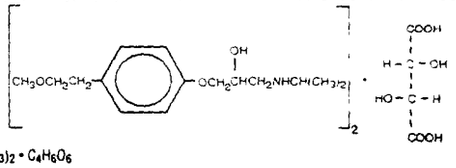
Attachment 3

etoprolol Tartrate Tablets USP

Rx only

DESCRIPTION

Metoprolol tartrate is a selective $beta_1$-adrenoreceptor blocking agent, available as 50 and 100 mg tablets for oral administration. Metoprolol tartrate is (±)-1-(isopropylamino)-3-[p-(2-methoxyethyl) phenoxy]-2-propanol (2:1) *dextro*-tartrate salt, and its structural formula is



$(C_{15}H_{25}NO_3)_2 \cdot C_4H_6O_6$

Metoprolol tartrate is a white, practically odorless, crystalline powder with a molecular weight of 684.82. It is very soluble in water; freely soluble in methylene chloride, in chloroform, and in alcohol; slightly soluble in acetone; and insoluble in ether.

Inactive Ingredients. Tablets contain colloidal silicon dioxide, hydroxypropyl methylcellulose, lactose monohydrate, magnesium stearate, microcrystalline cellulose, polyethylene glycol, polysorbate, povidone, sodium starch glycolate, talc and titanium dioxide.

CLINICAL PHARMACOLOGY

Metoprolol tartrate is a beta-adrenergic receptor blocking agent. *In vitro* and *in vivo* animal studies have shown that it has a preferential effect on $beta_1$ adrenoreceptors, chiefly located in cardiac muscle. This preferential effect is not absolute, however, and at higher doses, metoprolol also inhibits $beta_2$ adrenoreceptors, chiefly located in the bronchial and vascular musculature.

Clinical pharmacology studies have confirmed the beta-blocking activity of metoprolol in man, as shown by (1) reduction in heart rate and cardiac output at rest and upon exercise, (2) reduction of systolic blood pressure upon exercise, (3) inhibition of isoproterenol-induced tachycardia, and (4) reduction of reflex orthostatic tachycardia.

Relative $beta_1$ selectivity has been confirmed by the following: (1) In normal subjects, metoprolol is unable to reverse the $beta_2$-mediated vasodilating effects of epinephrine. This contrasts with the effect of nonselective ($beta_1$ plus $beta_2$) beta blockers, which completely reverse the vasodilating effects of epinephrine. (2) In asthmatic patients, metoprolol reduces FEV_1 and FVC significantly less than a nonselective beta blocker, propranolol, at equivalent $beta_1$-receptor blocking doses.

Metoprolol has no intrinsic sympathomimetic activity, and membrane-stabilizing activity is detectable only at doses much greater than required for beta blockade. Metoprolol crosses the blood-brain barrier and has been reported in the CSF in a concentration 78% of the simultaneous plasma concentration. Animal and human experiments indicate that metoprolol slows the sinus rate and decreases AV nodal conduction.

In controlled clinical studies, metoprolol tartrate has been shown to be an effective antihypertensive agent when used alone or as concomitant therapy with thiazide-type diuretics, at dosages of 100 to 450 mg daily. In controlled, comparative, clinical studies, metoprolol has been shown to be as effective an antihypertensive agent as propranolol, methyldopa, and thiazide-type diuretics, and to be equally effective in supine and standing positions.

The mechanism of the antihypertensive effects of beta-blocking agents has not been elucidated. However, several possible mechanisms have been proposed: (1) competitive antagonism of catecholamines at peripheral (especially cardiac) adrenergic neuron sites, leading to decreased cardiac output; (2) a central effect leading to reduced sympathetic outflow to the periphery; and (3) suppression of renin activity.

By blocking catecholamine-induced increases in heart rate, in velocity and extent of myocardial contraction, and in blood pressure, metoprolol reduces the oxygen requirements of the heart at any given level of effort, thus making it useful in the long-term management of angina pectoris. However, in patients with heart failure, beta-adrenergic blockade may increase oxygen requirements by increasing left ventricular fiber length and end-diastolic pressure.

