



Think Reliable Service



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Available Supply



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Mallinckrodt Introduces

Fentanyl Transdermal System CII

- AB rated to DURAGESIC® (fentanyl transdermal system) CII
- Utilizes matrix technology
- Available in 4 dosages – color coded for identification
- Adhesive covers entire back surface of patch
- Convenient size



25 mcg/hr



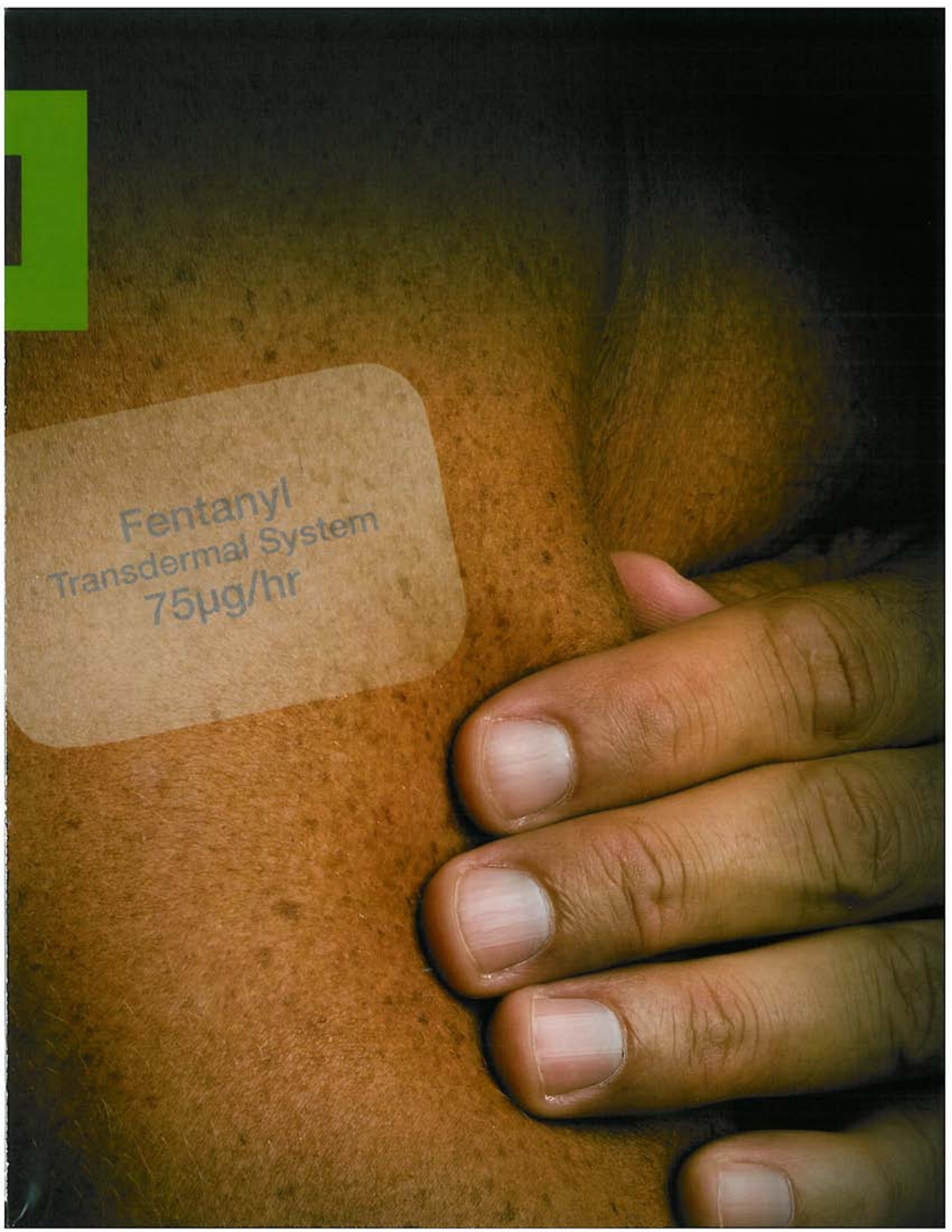
50 mcg/hr



75 mcg/hr



100 mcg/hr



Fentanyl
Transdermal System
75 μ g/hr

INDICATION

Fentanyl transdermal system is indicated for management of persistent, moderate to severe chronic pain that:

- requires continuous, around-the-clock opioid administration for an extended period of time, and
- cannot be managed by other means such as non-steroidal analgesics, opioid combination products, or immediate-release

FOR USE IN OPIOID-TOLERANT PATIENTS ONLY

Fentanyl transdermal system contains a high concentration of a potent Schedule II opioid agonist, fentanyl. Schedule II or III opioids have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression. Fentanyl can be abused and is a particular target for abuse and diversion.

Fentanyl transdermal system is indicated for management of persistent, moderate to severe chronic pain that:

- requires continuous, around-the-clock opioid administration for an extended period of time, and
- cannot be managed by other means such as non-steroidal analgesics, opioid combination products, or immediate-release

Fentanyl transdermal system should **ONLY** be used in patients who are already receiving opioid therapy, who have demonstrated opioid tolerance. Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine equivalent dose of another opioid.

Because serious or life-threatening hypoventilation could occur, fentanyl transdermal system is contraindicated:

- in patients who are not opioid-tolerant
- in the management of acute pain or in patients who require opioid analgesia for a short period of time
- in the management of post-operative pain, including use after out-patient or day surgeries (e.g., tonsillectomies)
- in the management of mild pain
- in the management of intermittent pain (e.g., use on an as needed basis [prn])

(see CONTRAINDICATIONS for further information).

