoms of chest pain,
503 shortness of breath, weakness, slurring of speech, and should ask for
504 medical advice when observing any indicative sign or symptoms. Patients
505 should be apprised of the importance of this follow-up (see **WARNINGS:**
506 **Cardiovascular Effects**).

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- 507 2. NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
508 NAPROSYN Suspension, like other NSAIDs, can cause GI discomfort
509 and, rarely, serious GI side effects, such as ulcers and bleeding, which
510 may result in hospitalization and even death. Although serious GI tract
511 ulcerations and bleeding can occur without warning symptoms, patients
512 should be alert for the signs and symptoms of ulcerations and bleeding,
513 and should ask for medical advice when observing any indicative sign or
514 symptoms including epigastric pain, dyspepsia, melena, and hematemesis.
515 Patients should be apprised of the importance of this follow-up (see
516 **WARNINGS: Gastrointestinal Effects: Risk of Ulceration, Bleeding,**
517 **and Perforation**).
- 518 3. NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
519 NAPROSYN Suspension, like other NSAIDs, can cause serious skin side
520 effects such as exfoliative dermatitis, SJS, and TEN, which may result in
521 hospitalizations and even death. Although serious skin reactions may
522 occur without warning, patients should be alert for the signs and
523 symptoms of skin rash and blisters, fever, or other signs of
524 hypersensitivity such as itching, and should ask for medical advice when
525 observing any indicative signs or symptoms. Patients should be advised to
526 stop the drug immediately if they develop any type of rash and contact
527 their physicians as soon as possible.
- 528 4. Patients should promptly report signs or symptoms of unexplained weight
529 gain or edema to their physicians.
- 530 5. Patients should be informed of the warning signs and symptoms of
531 hepatotoxicity (eg, nausea, fatigue, lethargy, pruritus, jaundice, right upper
532 quadrant tenderness, and “flu-like” symptoms). If these occur, patients
533 should be instructed to stop therapy and seek immediate medical therapy.
- 534 6. Patients should be informed of the signs of an anaphylactoid reaction (eg,
535 difficulty breathing, swelling of the face or throat). If these occur, patients
536 should be instructed to seek immediate emergency help (see
537 **WARNINGS**).
- 538 7. In late pregnancy, as with other NSAIDs, NAPROSYN, EC-NAPROSYN,
539 ANAPROX, ANAPROX DS and NAPROSYN Suspension should be
540 avoided because it may cause premature closure of the ductus arteriosus.
- 541 8. Caution should be exercised by patients whose activities require alertness
542 if they experience drowsiness, dizziness, vertigo or depression during
543 therapy with naproxen.

544 **Laboratory Tests**

545 Because serious GI tract ulcerations and bleeding can occur without warning
546 symptoms, physicians should monitor for signs or symptoms of GI bleeding.
547 Patients on long-term treatment with NSAIDs should have their CBC and a
548 chemistry profile checked periodically. If clinical signs and symptoms
549 consistent with liver or renal disease develop, systemic manifestations occur
550 (eg, eosinophilia, rash, etc.) or if abnormal liver tests persist or worsen,

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551 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
552 NAPROSYN Suspension should be discontinued.

553 **Drug Interactions**

554 ***ACE-inhibitors***

555 Reports suggest that NSAIDs may diminish the antihypertensive effect of
556 ACE-inhibitors. This interaction should be given consideration in patients
557 taking NSAIDs concomitantly with ACE-inhibitors.

558 ***Antacids and Sucralfate***

559 Concomitant administration of some antacids (magnesium oxide or aluminum
560 hydroxide) and sucralfate can delay the absorption of naproxen.

561 ***Aspirin***

562 When naproxen as NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX
563 DS or NAPROSYN Suspension is administered with aspirin, its protein
564 binding is reduced, although the clearance of free NAPROSYN, EC-
565 NAPROSYN, ANAPROX, ANAPROX DS or NAPROSYN Suspension is
566 not altered. The clinical significance of this interaction is not known;
567 however, as with other NSAIDs, concomitant administration of naproxen and
568 naproxen sodium and aspirin is not generally recommended because of the
569 potential of increased adverse effects.