Although beta-adrenergic receptor blockade is useful in the treatment of angina and hypertension, there are situations in which sympathetic stimulation is vital. In patients with severely damaged hearts, adequate ventricular function may depend on sympathetic drive. In the presence of AV block, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. $Beta_2$-adrenergic blockade results in passive bronchial constriction by interfering with endogenous adrenergic bronchodilator activity in patients subject to bronchospasm and may also interfere with exogenous bronchodilators in such patients.

In controlled clinical trials, metoprolol tartrate administered two or four times daily, has been shown to be an effective antianginal agent, reducing the number of angina attacks and increasing exercise tolerance. The dosage used in these studies ranged from 100 to 400 mg daily. A controlled, comparative, clinical trial showed that metoprolol was indistinguishable from propranolol in the treatment of angina pectoris.

In a large (1,395 patients randomized), double-blind, placebo-controlled clinical study, metoprolol was shown to reduce 3-month mortality by 36% in patients with suspected or definite myocardial infarction.

Patients were randomized and treated as soon as possible after their arrival in the hospital, once their clinical condition had stabilized and their hemodynamic status had been carefully evaluated. Subjects were ineligible if they had hypotension, bradycardia, peripheral signs of shock, and/or more than minimal basal rales as signs of congestive heart failure. Initial treatment consisted of intravenous followed by oral administration of metoprolol tartrate or placebo, given in a coronary care or comparable unit. Oral maintenance therapy with metoprolol or placebo was then continued for 3 months. After this double-blind period, all patients were given metoprolol and followed up to 1 year.

The median delay from the onset of symptoms to the initiation of therapy was 8 hours in both the metoprolol and placebo treatment groups. Among patients treated with metoprolol, there were comparable reductions in 3-month mortality for those treated early (≤ 8 hours) and those in whom treatment was started later. Significant reductions in the incidence of ventricular fibrillation and in chest pain following initial intravenous therapy were also observed with metoprolol and were independent of the interval between onset of symptoms and initiation of therapy.

The precise mechanism of action of metoprolol in patients with suspected or definite myocardial infarction is not known.

In this study, patients treated with metoprolol received the drug both very early (intravenously) and during a subsequent 3-month period, while placebo patients received no beta-blocker treatment for this period. The study thus was able to show a benefit from the overall metoprolol regimen but cannot separate the benefit of very early intravenous treatment from the benefit of later beta-blocker therapy. Nonetheless, because the overall regimen showed a clear beneficial effect on survival without evidence of an early adverse effect on survival, one acceptable dosage regimen is the precise regimen used in the trial. Because the specific benefit of very early treatment remains to be defined however, it is also reasonable to administer the drug orally to patients at a later time as is recommended for certain other beta blockers.

Pharmacokinetics

In man, absorption of metoprolol is rapid and complete. Plasma levels following oral administration, however, approximate 50% of levels following intravenous administration, indicating about 50% first-pass metabolism.

Plasma levels achieved are highly variable after oral administration. Only a small fraction of the drug (about 12%) is bound to human serum albumin. Elimination is mainly by biotransformation in the liver, and the plasma half-life ranges from approximately 3 to 7 hours. Less than 5% of an oral dose of metoprolol is recovered unchanged in the urine; the rest is excreted by the kidneys as metabolites that appear to have no clinical significance. The systemic availability and half-life of metoprolol in patients with renal failure do not differ to a clinically significant degree from those in normal subjects. Consequently, no reduction in dosage is usually needed in patients with chronic renal failure.

Significant beta-blocking effect (as measured by reduction of exercise heart rate) occurs within 1 hour after oral administration, and its duration is dose-related. For example, a 50% reduction of the maximum registered effect after single oral doses of 20, 50, and 100 mg occurred at 3.3, 5.0, and 6.4 hours, respectively, in normal subjects. After repeated oral dosages of 100 mg twice daily, a significant reduction in exercise systolic blood pressure was evident at 12 hours.