Since the peak fentanyl concentrations generally occur between 24 and 72 hours of treatment, prescribers should be aware of the application period.

The concomitant use of fentanyl transdermal system with all cytochrome P450 3A4 inhibitors (such as ritonavir, ketoconazole, erythromycin, fluconazole, fosamprenavir, grapefruit juice, and verapamil) may result in an increase in fentanyl plasma concentration. Patients receiving fentanyl transdermal system and any CYP3A4 inhibitor should be carefully monitored for an extended period. (see WARNINGS; PRECAUTIONS and DOSAGE AND ADMINISTRATION for further information).

The safety of fentanyl transdermal system has not been established in children under 2 years of age. Fentanyl transdermal system should not be used in children under 2 years of age. (see PRECAUTIONS, Pediatric Use).

Fentanyl transdermal system is **ONLY** for use in patients who are already tolerant to opioid therapy of comparable potency. Converting patients from another opioid medication to fentanyl transdermal system dose when converting patients from another opioid medication can result in fatal overdose with the first dose (see WARNINGS). Within approximately 17 hours, patients who are thought to have had a serious adverse event, including overdose, will require medical attention. Fentanyl transdermal system can be abused in a manner similar to other opioid agonists, legal or illicit. This risk should be considered by the professional is concerned about increased risk of misuse, abuse or diversion.

Persons at increased risk for opioid abuse include those with a personal or family history of substance abuse (including drug and alcohol abuse) or for opioid abuse or addiction prior to being prescribed opioids. All patients receiving opioids should be routinely monitored for signs of abuse or addiction. Fentanyl transdermal systems are intended for transdermal use (on intact skin) only. Do not use a fentanyl transdermal system if the patient is taking other opioids. Avoid exposing the fentanyl transdermal system application site and surrounding area to direct external heat sources, such as a heating pad, electric blanket, or sunbathing. There is a potential for temperature-dependent increases in fentanyl release. Fever or increased core body temperature due to strenuous exertion should be monitored for opioid side effects and the

IMPORTANT RISK INFORMATION

Fentanyl transdermal system is also contraindicated in:

- situations of significant respiratory depression, especially in unmonitored settings where there is a lack of resuscitative equipment
- patients who have acute or severe bronchial asthma
- patients who have or are suspected of having paralytic ileus
- patients with known hypersensitivity to fentanyl or any components of this product

Deaths from hypoventilation due to use of fentanyl transdermal system have been reported. Hypoventilation was the most common cause of death. Hypertension was also reported.

The most common adverse events (>10%) seen in adults were: nausea, vomiting, constipation, dry mouth, somnolence, confusion, and dizziness. Nausea and vomiting were most common in pediatric patients.

Pruritus was seen in under 10% of patients and application site reactions were seen in under 3% of adults and under 10% of pediatric patients. Each patch may be worn continuously for 72 hours. If problems with adhesion occur, the edges of the patch may be taped to the skin. Do not use a patch on a site that has been previously used. If problems with adhesion occur, the edges of the patch may be taped to a different skin site after removal of previous one.

In young children or persons with cognitive impairment, the patch should be put on the upper back to lower the chances of removal.

Please see boxed warning and Full Prescribing Information on back.

opioids

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is subject to criminal diversion. The high content of fentanyl in the patches (fentanyl transdermal system) may be a

se opioids

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centrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression.
eriod of time and dosage adjustments should be made if warranted (see CLINICAL PHARMACOLOGY, Drug Interactions;

system should be administered to children only if they are opioid-tolerant and 2 years of age or older

Use in non-opioid tolerant patients may lead to fatal respiratory depression. Overestimating the fentanyl transdermal
DOSAGE AND ADMINISTRATION, Initial Fentanyl Transdermal System Dose Selection). Due to the mean half-life of
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fentanyl transdermal system dose should be adjusted if necessary.

equipment

erious adverse reaction observed in pre-marketing clinical studies. Other serious adverse events included hypotension
sion, asthenia, sweating.

pediatric patients.

th first aid tape or, for continued adhesion problems, overlaid with a transparent adhesive film dressing. Apply the next

t it will be removed and placed in the mouth.

ing: 800-778-7898

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902506101

FENTANYL TRANSDERMAL SYSTEM

25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr

Full Prescribing Information

Rx only

FOR USE IN OPIOID-TOLERANT PATIENTS ONLY

Fentanyl transdermal system contains a high concentration of a potent Schedule II opioid agonist, fentanyl. Schedule II opioid substances which include fentanyl, hydromorphone, methadone, morphine, oxycodone, and oxycodone have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression. Fentanyl can be abused and is subject to criminal diversion. The high content of fentanyl in the patches (fentanyl transdermal system) may be a particular target for abuse and diversion.

Fentanyl transdermal system is indicated for management of persistent, moderate to severe chronic pain that:

- requires continuous, around-the-clock opioid administration for an extended period of time, and
- cannot be managed by other means such as non-steroidal analgesics, opioid combination products, or immediate-release opioids.

Fentanyl transdermal system should ONLY be used in patients who are already receiving opioid therapy, who have demonstrated opioid tolerance, and who require a total daily dose of at least equivalent to fentanyl transdermal system 25 mcg/hr. Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid.

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- in the management of intermittent pain (e.g., use on an as needed basis [prn])

(see CONTRAINDICATIONS for further information).

Since the peak fentanyl concentrations generally occur between 24 and 72 hours of treatment, prescribers should be aware that serious or life-threatening hyperventilation may occur, even in opioid-tolerant patients, during the initial application period.