570 ***Cholestyramine***

571 As with other NSAIDs, concomitant administration of cholestyramine can
572 delay the absorption of naproxen.

573 ***Diuretics***

574 Clinical studies, as well as postmarketing observations, have shown that
575 NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX DS and
576 NAPROSYN Suspension can reduce the natriuretic effect of furosemide and
577 thiazides in some patients. This response has been attributed to inhibition of
578 renal prostaglandin synthesis. During concomitant therapy with NSAIDs, the
579 patient should be observed closely for signs of renal failure (see
580 **WARNINGS: Renal Effects**), as well as to assure diuretic efficacy.

581 ***Lithium***

582 NSAIDs have produced an elevation of plasma lithium levels and a reduction
583 in renal lithium clearance. The mean minimum lithium concentration
584 increased 15% and the renal clearance was decreased by approximately 20%.
585 These effects have been attributed to inhibition of renal prostaglandin
586 synthesis by the NSAID. Thus, when NSAIDs and lithium are administered

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587 concurrently, subjects should be observed carefully for signs of lithium
588 toxicity.

589 ***Methotrexate***

590 NSAIDs have been reported to competitively inhibit methotrexate
591 accumulation in rabbit kidney slices. Naproxen, naproxen sodium and other
592 nonsteroidal anti-inflammatory drugs have been reported to reduce the tubular
593 secretion of methotrexate in an animal model. This may indicate that they
594 could enhance the toxicity of methotrexate. Caution should be used when
595 NSAIDs are administered concomitantly with methotrexate.

596 ***Warfarin***

597 The effects of warfarin and NSAIDs on GI bleeding are synergistic, such that
598 users of both drugs together have a risk of serious GI bleeding higher than
599 users of either drug alone. No significant interactions have been observed in
600 clinical studies with naproxen and coumarin-type anticoagulants. However,
601 caution is advised since interactions have been seen with other nonsteroidal
602 agents of this class. The free fraction of warfarin may increase substantially in
603 some subjects and naproxen interferes with platelet function.

604 **Other Information Concerning Drug Interactions**

605 Naproxen is highly bound to plasma albumin; it thus has a theoretical
606 potential for interaction with other albumin-bound drugs such as coumarin-
607 type anticoagulants, sulphonylureas, hydantoins, other NSAIDs, and aspirin.
608 Patients simultaneously receiving naproxen and a hydantoin, sulphonamide or
609 sulphonylurea should be observed for adjustment of dose if required.

610 Naproxen and other nonsteroidal anti-inflammatory drugs can reduce the
611 antihypertensive effect of propranolol and other beta-blockers.

612 Probenecid given concurrently increases naproxen anion plasma levels and
613 extends its plasma half-life significantly.

614 Due to the gastric pH elevating effects of H₂-blockers, sucralfate and intensive
615 antacid therapy, concomitant administration of EC-NAPROSYN is not
616 recommended.

617 **Drug/Laboratory Test Interaction**

618 Naproxen may decrease platelet aggregation and prolong bleeding time. This
619 effect should be kept in mind when bleeding times are determined.

620 The administration of naproxen may result in increased urinary values for 17-
621 ketogenic steroids because of an interaction between the drug and/or its
622 metabolites with m-di-nitrobenzene used in this assay. Although 17-hydroxy-
623 corticosteroid measurements (Porter-Silber test) do not appear to be

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624 artifactually altered, it is suggested that therapy with naproxen be temporarily
625 discontinued 72 hours before adrenal function tests are performed if the
626 Porter-Silber test is to be used.

627 Naproxen may interfere with some urinary assays of 5-hydroxy indoleacetic
628 acid (5HIAA).

629 **Carcinogenesis**

630 A 2-year study was performed in rats to evaluate the carcinogenic potential of
631 naproxen at rat doses of 8, 16, and 24 mg/kg/day (50, 100, and 150 mg/m²).
632 The maximum dose used was 0.28 times the systemic exposure to humans at
633 the recommended dose. No evidence of tumorigenicity was found.

634 **Pregnancy**

635 **Teratogenic Effects**

636 *Pregnancy Category C*

637 Reproduction studies have been performed in rats at 20 mg/kg/day
638 (125 mg/m²/day, 0.23 times the human systemic exposure), rabbits at 20
639 mg/kg/day (220 mg/m²/day, 0.27 times the human systemic exposure), and
640 mice at 170 mg/kg/day (510 mg/m²/day, 0.28 times the human systemic
641 exposure) with no evidence of impaired fertility or harm to the fetus due to the
642 drug. However, animal reproduction studies are not always predictive of
643 human response. There are no adequate and well-controlled studies in
644 pregnant women. NAPROSYN, EC-NAPROSYN, ANAPROX, ANAPROX
645 DS and NAPROSYN Suspension should be used in pregnancy only if the
646 potential benefit justifies the potential risk to the fetus.