Equivalent maximal beta-blocking effect is achieved with oral and intravenous doses in the ratio of approximately 2.5:1.

There is a linear relationship between the log of plasma levels and reduction of exercise h rate. However, antihypertensive activity does not appear to be related to plasma levels. Beca of variable plasma levels attained with a given dose and lack of a consistent relationship of a hypertensive activity to dose, selection of proper dosage requires individual titration.

In several studies of patients with acute myocardial infarction, intravenous followed by administration of metoprolol caused a reduction in heart rate, systolic blood pressure cardiac output, Stroke volume, diastolic blood pressure and pulmonary artery end diast pressure remained unchanged.

In patients with angina pectoris, plasma concentration measured at 1 hour is linearly rela to the oral dose within the range of 50 to 400 mg. Exercise heart rate and systolic blood press are reduced in relation to the logarithm of the oral dose of metoprolol. The increase in exer capacity and the reduction in left ventricular ischemia are also significantly related to logarithm of the oral dose.

INDICATIONS AND USAGE

Hypertension

Metoprolol tartrate tablets are indicated for the treatment of hypertension. They may be us alone or in combination with other antihypertensive agents.

Angina Pectoris

Metoprolol tartrate tablets are indicated in the long-term treatment of angina pectoris.

Myocardial Infarction

Metoprolol tartrate injection and tablets are indicated in the treatment of hemodynamica stable patients with definite or suspected acute myocardial infarction to reduce cardiovascul mortality. Treatment with intravenous metoprolol tartrate can be initiated as soon as the patient clinical condition allows (see DOSAGE AND ADMINISTRATION, CONTRAINDICATIONS, ar WARNINGS). Alternatively, treatment can begin within 3 to 10 days of the acute event (se DOSAGE AND ADMINISTRATION).

CONTRAINDICATIONS

Hypertension and Angina

Metoprolol tartrate is contraindicated in sinus bradycardia, heart block greater than fir degree, cardiogenic shock, and overt cardiac failure (see WARNINGS).

Myocardial Infarction

Metoprolol is contraindicated in patients with a heart rate < 45 beats/min, second- and thir degree heart block; significant first-degree heart block (P-R interval ≥ 0.24 sec), systolic bloc pressure < 100 mmHg, or moderate-to-severe cardiac failure (see WARNINGS).

WARNINGS

Hypertension and Angina

Cardiac Failure: Sympathetic stimulation is a vital component supporting circulatory functic in congestive heart failure, and beta blockade carries the potential hazard of further depressir myocardial contractility and precipitating more severe failure. In hypertensive and angina patient who have congestive heart failure controlled by digitalis and diuretics, metoprolol should c administered cautiously. Both digitalis and metoprolol slow AV conduction.

In Patients Without a History of Cardiac Failure: Continued depression of the myocardium with beta blocking agents over a period of time can, in some cases, lead to cardiac failure. At the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic. The response should be observed closely. If cardiac failure continues, despite adequate digitalization and diuretic therapy, metoprolol should be withdrawn.

Ischemic Heart Disease: Following abrupt cessation of therapy with certain beta-blocking agents, exacerbations of angina pectoris and, in some cases, myocardial infarction have occurred. When discontinuing chronically administered metoprolol, particularly in patients with ischemic heart disease, the dosage should be gradually reduced over a period of 1 to 2 weeks and the patient should be carefully monitored. If angina markedly worsens or acute coronary insufficiency develops, metoprolol administration should be reinstates promptly, at least temporarily, and other measures appropriate for the management of unstable angina should be taken. Patients should be warned against interruption or discontinuation of therapy without the physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue metoprolol therapy abruptly even in patients treated only for hypertension.