The concomitant use of fentanyl transdermal system with all cytochrome P450 3A4 inhibitors (such as ritonavir, ketoconazole, itraconazole, trioleandomycin, clarithromycin, neflavin, nefazodone, amiodarone, aprepitant, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, grapefruit juice, and verapamil) may result in an increase in fentanyl plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression. Patients receiving fentanyl transdermal system and any CYP3A4 inhibitor should be carefully monitored for an extended period of time and dosage adjustments should be made if warranted (see CLINICAL PHARMACOLOGY, Drug Interactions, WARNINGS, PRECAUTIONS, AND DOSAGE AND ADMINISTRATION for further information).

The safety of fentanyl transdermal system has not been established in children under 2 years of age. Fentanyl transdermal system should be administered to children only if they are opioid-tolerant and 2 years of age or older (see PRECAUTIONS, Pediatric Use).

Fentanyl transdermal system is ONLY for use in patients who are already tolerant to opioid therapy of comparable potency. Use in non-opioid-tolerant patients may lead to fatal respiratory depression. Overestimating the fentanyl transdermal system dose when converting patients from another opioid medication can result in fatal overdose with the first dose (see DOSAGE AND ADMINISTRATION, Initial Fentanyl Transdermal System Dose Selection). Due to the mean half-lives of approximately 17 hours, patients who are thought to have had a serious adverse event, including overdose, will require monitoring and treatment for at least 24 hours.

Fentanyl transdermal system can be abused in a manner similar to other opioid agonists, legal or illicit. This risk should be considered when administering, prescribing, or dispensing fentanyl transdermal system in situations where the healthcare professional is concerned about increased risk of misuse, abuse or diversion.

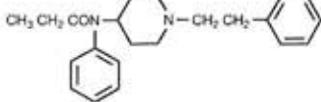
Persons at increased risk for opioid abuse include those with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). Patients should be assessed for their clinical risks for opioid abuse or addiction prior to being prescribed opioids. All patients receiving opioids should be routinely monitored for signs of misuse, abuse and addiction. Patients at increased risk of opioid abuse may still be appropriately treated with modified-release opioid formulations; however, these patients will require intensive monitoring for signs of misuse, abuse, or addiction.

Fentanyl transdermal systems are intended for transdermal use (on intact skin) only. Do not use a fentanyl transdermal system if the pouch seal is broken or the patch is cut, damaged, or changed in any way.

Avoid exposing the fentanyl transdermal system application site and surrounding area to direct external heat sources such as heating pads or electric blankets, heat or tanning lamps, saunas, hot tubs, and heated water beds, while wearing the system. Avoid taking hot baths or sunbathing. There is a potential for temperature-dependent increases in fentanyl released from the system resulting in possible overdose and death. Patients wearing fentanyl transdermal systems who develop fever or increased core body temperature due to strenuous exertion should be monitored for opioid side effects and the fentanyl transdermal system dose should be adjusted if necessary.

DESCRIPTION

Fentanyl transdermal system is a transdermal system providing continuous systemic delivery of fentanyl, a potent opioid analgesic, for 72 hours. The chemical name is N-Phenyl-N-(1-(2-phenylethyl)-4-piperidinyl)propanamide. The structural formula is:



The molecular weight of fentanyl base is 336.5, and the molecular formula is $C_{20}H_{24}N_2O$. The n-octanol/water partition coefficient is 860:1. The pKa is 8.4.

System Components and Structure

The amount of fentanyl released from each system per hour is proportional to the surface area (25 mcg/hr per 7.6 cm²).

The composition per unit area of all system sizes is identical.

Dose* (mcg/hr)	Size (cm ²)	Fentanyl Content (mg)
25	7.6	2.75
50	15.2	5.50
75	22.8	8.25
100	30.4	11.0

*Nominal delivery rate per hour

Fentanyl transdermal system is a rectangular transparent unit comprising a protective liner and four functional layers. Proceeding from the outer surface toward the surface adhering to skin, these layers are:

- 1) a backing layer of PET foil,
- 2) a drug containing layer of fentanyl and dipropylene glycol with hydroxypropyl cellulose,
- 3) an ethylene vinyl-acetate copolymer membrane that controls the rate of fentanyl delivery to the skin surface, and
- 4) a silicone adhesive. Before use, a protective liner covering the adhesive layer is removed and discarded.



The active component of the system is fentanyl. The remaining components are pharmacologically inactive: dipropylene glycol, hydroxypropyl cellulose, ethylene vinyl-acetate copolymer, silicone adhesives between polyester backings, silicone fluid.

CLINICAL PHARMACOLOGY**Pharmacology**

Fentanyl is an opioid analgesic. Fentanyl interacts predominantly with the opioid receptor. These mu-binding sites are discretely distributed in the human brain, spinal cord, and other tissues. In clinical settings, fentanyl exerts its principal pharmacologic effects on the central nervous system.

In addition to analgesia, alterations in mood, euphoria, dysphoria, and drowsiness commonly occur. Fentanyl depresses the respiratory centers, depresses the cough reflex, and constricts the pupils. Analgesic blood concentrations of fentanyl may cause nausea and vomiting directly by stimulating the chemoreceptor trigger zone, but nausea and vomiting are significantly more common in ambulatory than in recumbent patients, as is postural syncope.

Opioids increase the tone and decrease the propulsive contractions of the smooth muscle of the gastrointestinal tract. The resultant prolongation in gastrointestinal transit time may be responsible for the constipating effect of fentanyl. Because opioids may increase biliary tract pressure, some patients with biliary colic may experience worsening rather than relief of pain.