647 **Nonteratogenic Effects**

648 There is some evidence to suggest that when inhibitors of prostaglandin
649 synthesis are used to delay preterm labor there is an increased risk of neonatal
650 complications such as necrotizing enterocolitis, patent ductus arteriosus and
651 intracranial hemorrhage. Naproxen treatment given in late pregnancy to delay
652 parturition has been associated with persistent pulmonary hypertension, renal
653 dysfunction and abnormal prostaglandin E levels in preterm infants. Because
654 of the known effects of nonsteroidal anti-inflammatory drugs on the fetal
655 cardiovascular system (closure of ductus arteriosus), use during pregnancy
656 (particularly late pregnancy) should be avoided.

657 **Labor and Delivery**

658 In rat studies with NSAIDs, as with other drugs known to inhibit
659 prostaglandin synthesis, an increased incidence of dystocia, delayed
660 parturition, and decreased pup survival occurred. Naproxen-containing

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661 products are not recommended in labor and delivery because, through its
662 prostaglandin synthesis inhibitory effect, naproxen may adversely affect fetal
663 circulation and inhibit uterine contractions, thus increasing the risk of uterine
664 hemorrhage. The effects of NAPROSYN, EC-NAPROSYN, ANAPROX,
665 ANAPROX DS and NAPROSYN Suspension on labor and delivery in
666 pregnant women are unknown.

667 **Nursing Mothers**

668 The naproxen anion has been found in the milk of lactating women at a
669 concentration equivalent to approximately 1% of maximum naproxen
670 concentration in plasma. Because of the possible adverse effects of
671 prostaglandin-inhibiting drugs on neonates, use in nursing mothers should be
672 avoided.

673 **Pediatric Use**

674 Safety and effectiveness in pediatric patients below the age of 2 years have
675 not been established. Pediatric dosing recommendations for juvenile arthritis
676 are based on well-controlled studies (see **DOSAGE AND**
677 **ADMINISTRATION**). There are no adequate effectiveness or dose-response
678 data for other pediatric conditions, but the experience in juvenile arthritis and
679 other use experience have established that single doses of 2.5 to 5 mg/kg (as
680 naproxen suspension, see **DOSAGE AND ADMINISTRATION**), with total
681 daily dose not exceeding 15 mg/kg/day, are well tolerated in pediatric patients
682 over 2 years of age.

683 **Geriatric Use**

684 Studies indicate that although total plasma concentration of naproxen is
685 unchanged, the unbound plasma fraction of naproxen is increased in the
686 elderly. Caution is advised when high doses are required and some adjustment
687 of dosage may be required in elderly patients. As with other drugs used in the
688 elderly, it is prudent to use the lowest effective dose.

689 Experience indicates that geriatric patients may be particularly sensitive to
690 certain adverse effects of nonsteroidal anti-inflammatory drugs. Elderly or
691 debilitated patients seem to tolerate peptic ulceration or bleeding less well
692 when these events do occur. Most spontaneous reports of fatal GI events are in
693 the geriatric population (see **WARNINGS**).

694 Naproxen is known to be substantially excreted by the kidney, and the risk of
695 toxic reactions to this drug may be greater in patients with impaired renal
696 function. Because elderly patients are more likely to have decreased renal
697 function, care should be taken in dose selection, and it may be useful to
698 monitor renal function. Geriatric patients may be at a greater risk for the
699 development of a form of renal toxicity precipitated by reduced prostaglandin

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700 formation during administration of nonsteroidal anti-inflammatory drugs (see
701 **WARNINGS: Renal Effects**).

702 **ADVERSE REACTIONS**

703 Adverse reactions reported in controlled clinical trials in 960 patients treated
704 for rheumatoid arthritis or osteoarthritis are listed below. In general, reactions
705 in patients treated chronically were reported 2 to 10 times more frequently
706 than they were in short-term studies in the 962 patients treated for mild to
707 moderate pain or for dysmenorrhea. The most frequent complaints reported
708 related to the gastrointestinal tract.

709 A clinical study found gastrointestinal reactions to be more frequent and more
710 severe in rheumatoid arthritis patients taking daily doses of 1500 mg naproxen
711 compared to those taking 750 mg naproxen (see **CLINICAL**
712 **PHARMACOLOGY**).