Bronchospastic Diseases: **PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. Because of its relative $beta_1$ selectivity, however metoprolol may be used with caution in patients with bronchospastic disease who do no respond to, or cannot tolerate, other antihypertensive treatment. Since $beta_1$ selectivity is no absolute, a $beta_2$ stimulating agent should be administered concomitantly, and the lowest possible dose of metoprolol tartrate should be used. In these circumstances it would be prudent initially to administer metoprolol in smaller doses three times daily, instead of larger doses two times daily, to avoid the higher plasma levels associated with the longer dosing interval. (SEE DOSAGE AND ADMINISTRATION.)**

Major Surgery: The necessity or desirability of withdrawing beta-blocking therapy prior to major surgery is controversial; the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Metoprolol, like other beta blockers, is a competitive inhibitor of beta-receptor agonists, and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported with beta blockers.

Diabetes and Hypoglycemia: Metoprolol should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected.

Thyrotoxicosis: Beta-adrenergic blockade may mask certain clinical signs (*e.g.*, tachycardia of hyperthyroidism. Patients suspected of developing thyrotoxicosis should be managed carefully to avoid abrupt withdrawal of beta blockade, which might precipitate a thyroid storm.

Myocardial Infarction

Cardiac Failure: Sympathetic stimulation is a vital component supporting circulatory function, and beta blockade carries the potential hazard of depressing myocardial contractility and precipitating or exacerbating minimal cardiac failure.

During treatment with metoprolol, the hemodynamic status of the patient should be carefully monitored. If heart failure occurs or persists despite appropriate treatment, metoprolol should be discontinued.

Bradycardia: Metoprolol produces a decrease in sinus heart rate in most patients, this decrease is greatest among patients with high initial heart rates and least among patients with low initial heart rates. Acute myocardial infarction (particularly inferior infarction) may in itse produce significant lowering of the sinus rate. If the sinus rate decreases to < 40 beats/min particularly if associated with evidence of lowered cardiac output, atropine (0.25 to 0.5 mg should be administered intravenously. If treatment with atropine is not successful, metoprolo should be discontinued, and cautious administration of isoproterenol or installation of a cardiac pace-maker should be considered.

AV Block: Metoprolol slows AV conduction and may produce significant first- (P-R interval ≥ 0.26 sec), second-, or third-degree heart block. Acute myocardial infarction also produces heart block.

If heart block occurs, metoprolol should be discontinued and atropine (0.25 to 0.5 mg) should be administered intravenously. If treatment with atropine is not successful, cautious administration of isoproterenol or installation of a cardiac pacemaker should be considered.

Hypotension: If hypotension (systolic blood pressure ≤ 90 mmHg) occurs, metoprolol should be discontinued, and the hemodynamic status of the patient and the extent of myocardial damag carefully assessed. Invasive monitoring of central venous, pulmonary capillary wedge, and arteri pressures may be required. Appropriate therapy with fluids, positive inotropic agents, balloo counterpulsation, or other treatment modalities should be instituted. If hypotension is associa with sinus bradycardia or AV block, treatment should be directed at reversing these (see above

Bronchospastic Diseases: **PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD GENERAL, NOT RECEIVE BETA BLOCKERS. Because of its relative $beta_1$ selectivity, metopro may be used with extreme caution in patients with bronchospastic disease. Because t unknown to what extent $beta_2$-stimulating agents may exacerbate myocardial ischemia a the extent of infarction, these agents should *not* be used prophylactically. If bronchospa**

Attachment 3

not related to congestive heart failure occurs, metoprolol should be discontinued. A theophylline derivative or a $beta_2$ agonist may be administered cautiously, depending on the clinical condition of the patient. Both theophylline derivatives and $beta_2$ agonists may produce serious cardiac arrhythmias.

PRECAUTIONS

General

Metoprolol should be used with caution in patients with impaired hepatic function.