While opioids generally increase the tone of urinary tract smooth muscle, the net effect tends to be variable, in some cases producing urinary urgency, in others, difficulty in urination. At therapeutic dosages, fentanyl usually does not exert major effects on the cardiovascular system. However, some patients may exhibit orthostatic hypotension and fainting.

Histamine assays and skin wheel testing in clinical studies indicate that clinically significant histamine release rarely occurs with fentanyl administration. Clinical assays show no clinically significant histamine release in dosages up to 50 mcg/kg.

Pharmacokinetics (see graph and tables)

Fentanyl transdermal system is a drug-in-adhesive matrix designed formulation. Fentanyl is released from the matrix at a nearly constant amount per unit time. The concentration gradient existing between the matrix and the lower concentration in the skin drives drug release. Fentanyl moves in the direction of the lower concentration at a rate determined by the copolymer release membrane and the diffusion of fentanyl through the skin layers. While the actual rate of fentanyl delivery to the skin varies over the 72-hour application period, each system is labeled with a nominal flux which represents the average amount of drug delivered to the systemic circulation per hour across average skin.

While there is variation in dose delivered among patients, the nominal flux of the systems (25, 50, 75, and 100 mcg of fentanyl per hour) is sufficiently accurate as to allow individual titration of dosage for a given patient.

Following fentanyl transdermal system application, the skin under the system absorbs fentanyl, and a depot of fentanyl concentrates in the upper skin layers. Fentanyl then becomes available to the systemic circulation. Serum fentanyl concentrations increase gradually following initial fentanyl transdermal system application, generally leveling off between 12 and 24 hours and remaining relatively constant, with some fluctuation, for the remainder of the 72-hour application period. Peak serum concentrations of fentanyl generally occurred between 24 and 72 hours after initial application (see Table A). Serum fentanyl concentrations achieved are proportional to the fentanyl transdermal system delivery rate. With continuous use, serum fentanyl concentrations continue to rise for the first two system applications. By the end of the second 72-hour application, a steady-state serum concentration is reached and is maintained during subsequent applications of a patch of the same size. Patients reach and maintain a steady-state serum concentration that is determined by individual variation in skin permeability and body clearance of fentanyl.

After system removal, serum fentanyl concentrations decline gradually, falling about 50% in approximately 17 (range 13 to 22) hours. Continued absorption of fentanyl from the skin accounts for a slower disappearance of the drug from the serum than is seen after an IV infusion, where the apparent half-life is approximately 7 hours (3 to 12 hours).

Serum Fentanyl Concentrations Following Multiple Applications of a Fentanyl Transdermal System 100 mcg/hr (n=10)

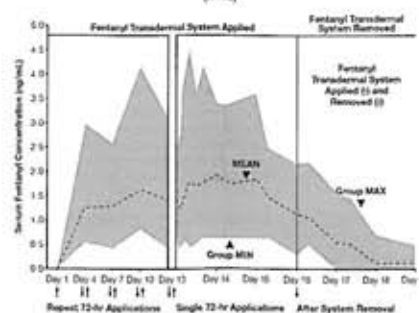


TABLE A FENTANYL PHARMACOKINETIC PARAMETERS FOLLOWING FIRST 72-HOUR APPLICATION OF A FENTANYL TRANSDERMAL SYSTEM

	Mean (SD) Time to Maximal Concentration (hr)	Mean (SD) Maximal Concentration (ng/mL)
Fentanyl transdermal system 25 mcg/hr	18 (1.0)	0.6 (0.2)
Fentanyl transdermal system 50 mcg/hr	34.0 (1.4)	1.4 (0.5)
Fentanyl transdermal system 75 mcg/hr	33.0 (1.1)	1.7 (0.7)
Fentanyl transdermal system 100 mcg/hr	36.0 (1.7)	2.3 (0.7)

NOTE: After system removal there is continued systemic absorption from residual fentanyl in the skin so that serum concentrations fall 50%, on average, in approximately 17 hours.

TABLE B RANGE OF PHARMACOKINETIC PARAMETERS OF INTRAVENOUS FENTANYL IN PATIENTS

	Clearance (L/hr) Range (N=6)	Volume of Distribution (L/kg) Range	Half-Life (hr) Range
Surgical Patients	21-71	3-8	3-12
Neurologically Impaired Patients	7-60	0.8-9*	4-12*
Severely Impaired Patients	30-38	-	-

*Estimated

NOTE: Information on volume of distribution and half-life not available for severely impaired patients.

Fentanyl plasma protein binding capacity decreases with increasing ionization of the drug. Alterations in pH may affect its distribution between plasma and the central nervous system. Fentanyl accumulates in the skeletal muscle and fat and is released slowly into the blood. The average volume of distribution for fentanyl is 6 L/kg (range 3 to 8, N=8).

Fentanyl is metabolized primarily via human cytochrome P450 3A4 isoenzyme system. In humans, the drug appears to be metabolized primarily by oxidative N-dealkylation to norfentanyl and other inactive metabolites that do not contribute materially to the observed activity of the drug. Within 72 hours of IV fentanyl administration, approximately 75% of the dose is excreted in urine, mostly as metabolites with less than 10% representing unchanged drug. Approximately 9% of the dose is recovered in the feces, primarily as metabolites. Mean values for unbound fractions of fentanyl in plasma are estimated to be between 13 and 21%.