713 In controlled clinical trials with about 80 pediatric patients and in well-
714 monitored, open-label studies with about 400 pediatric patients with juvenile
715 arthritis treated with naproxen, the incidence of rash and prolonged bleeding
716 times were increased, the incidence of gastrointestinal and central nervous
717 system reactions were about the same, and the incidence of other reactions
718 were lower in pediatric patients than in adults.

719 In patients taking naproxen in clinical trials, the most frequently reported
720 adverse experiences in approximately 1% to 10% of patients are:

721 **Gastrointestinal (GI) Experiences, including:** heartburn*, abdominal pain*,
722 nausea*, constipation*, diarrhea, dyspepsia, stomatitis

723 **Central Nervous System:** headache*, dizziness*, drowsiness*,
724 lightheadedness, vertigo

725 **Dermatologic:** pruritus (itching)*, skin eruptions*, ecchymoses*, sweating,
726 purpura

727 **Special Senses:** tinnitus*, visual disturbances, hearing disturbances

728 **Cardiovascular:** edema*, palpitations

729 **General:** dyspnea*, thirst

730 *Incidence of reported reaction between 3% and 9%. Those reactions
731 occurring in less than 3% of the patients are unmarked.

732 In patients taking NSAIDs, the following adverse experiences have also been
733 reported in approximately 1% to 10% of patients.

734 **Gastrointestinal (GI) Experiences, including:** flatulence, gross
735 bleeding/perforation, GI ulcers (gastric/duodenal), vomiting

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736 **General:** abnormal renal function, anemia, elevated liver enzymes, increased
737 bleeding time, rashes

738 The following are additional adverse experiences reported in <1% of patients
739 taking naproxen during clinical trials and through postmarketing reports.
740 Those adverse reactions observed through postmarketing reports are italicized.

741 **Body as a Whole:** *anaphylactoid reactions, angioneurotic edema, menstrual*
742 *disorders, pyrexia (chills and fever)*

743 **Cardiovascular:** *congestive heart failure, vasculitis, hypertension, pulmonary*
744 *edema*

745 **Gastrointestinal:** *gastrointestinal bleeding and/or perforation, hematemesis,*
746 *pancreatitis, vomiting, colitis, nonpeptic gastrointestinal ulceration,*
747 *ulcerative stomatitis, esophagitis, peptic ulceration*

748 **Hepatobiliary:** *jaundice, abnormal liver function tests, hepatitis (some cases*
749 *have been fatal)*

750 **Hemic and Lymphatic:** *eosinophilia, leucopenia, melena, thrombocytopenia,*
751 *agranulocytosis, granulocytopenia, hemolytic anemia, aplastic anemia*

752 **Metabolic and Nutritional:** *hyperglycemia, hypoglycemia*

753 **Nervous System:** *inability to concentrate, depression, dream abnormalities,*
754 *insomnia, malaise, myalgia, muscle weakness, aseptic meningitis, cognitive*
755 *dysfunction, convulsions*

756 **Respiratory:** *eosinophilic pneumonitis, asthma*

757 **Dermatologic:** *alopecia, urticaria, skin rashes, toxic epidermal necrolysis,*
758 *erythema multiforme, erythema nodosum, fixed drug eruption, lichen planus,*
759 *pustular reaction, systemic lupus erythematoses, Stevens-Johnson syndrome,*
760 *photosensitive dermatitis, photosensitivity reactions, including rare cases*
761 *resembling porphyria cutanea tarda (pseudoporphyria) or epidermolysis*
762 *bullosa. If skin fragility, blistering or other symptoms suggestive of*
763 *pseudoporphyria occur, treatment should be discontinued and the patient*
764 *monitored.*

765 **Special Senses:** *hearing impairment, corneal opacity, papillitis, retrobulbar*
766 *optic neuritis, papilledema*

767 **Urogenital:** *glomerular nephritis, hematuria, hyperkalemia, interstitial*
768 *nephritis, nephrotic syndrome, renal disease, renal failure, renal papillary*
769 *necrosis, raised serum creatinine*

770 **Reproduction (female):** *infertility*

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771 In patients taking NSAIDs, the following adverse experiences have also been
772 reported in <1% of patients.