Information for Patients

Patients should be advised to take metoprolol regularly and continuously, as directed, with or immediately following meals. If a dose should be missed, the patient should take only the next scheduled dose (without doubling it). Patients should not discontinue metoprolol without consulting the physician.

Patients should be advised (1) to avoid operating automobiles and machinery or engaging in other tasks requiring alertness until the patient's response to therapy with metoprolol has been determined; (2) to contact the physician if any difficulty in breathing occurs; (3) to inform the physician or dentist before any type of surgery that he or she is taking metoprolol.

Drug Interactions

Catecholamine-depleting drugs (e.g., reserpine) may have an additive effect when given with beta-blocking agents. Patients treated with metoprolol plus a catecholamine depletor should therefore be closely observed for evidence of hypotension or marked bradycardia, which may produce vertigo, syncope, or postural hypotension.

Risk of Anaphylactic Reaction. While taking beta-blockers, patients with a history of severe anaphylactic reaction to a variety of allergens may be more reactive to repeated challenge, either accidental, diagnostic, or therapeutic. Such patients may be unresponsive to the usual doses of epinephrine used to treat allergic reaction.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term studies in animals have been conducted to evaluate carcinogenic potential. In a 2-year study in rats at three oral dosage levels of up to 800 mg/kg per day, there was no increase in the development of spontaneously occurring benign or malignant neoplasms of any type. The only histologic changes that appeared to be drug related were an increased incidence of generally mild focal accumulation of foamy macrophages in pulmonary alveoli and a slight increase in biliary hyperplasia. In a 21-month study in Swiss albino mice at three oral dosage levels of up to 750 mg/kg per day, benign lung tumors (small adenomas) occurred more frequently in female mice receiving the highest dose than in untreated control animals. There was no increase in malignant or total (benign plus malignant) lung tumors, nor in the overall incidence of tumors or malignant tumors. This 21-month study was repeated in CD-1 mice, and no statistically or biologically significant differences were observed between treated and control mice of either sex for any type of tumor.

All mutagenicity tests performed (a dominant lethal study in mice, chromosome studies in somatic cells, a Salmonella/mammalian-microsome mutagenicity test, and a nucleus anomaly test in somatic interphase nuclei) were negative.

No evidence of impaired fertility due to metoprolol was observed in a study performed in rats at doses up to 55.5 times the maximum daily human dose of 450 mg.

Pregnancy Category C

Metoprolol has been shown to increase postimplantation loss and decrease neonatal survival in rats at doses up to 55.5 times the maximum daily human dose of 450 mg. Distribution studies in mice confirm exposure of the fetus when metoprolol is administered to the pregnant animal. These studies have revealed no evidence of impaired fertility or teratogenicity. There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers

Metoprolol is excreted in breast milk in very small quantity. An infant consuming 1 liter of breast milk daily would receive a dose of less than 1 mg of the drug. Caution should be exercised when metoprolol is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

ADVERSE REACTIONS

Hypertension and Angina

Most adverse effects have been mild and transient.

Central Nervous System: Tiredness and dizziness have occurred in about 10 of 100 patients. Depression has been reported in about 5 of 100 patients. Mental confusion and short-term memory loss have been reported. Headache, nightmares, and insomnia have also been reported.

Cardiovascular: Shortness of breath and bradycardia have occurred in approximately 3 of 100 patients. Cold extremities; arterial insufficiency, usually of the Raynaud type; palpitations; congestive heart failure; peripheral edema; and hypotension have been reported in about 1 of 100 patients. (See CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS.)

Respiratory: Wheezing (bronchospasm) and dyspnea have been reported in about 1 of 100 patients (see WARNINGS).

Gastrointestinal: Diarrhea has occurred in about 5 of 100 patients. Nausea, dry mouth, gastric pain, constipation, flatulence, and heartburn have been reported in about 1 of 100 patients.

Post-marketing experience reveals very rare reports of hepatitis, jaundice and non-specific hepatic dysfunction. Isolated cases of transaminase, alkaline phosphatase, and lactic dehydrogenase elevations have also been reported.