Skin does not appear to metabolize fentanyl delivered transdermally. This was determined in a human keratinocyte cell assay and in clinical studies in which 92% of the dose delivered from the system was accounted for as unchanged fentanyl that appeared in the systemic circulation.

Special Populations**Hepatic or Renal Disease**

Inadequate information exists to make recommendations regarding the use of fentanyl transdermal system in patients with impaired renal or hepatic function. Fentanyl is metabolized primarily via human cytochrome P450 3A4 isoenzyme system and mostly eliminated in urine. If the drug is used in these patients, it should be used with caution because of the hepatic metabolism and renal excretion of fentanyl.

Pediatric Use

In 1.5 to 5 year old, non-opioid-tolerant pediatric patients, the fentanyl plasma concentrations were approximately twice as high as that of adult patients. In older pediatric patients, the pharmacokinetic parameters were similar to that of adults. However, these findings have been taken into consideration in determining the dosing recommendations for opioid-tolerant pediatric patients (2 years of age and older). For pediatric dosing information, refer to DOSAGE AND ADMINISTRATION section.

Geriatric Use

Data from intravenous studies with fentanyl suggest that the elderly patients may have reduced clearance and a prolonged half-life. Moreover, elderly patients may be more sensitive to the active substance than younger patients. A study conducted with the fentanyl transdermal system in elderly patients demonstrated that fentanyl pharmacokinetics did not differ significantly from young adult subjects, although peak serum concentrations tended to be lower and mean half-life values were prolonged to approximately 34 hours.

Respiratory depression is the chief hazard in elderly or debilitated patients, usually following large initial doses in non-tolerant patients or when opioids are given in conjunction with other agents that depress respiration.

Fentanyl transdermal system should be used with caution in elderly, cachectic or debilitated patients as they may have altered pharmacokinetics due to poor fat stores, muscle wasting, or altered clearance (see DOSAGE AND ADMINISTRATION).

Drug Interactions

The interaction between ritonavir, a CYP3A4 inhibitor, and fentanyl was investigated in eleven healthy volunteers in a randomized crossover study. Subjects received oral ritonavir or placebo for 3 days. The ritonavir dose was 200 mg tid on Day 1 and 300 mg tid on Day 2 followed by one morning dose of 300 mg on Day 3. On Day 2, fentanyl was given as a single IV dose at 5 mcg/kg two hours after the afternoon dose of oral ritonavir or placebo. Naloxone was administered to counteract the side effects of fentanyl. The results suggested that ritonavir might decrease the clearance of fentanyl by 67%, resulting in a 174% (range 52% to 420%) increase in fentanyl AUC_{0-∞}. Co-administration of ritonavir in patients receiving fentanyl transdermal system has not been studied; however, an increase in fentanyl AUC is expected (see BOX WARNING, WARNINGS, PRECAUTIONS AND DOSAGE AND ADMINISTRATION).

Fentanyl is metabolized mainly via the human cytochrome P450 3A4 isoenzyme system (CYP3A4); therefore, potential interactions may occur when fentanyl transdermal system is given concurrently with agents that affect CYP3A4 activity. Co-administration with agents that induce CYP3A4 activity may reduce the efficacy of fentanyl transdermal system. The concomitant use of transdermal fentanyl with all CYP3A4 inhibitors (such as ritonavir, ketoconazole, itraconazole, trioleandomycin, clarithromycin, neflavin, nefazodone, amiodarone, aprepitant, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, grapefruit juice, and verapamil) may result in an increase in fentanyl plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression. Patients receiving fentanyl transdermal system and any CYP3A4 inhibitor should be carefully monitored for an extended period of time and dosage adjustments should be made if warranted (see BOX WARNING, WARNINGS, PRECAUTIONS AND DOSAGE AND ADMINISTRATION for further information).

Pharmacodynamics**Ventilatory Effects**

Because of the risk for serious or life-threatening hyperventilation, fentanyl transdermal system is CONTRAINDICATED in the treatment of post-operative and acute pain and in patients who are not opioid-tolerant. In clinical trials of 357 patients with acute pain treated with fentanyl transdermal system, 13 patients experienced hyperventilation. Hyperventilation was manifested by respiratory rates of less than 8 breaths/minute or a pCO₂ greater than 55 mm Hg. In these studies, the incidence of hyperventilation was higher in non-tolerant women (10) than in men (3) and in patients weighing less than 63 kg (8 of 13). Although patients with impaired respiration were not common in the trials, they had higher rates of hyperventilation. In addition, post-marketing reports have been received that describe opioid-naïve post-operative patients who have experienced clinically significant hyperventilation and death with fentanyl transdermal system.

While most patients using fentanyl transdermal system chronically develop tolerance to fentanyl-induced hyperventilation, episodes of slowed respirations may occur at any time during therapy.

Hyperventilation can occur throughout the therapeutic range of fentanyl serum concentrations, especially for patients who have an underlying pulmonary condition or who receive usual doses of opioids or other CNS drugs associated with hyperventilation in addition to fentanyl transdermal system. The use of fentanyl transdermal system is contraindicated in patients who are not tolerant to opioid therapy.

The use of fentanyl transdermal system should be monitored by clinical evaluation, especially within the initial 24 to 72 hours when serum concentrations from the initial patch will peak, and following increases in dosage. Fentanyl transdermal system should be administered to children only if they are opioid-tolerant and 2 years of age or older.

See BOX WARNING, CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, ADVERSE REACTIONS AND OVERDOSAGE for additional information on hyperventilation.

Cardiovascular Effects

Fentanyl may infrequently produce bradycardia. The incidence of bradycardia in clinical trials with fentanyl transdermal system was less than 1%.