773 **Body as a Whole:** fever, infection, sepsis, anaphylactic reactions, appetite
774 changes, death

775 **Cardiovascular:** hypertension, tachycardia, syncope, arrhythmia,
776 hypotension, myocardial infarction

777 **Gastrointestinal:** dry mouth, esophagitis, gastric/peptic ulcers, gastritis,
778 glossitis, eructation

779 **Hepatobiliary:** hepatitis, liver failure

780 **Hemic and Lymphatic:** rectal bleeding, lymphadenopathy, pancytopenia

781 **Metabolic and Nutritional:** weight changes

782 **Nervous System:** anxiety, asthenia, confusion, nervousness, paresthesia,
783 somnolence, tremors, convulsions, coma, hallucinations

784 **Respiratory:** asthma, respiratory depression, pneumonia

785 **Dermatologic:** exfoliative dermatitis

786 **Special Senses:** blurred vision, conjunctivitis

787 **Urogenital:** cystitis, dysuria, oliguria/polyuria, proteinuria

788 **OVERDOSAGE**

789 Significant naproxen overdose may be characterized by lethargy, dizziness,
790 drowsiness, epigastric pain, abdominal discomfort, heartburn, indigestion,
791 nausea, transient alterations in liver function, hypoprothrombinemia, renal
792 dysfunction, metabolic acidosis, apnea, disorientation or vomiting.
793 Gastrointestinal bleeding can occur. Hypertension, acute renal failure,
794 respiratory depression, and coma may occur, but are rare. Anaphylactoid
795 reactions have been reported with therapeutic ingestion of NSAIDs, and may
796 occur following an overdose. Because naproxen sodium may be rapidly
797 absorbed, high and early blood levels should be anticipated. A few patients
798 have experienced convulsions, but it is not clear whether or not these were
799 drug-related. It is not known what dose of the drug would be life threatening.
800 The oral LD₅₀ of the drug is 543 mg/kg in rats, 1234 mg/kg in mice, 4110
801 mg/kg in hamsters, and greater than 1000 mg/kg in dogs.

802 Patients should be managed by symptomatic and supportive care following a
803 NSAID overdose. There are no specific antidotes. Hemodialysis does not
804 decrease the plasma concentration of naproxen because of the high degree of
805 its protein binding. Emesis and/or activated charcoal (60 to 100 g in adults, 1
806 to 2 g/kg in children) and/or osmotic cathartic may be indicated in patients

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807 seen within 4 hours of ingestion with symptoms or following a large overdose.
808 Forced diuresis, alkalization of urine or hemoperfusion may not be useful
809 due to high protein binding.

810 **DOSAGE AND ADMINISTRATION**

811 Carefully consider the potential benefits and risks of NAPROSYN, EC-
812 NAPROSYN, ANAPROX, ANAPROX DS and NAPROSYN Suspension and
813 other treatment options before deciding to use NAPROSYN, EC-
814 NAPROSYN, ANAPROX, ANAPROX DS and NAPROSYN Suspension.
815 Use the lowest effective dose for the shortest duration consistent with
816 individual patient treatment goals (see **WARNINGS**).

817 After observing the response to initial therapy with NAPROSYN, EC-
818 NAPROSYN, ANAPROX, ANAPROX DS or NAPROSYN Suspension, the
819 dose and frequency should be adjusted to suit an individual patient's needs.

820 **Different dose strengths and formulations (ie, tablets, suspension) of the**
821 **drug are not necessarily bioequivalent. This difference should be taken**
822 **into consideration when changing formulation.**

823 Although NAPROSYN, NAPROSYN Suspension, EC-NAPROSYN,
824 ANAPROX and ANAPROX DS all circulate in the plasma as naproxen, they
825 have pharmacokinetic differences that may affect onset of action. Onset of
826 pain relief can begin within 30 minutes in patients taking naproxen sodium
827 and within 1 hour in patients taking naproxen. Because EC-NAPROSYN
828 dissolves in the small intestine rather than in the stomach, the absorption of
829 the drug is delayed compared to the other naproxen formulations (see
830 **CLINICAL PHARMACOLOGY**).

831 The recommended strategy for initiating therapy is to choose a formulation
832 and a starting dose likely to be effective for the patient and then adjust the
833 dosage based on observation of benefit and/or adverse events. A lower dose
834 should be considered in patients with renal or hepatic impairment or in elderly
835 patients (see **WARNINGS** and **PRECAUTIONS**).

836 **Geriatric Patients**

837 Studies indicate that although total plasma concentration of naproxen is
838 unchanged, the unbound plasma fraction of naproxen is increased in the
839 elderly. Caution is advised when high doses are required and some adjustment
840 of dosage may be required in elderly patients. As with other drugs used in the
841 elderly, it is prudent to use the lowest effective dose.