Hypersensitive Reactions: Pruritus or rash have occurred in about 5 of 100 patients. Worsening of psoriasis has also been reported.

Miscellaneous: Peyronie's disease has been reported in fewer than 1 of 100,000 patients. Musculoskeletal pain, blurred vision, and tinnitus have also been reported.

There have been rare reports of reversible alopecia, agranulocytosis, and dry eyes. Discontinuation of the drug should be considered if any such reaction is not otherwise explicable.

The oculomucocutaneous syndrome associated with the beta blocker practolol has not been reported with metoprolol.

Myocardial Infarction

Central Nervous System: Tiredness has been reported in about 1 of 100 patients. Vertigo, sleep disturbances, hallucinations, headache, dizziness, visual disturbances, confusion, and reduced libido have also been reported, but a drug relationship is not clear.

Cardiovascular: In the randomized comparison of metoprolol and placebo described in the CLINICAL PHARMACOLOGY section, the following adverse reactions were reported:

	metoprolol	Placebo
Hypotension (systolic BP < 90 mmHg)	27.4%	23.2%
Bradycardia (heart rate < 40 beats/min)	15.9%	6.7%
Second- or third-degree heart block	4.7%	4.7%
First-degree heart block (PCR ≥ 0.26 sec)	5.3%	1.9%
Heart failure	27.5%	29.6%

Respiratory: Dyspnea of pulmonary origin has been reported in fewer than 1 of 100 patients.

Gastrointestinal: Nausea and abdominal pain have been reported in fewer than 1 of 100 patients. Post-marketing experience reveals very rare reports of hepatitis, jaundice and non-specific hepatic dysfunction. Isolated cases of transaminase, alkaline phosphatase, and lactic dehydrogenase elevations have also been reported.

Dermatologic: Rash and worsened psoriasis have been reported, but a drug relationship is not clear.

Miscellaneous: Unstable diabetes and claudication have been reported, but a drug relationship is not clear.

Potential Adverse Reactions

A variety of adverse reactions not listed above have been reported with other beta-adrenergic blocking agents and should be considered potential adverse reactions to metoprolol.

Central Nervous System: Reversible mental depression progressing to catatonia; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Cardiovascular: Intensification of AV block. See CONTRAINDICATIONS.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Hypersensitive Reactions: Fever combined with aching and sore throat, laryngospasm, and respiratory distress.

OVERDOSAGE

Acute Toxicity

Several cases of overdosage have been reported, some leading to death.

Oral LD_{50}'s (mg/kg): mice, 1158 to 2460; rats, 3090 to 4670.

Signs and Symptoms

Potential signs and symptoms associated with overdosage with metoprolol are bradycardia, hypotension, bronchospasm, and cardiac failure.

Treatment

There is no specific antidote.

In general, patients with acute or recent myocardial infarction may be more hemodynamically unstable than other patients and should be treated accordingly (see WARNINGS, Myocardial Infarction).

On the basis of the pharmacologic actions of metoprolol, the following general measures should be employed:

Elimination of the Drug: Gastric lavage should be performed.

Bradycardia: Atropine should be administered. If there is no response to vagal blockade, isoproterenol should be administered cautiously.

Hypotension: A vasopressor should be administered, e.g., norepinephrine or dopamine.

Bronchospasm: A $beta_2$-stimulating agent and/or a theophylline derivative should be administered.

Cardiac Failure: A digitalis glycoside and diuretic should be administered. In shock resulting from inadequate cardiac contractility, administration of dobutamine, isoproterenol, or glucagon may be considered.

DOSAGE AND ADMINISTRATION

Hypertension

The dosage of metoprolol tartrate should be individualized. Metoprolol tartrate should be taken with or immediately following meals.