CNS Effects

Central nervous system effects increase with increasing serum fentanyl concentrations.

INDICATIONS AND USAGE

Fentanyl transdermal system is indicated for management of persistent, moderate to severe chronic pain that:

- requires continuous, around-the-clock opioid administration for an extended period of time, and
- cannot be managed by other means such as non-steroidal analgesics, opioid combination products, or immediate-release opioids.

Fentanyl transdermal system should ONLY be used in patients who are already receiving opioid therapy who have demonstrated opioid tolerance, and who require a total daily dose at least equivalent to fentanyl transdermal system 25 mcg/hr (see DOSAGE AND ADMINISTRATION). Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily, or an equianalgesic dose of another opioid.

Because serious or life-threatening hyperventilation could result, fentanyl transdermal system is contraindicated for use on an as-needed basis (i.e., prn), for the management of post-operative or acute pain, or in patients who are not opioid-tolerant or who require opioid analgesia for a short period of time (see BOX WARNINGS and CONTRAINDICATIONS).

An evaluation of the appropriateness and adequacy of treating with immediate-release opioids is advisable prior to initiating therapy with any modified-release opioid. Prescribers should individualize treatment in every case, initiating therapy at the appropriate point along a progression from non-opioid analgesics, such as non-steroidal anti-inflammatory drugs and acetaminophen, to opioids, in a plan of pain management such as outlined by the World Health Organization, the Agency for Health Research and Quality, the Federation of State Medical Boards Model Policy, or the American Pain Society.

Patients should be assessed for their clinical risks for opioid abuse or addiction prior to being prescribed opioids. Patients receiving opioids should be routinely monitored for signs of misuse, abuse, and addiction. Persons at increased risk for opioid abuse include those with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). Patients at increased risk may still be appropriately treated with modified-release opioid formulations; however, these patients will require intensive monitoring for signs of misuse, abuse, or addiction.

CONTRAINDICATIONS

Because serious or life-threatening hyperventilation could occur, fentanyl transdermal system is contraindicated:

- in patients who are not opioid-tolerant
- in the management of acute pain or in patients who require opioid analgesia for a short period of time
- in the management of post-operative pain, including use after out-patient or day surgeries, (e.g., tonsillectomies)
- in the management of mild pain
- in the management of intermittent pain (e.g., use on an as-needed basis [prn])
- in situations of significant respiratory depression, especially in unmonitored settings where there is a lack of resuscitative equipment
- in patients who have acute or severe bronchial asthma

Fentanyl transdermal system is contraindicated in patients who have or are suspected of having paralytic ileus.

Fentanyl transdermal system is contraindicated in patients with known hypersensitivity to fentanyl or any components of this product.

WARNINGS

Fentanyl transdermal systems are intended for transdermal use (on intact skin only). Do not use a fentanyl transdermal system if the pouch seal is broken or the patch is cut, damaged, or changed in any way.

The safety of fentanyl transdermal system has not been established in children under 2 years of age. Fentanyl transdermal system should be administered to children only if they are opioid-tolerant and 2 years of age or older (see PRECAUTIONS, Pediatric Use).

Fentanyl transdermal system is ONLY for use in patients who are already tolerant to opioid therapy of comparable potency. Use in non-opioid-tolerant patients may lead to fatal respiratory depression. Overestimating the fentanyl transdermal system dose when converting patients from another opioid medication can result in fatal overdose with the first dose. The mean half-life is approximately 17 hours. Therefore, patients who have experienced serious adverse effects, including overdose, will require monitoring for at least 24 hours after fentanyl transdermal system removal since serum fentanyl concentrations decline gradually and reach an approximate 50% reduction in serum concentrations 17 hours after system removal.

Fentanyl transdermal system should be prescribed only by persons knowledgeable in the continuous administration of potent opioids, in the management of patients receiving potent opioids for treatment of pain, and in the detection and management of hyperventilation including the use of opioid antagonists.

All patients and their caregivers should be advised to avoid exposing the fentanyl transdermal system application site and surrounding area to direct external heat sources, such as heating pads or electric blankets, heat or tanning lamps, saunas, hot tubs, and heated water beds, etc., while wearing the system. Patients should be advised against taking hot baths or sunbathing. There is a potential for temperature-dependent increases in fentanyl released from the system resulting in possible overdose and death. A clinical pharmacology trial conducted in healthy adult subjects has shown that the application of heat over the fentanyl transdermal system increased mean fentanyl AUC values by 120% and mean C_{max} values by 61%.

Based on a pharmacokinetic model, serum fentanyl concentrations could theoretically increase by approximately one-third for patients with a body temperature of 40°C (104°F) due to temperature-dependent increases in fentanyl released from the system and increased skin permeability. Patients wearing fentanyl transdermal systems who develop fever or increased core body temperature due to strenuous exertion should be monitored for opioid side effects and the fentanyl transdermal system dose should be adjusted if necessary.

Death and other serious medical problems have occurred when people were accidentally exposed to fentanyl transdermal system. Examples of accidental exposure include transfer of a fentanyl transdermal system from an adult's body to a child while hugging, accidental sitting on a patch and possible accidental exposure of a caregiver's skin to the medication in the patch while the caregiver was applying or removing the patch.

Placing fentanyl transdermal system in the mouth, chewing it, swallowing it, or using it in ways other than indicated may cause choking or overdose that could result in death.

Misuse, Abuse and Diversion of Opioids

Fentanyl is an opioid agonist of the morphine-type. Such drugs are sought by drug abusers and people with addiction disorders and are subject to criminal diversion.