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842 **Patients With Moderate to Severe Renal Impairment**

843 Naproxen-containing products are not recommended for use in patients with
844 moderate to severe and severe renal impairment (creatinine clearance <30
845 mL/min) (see **WARNINGS: Renal Effects**).

846 **Rheumatoid Arthritis, Osteoarthritis and Ankylosing Spondylitis**

NAPROSYN	250 mg or 375 mg or 500 mg	twice daily twice daily twice daily
ANAPROX	275 mg (naproxen 250 mg with 25 mg sodium)	twice daily
ANAPROX DS	550 mg (naproxen 500 mg with 50 mg sodium)	twice daily
NAPROSYN Suspension	250 mg (10 mL/2 tsp) or 375 mg (15 mL/3 tsp) or 500 mg (20 mL/4 tsp)	twice daily twice daily twice daily
EC-NAPROSYN	375 mg or 500 mg	twice daily twice daily

847 To maintain the integrity of the enteric coating, the EC-NAPROSYN tablet
848 should not be broken, crushed or chewed during ingestion. NAPROSYN
849 Suspension should be shaken gently before use.

850 During long-term administration, the dose of naproxen may be adjusted up or
851 down depending on the clinical response of the patient. A lower daily dose
852 may suffice for long-term administration. The morning and evening doses do
853 not have to be equal in size and the administration of the drug more frequently
854 than twice daily is not necessary.

855 In patients who tolerate lower doses well, the dose may be increased to
856 naproxen 1500 mg/day for limited periods of up to 6 months when a higher
857 level of anti-inflammatory/analgesic activity is required. When treating such
858 patients with naproxen 1500 mg/day, the physician should observe sufficient
859 increased clinical benefits to offset the potential increased risk. The morning
860 and evening doses do not have to be equal in size and administration of the
861 drug more frequently than twice daily does not generally make a difference in
862 response (see **CLINICAL PHARMACOLOGY**).

863 **Juvenile Arthritis**

864 The use of NAPROSYN Suspension is recommended for juvenile arthritis in
865 children 2 years or older because it allows for more flexible dose titration
866 based on the child's weight. In pediatric patients, doses of 5 mg/kg/day
867 produced plasma levels of naproxen similar to those seen in adults taking 500
868 mg of naproxen (see **CLINICAL PHARMACOLOGY**).

869 The recommended total daily dose of naproxen is approximately 10 mg/kg
870 given in 2 divided doses (ie, 5 mg/kg given twice a day). A measuring cup

EC-NAPROSYN® (naproxen delayed-release tablets), NAPROSYN® (naproxen tablets), ANAPROX®/ANAPROX® DS (naproxen sodium tablets), NAPROSYN® (naproxen suspension)

871 marked in 1/2 teaspoon and 2.5 milliliter increments is provided with the
872 NAPROSYN Suspension. The following table may be used as a guide for
873 dosing of NAPROSYN Suspension:

874	Patient's Weight	Dose	Administered as
875	13 kg (29 lb)	62.5 mg bid	2.5 mL (1/2 tsp) twice daily
876	25 kg (55 lb)	125 mg bid	5.0 mL (1 tsp) twice daily
877	38 kg (84 lb)	187.5 mg bid	7.5 mL (1 1/2 tsp) twice daily

878 **Management of Pain, Primary Dysmenorrhea, and Acute**
879 **Tendonitis and Bursitis**

880 The recommended starting dose is 550 mg of naproxen sodium as
881 ANAPROX/ANAPROX DS followed by 550 mg every 12 hours or 275 mg
882 every 6 to 8 hours as required. The initial total daily dose should not exceed
883 1375 mg of naproxen sodium. Thereafter, the total daily dose should not
884 exceed 1100 mg of naproxen sodium. Because the sodium salt of naproxen is
885 more rapidly absorbed, ANAPROX/ANAPROX DS is recommended for the
886 management of acute painful conditions when prompt onset of pain relief is
887 desired. NAPROSYN may also be used but EC-NAPROSYN is not
888 recommended for initial treatment of acute pain because absorption of
889 naproxen is delayed compared to other naproxen-containing products (see
890 **CLINICAL PHARMACOLOGY, INDICATIONS AND USAGE**).