The usual initial dosage is 100 mg daily in single or divided doses, whether used alone or added to a diuretic. The dosage may be increased at weekly (or longer) intervals until optimum blood pressure reduction is achieved. In general, the maximum effect of any given dosage level will be apparent after 1 week of therapy. The effective dosage range is 100 to 450 mg per day. Dosages above 450 mg per day have not been studied. While once-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, lower doses (especially 100 mg) may not maintain a full effect at the end of the 24-hour period, and larger or more frequent daily doses may be required. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. $Beta_1$ selectivity diminishes as the dose of metoprolol is increased.

Angina Pectoris

The dosage of metoprolol tartrate should be individualized. Metoprolol tartrate should be taken with or immediately following meals.

The usual initial dosage is 100 mg daily, given in two divided doses. The dosage may be gradually increased at weekly intervals until optimum clinical response has been obtained or there is pronounced slowing of the heart rate. The effective dosage range is 100 to 400 mg per day. Dosages above 400 mg per day have not been studied. If treatment is to be discontinued, the dosage should be reduced gradually over a period of 1 to 2 weeks. (See WARNINGS.)

Myocardial Infarction

Early Treatment: During the early phase of definite or suspected acute myocardial infarction, treatment with metoprolol tartrate can be initiated as soon as possible after the patient's arrival in the hospital. Such treatment should be initiated in a coronary care or similar unit immediately after the patient's hemodynamic condition has stabilized.

Treatment in this early phase should begin with the intravenous administration of three bolus injections of 5 mg of metoprolol tartrate each; the injections should be given at approximately 2-minute intervals. During the intravenous administration of metoprolol, blood pressure, heart rate, and electrocardiogram should be carefully monitored.

In patients who tolerate the full intravenous dose (15 mg), metoprolol tartrate tablets, 50 mg every 6 hours, should be initiated 15 minutes after the last intravenous dose and continued for 48 hours. Thereafter, patients should receive a maintenance dosage of 100 mg twice daily (see Late Treatment below).

Patients who appear not to tolerate the full intravenous dose should be started on metoprolol tartrate tablets either 25 mg or 50 mg every 6 hours (depending on the degree of intolerance) 15 minutes after the last intravenous dose or as soon as their clinical condition allows. In patients with severe intolerance, treatment with metoprolol should be discontinued (see WARNINGS).

Late Treatment: Patients with contraindications to treatment during the early phase of suspected or definite myocardial infarction, patients who appear not to tolerate the full early treatment, and patients in whom the physician wishes to delay therapy for any other reason should be started on metoprolol tartrate tablets, 100 mg twice daily, as soon as their clinical condition allows. Therapy should be continued for at least 3 months. Although the efficacy of metoprolol beyond 3 months has not been conclusively established, data from studies with other beta blockers suggest that treatment should be continued for 1 to 3 years.

HOW SUPPLIED:

Metoprolol Tartrate Tablets USP, 25 mg - White, circular, film coated tablets with "1" on one side and plain on the other side

- Bottles of 30 ..... NDC 57664-506-83
- Bottles of 90 ..... NDC 57664-506-99
- Bottles of 100 ..... NDC 57664-506-08
- Bottles of 1000 ..... NDC 57664-506-18

Metoprolol Tartrate Tablets USP, 50 mg - capsule-shaped, biconvex, white, scored (debossed 166)

- Bottles of 100 ..... NDC 57664-166-08
- Bottles of 1000 ..... NDC 57664-166-18

Metoprolol Tartrate Tablets USP, 100 mg - capsule-shaped, biconvex, white, scored (debossed 167)

- Bottles of 100 ..... NDC 57664-167-08
- Bottles of 1000 ..... NDC 57664-167-18

Store between 15° - 30°C (59° - 86°F). Do not store above 30°C (86°F). Protect from moisture. Dispense in Tight, Light-resistant Container(USP).

C.S. 5094T
Iss. 9

CARACO PHARMACEUTICAL LABORATORIES, LTD.
DETROIT, MI 48202

5094T03

Metoprolol Tartrate Tablets, USP