Fentanyl can be abused in a manner similar to other opioids, legal or illicit. This should be considered when prescribing or dispensing fentanyl transdermal system in situations where the physician or pharmacist is concerned about an increased risk of misuse, abuse or diversion.

Fentanyl transdermal system has been reported as being abused by other methods and routes of administration. These practices will result in uncontrolled delivery of the opioid and pose a significant risk to the abuser that could result in overdose and death (see WARNINGS and DRUG ABUSE AND ADDICTION).

Concerns about abuse, addiction and diversion should not prevent the proper management of pain. However, all patients treated with opioids require careful monitoring for signs of abuse and addiction, since use of opioid analgesic products carries the risk of addiction even under appropriate medical use.

Healthcare professionals should contact their state professional licensing board or state controlled substances authority for information on how to prevent and detect abuse or diversion of this product.

Hyperventilation (Respiratory Depression)

Serious or life-threatening hyperventilation may occur at any time during the use of fentanyl transdermal system especially during the initial 24 to 72 hours following initiation of therapy and following increases in dose.

Because significant amounts of fentanyl continue to be absorbed from the skin for 17 hours or more after the patch is removed, hyperventilation may persist beyond the removal of fentanyl transdermal system. Consequently, patients with hyperventilation should be carefully observed for degree of sedation and their respiratory rate monitored until respiration has stabilized.

The use of concomitant CNS active drugs requires special patient care and observation.

Respiratory depression is the chief hazard of opioid agonists, including fentanyl, the active ingredient in fentanyl transdermal system. Respiratory depression is more likely to occur in elderly or debilitated patients, usually following large initial doses in non-tolerant patients, or when opioids are given in conjunction with other drugs that depress respiration.

Respiratory depression from opioids is manifested by a reduced urge to breathe and a decreased rate of respiration often associated with the "sighing" pattern of breathing (deep breaths separated by abnormally long pauses). Carbon dioxide retention from opioid-induced respiratory depression can exacerbate the sedating effects of opioids. This makes overdoses involving drugs with sedative properties and opioids especially dangerous.

Fentanyl transdermal system should be used with extreme caution in patients with significant chronic obstructive pulmonary disease or cor pulmonale, and in patients having a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression. In such patients, even usual therapeutic doses of fentanyl transdermal system may decrease respiratory drive to the point of apnea. In these patients, alternative non-opioid analgesic should be considered, and opioids should be employed only under careful medical supervision at the lowest effective dose.

Chronic Pulmonary Disease

Because potent opioids can cause serious or life-threatening hyperventilation, fentanyl transdermal system should be administered with caution to patients with pre-existing medical conditions predisposing them to hyperventilation in such patients, normal analgesic doses of opioids may further decrease respiratory drive to the point of respiratory failure.

Head Injuries and Increased Intracranial Pressure

Fentanyl transdermal system should not be used in patients who may be particularly susceptible to the intracranial effects of CO_2 retention such as those with evidence of increased intracranial pressure, impaired consciousness, or coma. Opioids may obscure the clinical course of patients with head injury. Fentanyl transdermal system should be used with caution in patients with brain tumors.

Interactions with Other CNS Depressants

The concomitant use of fentanyl transdermal system with other central nervous system depressants, including but not limited to other opioids, sedatives, hypnotics, tranquilizers (e.g., benzodiazepines), general anesthetics, phenothiazines, skeletal muscle relaxants, and alcohol, may cause respiratory depression, hypotension, and profound sedation or potentially result in coma. When such combined therapy is contemplated, the dose of one or both agents should be significantly reduced.

Interactions with Alcohol and Drugs of Abuse

Fentanyl may be expected to have additive CNS depressant effects when used in conjunction with alcohol, other opioids, or illicit drugs that cause central nervous system depression.

Interactions with CYP3A4 Inhibitors

The concomitant use of transdermal fentanyl with all CYP3A4 inhibitors (such as ritonavir, ketoconazole, itraconazole, trovafloxacin, clarithromycin, nefazodone, nefazodone, amiodarone, amprexan, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, grapefruit juice, and verapamil) may result in an increase in fentanyl plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression. Patients receiving fentanyl transdermal system and any CYP3A4 inhibitor should be carefully monitored for an extended period of time and dosage adjustments should be made if warranted. See BOX WARNING, CLINICAL PHARMACOLOGY, Drug Interactions, PRECAUTIONS and DOSAGE AND ADMINISTRATION for further information.

PRECAUTIONS

General

Fentanyl transdermal system should not be used to initiate opioid therapy in patients who are not opioid-tolerant. Children converting to fentanyl transdermal system should be opioid-tolerant and 2 years of age or older (see BOX WARNING).

Patients, family members and caregivers should be instructed to keep patches (new and used) out of the reach of children and others for whom fentanyl transdermal system was not prescribed. A considerable amount of active fentanyl remains in fentanyl transdermal system even after use as directed. Accidental or deliberate application or ingestion by a child or adolescent will cause respiratory depression that could result in death.

Cardiac Disease

Fentanyl may produce bradycardia. Fentanyl should be administered with caution to patients with bradyarrhythmias.

Hepatic or Renal Disease

Insufficient information exists to make recommendations regarding the use of fentanyl transdermal system in patients with impaired renal or hepatic function. If the drug is used in these patients, it should be used with caution because of the hepatic metabolism and renal excretion of fentanyl.