891 **Acute Gout**

892 The recommended starting dose is 750 mg of NAPROSYN followed by 250
893 mg every 8 hours until the attack has subsided. ANAPROX may also be used
894 at a starting dose of 825 mg followed by 275 mg every 8 hours. EC-
895 NAPROSYN is not recommended because of the delay in absorption (see
896 **CLINICAL PHARMACOLOGY**).

897 **HOW SUPPLIED**

898 **NAPROSYN Tablets:** 250 mg: round, yellow, biconvex, engraved with NPR
899 LE 250 on one side and scored on the other. Packaged in light-resistant bottles
900 of 100.

901 100's (bottle): NDC 0004-6313-01.

902 375 mg: pink, biconvex oval, engraved with NPR LE 375 on one side.
903 Packaged in light-resistant bottles of 100.

904 100's (bottle): NDC 0004-6314-01.

905 500 mg: yellow, capsule-shaped, engraved with NPR LE 500 on one side and
906 scored on the other. Packaged in light-resistant bottles of 100.

EC-NAPROSYN® (naproxen delayed-release tablets), NAPROSYN® (naproxen tablets), ANAPROX®/ANAPROX® DS (naproxen sodium tablets), NAPROSYN® (naproxen suspension)

907 100's (bottle): NDC 0004-6316-01.

908 Store at 15° to 30°C (59° to 86°F) in well-closed containers; dispense in light-
909 resistant containers.

910 **NAPROSYN Suspension:** 125 mg/5 mL (contains 39 mg sodium, about 1.5
911 mEq/teaspoon): Available in 1 pint (473 mL) light-resistant bottles (NDC
912 0004-0028-28).

913 Store at 15° to 30°C (59° to 86°F); avoid excessive heat, above 40°C (104°F).
914 Dispense in light-resistant containers. Shake gently before use.

915 **EC-NAPROSYN Delayed-Release Tablets:** 375 mg: white, capsule-shaped,
916 imprinted with EC-NAPROSYN on one side and 375 on the other. Packaged
917 in light-resistant bottles of 100.

918 100's (bottle): NDC 0004-6415-01.

919 500 mg: white, capsule-shaped, imprinted with EC-NAPROSYN on one side
920 and 500 on the other. Packaged in light-resistant bottles of 100.

921 100's (bottle): NDC 0004-6416-01.

922 Store at 15° to 30°C (59° to 86°F) in well-closed containers; dispense in light-
923 resistant containers.

924 **ANAPROX Tablets:** Naproxen sodium 275 mg: light blue, oval-shaped,
925 engraved with NPS-275 on one side. Packaged in bottles of 100.

926 100's (bottle): NDC 0004-6202-01.

927 Store at 15° to 30°C (59° to 86°F) in well-closed containers.

928 **ANAPROX DS Tablets:** Naproxen sodium 550 mg: dark blue, oblong-
929 shaped, engraved with NPS 550 on one side and scored on both sides.
930 Packaged in bottles of 100.

931 100's (bottle): NDC 0004-6203-01.

932 Store at 15° to 30°C (59° to 86°F) in well-closed containers.

933 Revised: March 2006

934

935 **Medication Guide**

936 **for**

937 **Non-steroidal Anti-Inflammatory Drugs (NSAIDs)**

938 (See the end of this Medication Guide for a list of prescription NSAID
939 medicines.)

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940

941 **What is the most important information I should know about medicines**
942 **called Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)?**

943 **NSAID medicines may increase the chance of a heart attack or**
944 **stroke that can lead to death.** This chance increases:

- 945 • with longer use of NSAID medicines
- 946 • in people who have heart disease

947
948 **NSAID medicines should never be used right before or after a**
949 **heart surgery called a “coronary artery bypass graft (CABG).”**

950 **NSAID medicines can cause ulcers and bleeding in the stomach**
951 **and intestines at any time during treatment. Ulcers and bleeding:**

- 952 • can happen without warning symptoms
- 953 • may cause death

954
955 **The chance of a person getting an ulcer or bleeding increases**
956 **with:**

- 957 • taking medicines called “corticosteroids” and
- 958 “anticoagulants”
- 959 • longer use
- 960 • smoking
- 961 • drinking alcohol
- 962 • older age
- 963 • having poor health

964
965 **NSAID medicines should only be used:**

- 966 • exactly as prescribed
- 967 • at the lowest dose possible for your treatment
- 968 • for the shortest time needed

970 **What are Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)?**

971 NSAID medicines are used to treat pain and redness, swelling, and heat
972 (inflammation) from medical conditions such as:

- 973 • different types of arthritis
- 974 • menstrual cramps and other types of short-term pain

975
976 **Who should not take a Non-Steroidal Anti-Inflammatory Drug (NSAID)?**

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977 **Do not take an NSAID medicine:**

- 978 • if you had an asthma attack, hives, or other allergic reaction with
- 979 aspirin or any other NSAID medicine
- 980 • for pain right before or after heart bypass surgery
- 981

982 **Tell your healthcare provider:**

- 983 • about all of your medical conditions.
- 984 • about all of the medicines you take. NSAIDs and some other
- 985 medicines can interact with each other and cause serious side
- 986 effects. **Keep a list of your medicines to show to your**
- 987 **healthcare provider and pharmacist.**
- 988 • if you are pregnant. **NSAID medicines should not be used by**
- 989 **pregnant women late in their pregnancy.**
- 990 • if you are breastfeeding. **Talk to your doctor.**
- 991

992 **What are the possible side effects of Non-Steroidal Anti-Inflammatory**
 993 **Drugs (NSAIDs)?**

<p>Serious side effects include:</p> <ul style="list-style-type: none"> • heart attack • stroke • high blood pressure • heart failure from body swelling (fluid retention) • kidney problems including kidney failure • bleeding and ulcers in the stomach and intestine • low red blood cells (anemia) • life-threatening skin reactions • life-threatening allergic reactions • liver problems including liver failure • asthma attacks in people who have asthma 	<p>Other side effects include:</p> <ul style="list-style-type: none"> • stomach pain • constipation • diarrhea • gas • heartburn • nausea • vomiting • dizziness
---	---

994 **Get emergency help right away if you have any of the following**
 995 **symptoms:**
 996

- shortness of breath or trouble breathing
- chest pain
- weakness in one part or side of your
- slurred speech
- swelling of the face or throat

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body

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Stop your NSAID medicine and call your healthcare provider right away if you have any of the following symptoms:

- nausea
- more tired or weaker than usual
- itching
- your skin or eyes look yellow
- stomach pain
- flu-like symptoms
- vomit blood
- there is blood in your bowel movement or it is black and sticky like tar
- unusual weight gain
- skin rash or blisters with fever
- swelling of the arms and legs, hands and feet

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These are not all the side effects with NSAID medicines. Talk to your healthcare provider or pharmacist for more information about NSAID medicines.

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Other information about Non-Steroidal Anti-Inflammatory Drugs (NSAIDs):

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- Aspirin is an NSAID medicine but it does not increase the chance of a heart attack. Aspirin can cause bleeding in the brain, stomach, and intestines. Aspirin can also cause ulcers in the stomach and intestines.
- Some of these NSAID medicines are sold in lower doses without a prescription (over-the-counter). Talk to your healthcare provider before using over-the-counter NSAIDs for more than 10 days.

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1013 **NSAID medicines that need a prescription**

Generic Name	Tradename
Celecoxib	Celebrex [®]
Diclofenac	Cataflam [®] , Voltaren [®] , Arthrotec [™] (combined with misoprostol)
Diffunisal	Dolobid [®]
Etodolac	Lodine [®] , Lodine [®] XL
Fenoprofen	Nalfon [®] , Nalfon [®] 200
Flurbiprofen	Ansaid [®]
Ibuprofen	Motrin [®] , Tab-Profen [®] , Vicoprofen [®] (combined with hydrocodone), Combunox [™] (combined with oxycodone)
Indomethacin	Indocin [®] , Indocin [®] SR, Indo-Lemmon [™] , Indomethagan [™]
Ketoprofen	Oruvail [®]
Ketorolac	Toradol [®]
Mefenamic Acid	Ponstel [®]
Meloxicam	Mobic [®]
Nabumetone	Relafen [®]
Naproxen	Naprosyn [®] , Anaprox [®] , Anaprox [®] DS, EC-Naprosyn [®] , Naprelan [®] , Naprapac [®] (copackaged with lansoprazole)
Oxaprozin	Daypro [®]
Piroxicam	Feldene [®]
Sulindac	Clinoril [®]
Tolmetin	Tolectin [®] , Tolectin DS [®] , Tolectin [®] 600

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1015 Issued: January 2006

1016 This Medication Guide has been approved by the U.S. Food and Drug
1017 Administration.

1018

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1020 owners.

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