Use in Pancreatic/Biliary Tract Disease

Fentanyl transdermal system may cause spasm of the sphincter of Oddi and should be used with caution in patients with biliary tract disease, including acute pancreatitis. Opioids like fentanyl transdermal system may cause increases in the serum amylase concentration.

Tolerance

Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time. Tolerance may occur to both the desired and undesired effects of drugs, and may develop at different rates for different effects.

Physical Dependence

Physical dependence is a state of adaptation that is manifested by an opioid-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood concentration of the drug, and/or administration of an antagonist. The opioid abstinence or withdrawal syndrome is characterized by some or all of the following: restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, piloerection, myalgia, mydriasis, irritability, anxiety, backache, joint pain, weakness, abdominal cramps, insomnia, nausea, anorexia, vomiting, diarrhea, or increased blood pressure, respiratory rate or heart rate. In general, opioids should not be abruptly discontinued (see DOSAGE AND ADMINISTRATION, Discontinuation of Fentanyl Transdermal System).

Ambulatory Patients

Strong opioid analgesics impair the mental or physical abilities required for the performance of potentially dangerous tasks, such as driving a car or operating machinery. Patients who have been given fentanyl transdermal system should not drive or operate dangerous machinery unless they are tolerant to the effects of the drug.

Information for Patients

Patients and their caregivers should be provided with a Medication Guide each time fentanyl transdermal system is dispensed because new information may be available.

Patients receiving fentanyl transdermal systems should be given the following instructions by the physician:

1. Patients should be advised that fentanyl transdermal systems contain fentanyl, an opioid pain medicine similar to morphine, hydromorphone, methadone, oxycodone, and oxycodone.
2. Patients should be advised that each fentanyl transdermal system may be worn continuously for 72 hours, and that each patch should be applied to a different skin site after removal of the previous transdermal patch.
3. Patients should be advised that fentanyl transdermal systems should be applied to intact, non-irritated, and non-irradiated skin on a flat surface such as the chest, back, flank, or upper arm. Additionally, patients should be advised of the following:
 - In young children or persons with cognitive impairment, the patch should be put on the upper back to lower the chances that the patch will be removed and placed in the mouth.
 - Hair at the application site should be clipped (not shaved) prior to patch application.
 - If the site of fentanyl transdermal system application must be cleaned prior to application of the patch, do so with clear water.
 - Do not use soaps, oils, lotions, alcohol, or any other agents that might irritate the skin or alter its characteristics.
 - Allow the skin to dry completely prior to patch application.
4. Patients should be advised that fentanyl transdermal system should be applied immediately upon removal from the sealed pouch and after removal of the protective liner. Additionally the patient should be advised of the following:
 - The fentanyl transdermal system should not be used if the pouch seal is broken, or if the patch is cut, damaged, or changed in any way.
 - The transdermal patch should be pressed firmly in place with the palm of the hand for 30 seconds, making sure the contact is complete, especially around the edges.
 - The patch should not be folded so that only part of the patch is exposed.
5. Patients should be advised that the dose of fentanyl transdermal system or the number of patches applied to the skin should NEVER be adjusted without the prescribing healthcare professional's instruction.
6. Patients should be advised that while wearing the patch, they should avoid exposing the fentanyl transdermal system application site and surrounding area to direct external heat sources, such as:
 - heating pads,
 - electric blankets,
 - sunbathing,
 - heat or tanning lamps,
 - saunas,
 - hot tubs or hot baths, and
 - heated water beds, etc.
7. Patients should also be advised of a potential for temperature-dependent increases in fentanyl release from the patch that could result in an overdose of fentanyl; therefore, patients who develop a high fever or increased body temperature due to strenuous exertion while wearing the patch should contact their physician.
8. Patients should be advised that if they experience problems with adhesion of the fentanyl transdermal system, they may tape the edges of the patch with first aid tape. If problems with adhesion persist, patients may overlay the patch with a transparent adhesive film dressing (e.g., Occlusiv™ or Tegaderm™).
9. Patients should be advised that if the patch falls off before 72 hours a new patch may be applied to a different skin site.
10. Patients should be advised to fold (so that the adhesive side adheres to itself) and immediately flush down the toilet used fentanyl transdermal systems after removal from the skin.
11. Patients should be advised that fentanyl transdermal system may impair mental and/or physical ability required for the performance of potentially hazardous tasks (e.g., driving, operating machinery).
12. Patients should be advised to refrain from any potentially dangerous activity when starting on fentanyl transdermal system or when their dose is being adjusted, until it is established that they have not been adversely affected.
13. Patients should be advised that fentanyl transdermal system should not be combined with alcohol or other CNS depressants (e.g., sleep medications, tranquilizers) because dangerous additive effects may occur, resulting in serious injury or death.
14. Patients should be advised to consult their physician or pharmacist if other medications are being or will be used with fentanyl transdermal system.
15. Patients should be advised of the potential for severe constipation.
16. Patients should be advised that if they have been receiving treatment with fentanyl transdermal system and cessation of therapy is indicated, it may be appropriate to taper the fentanyl transdermal system dose, rather than abruptly discontinue it, due to the risk of precipitating withdrawal symptoms.
17. Patients should be advised that fentanyl transdermal system contains fentanyl, a drug with high potential for abuse.
18. Patients, family members and caregivers should be advised to protect fentanyl transdermal system from theft or misuse in the work or home environment.
19. Patients should be instructed to keep fentanyl transdermal system in a secure place out of the reach of children due to the high risk of fatal respiratory depression.
20. Patients should be advised that fentanyl transdermal system should never be given to anyone other than the individual for whom it was prescribed because of the risk of death or other serious medical problems to that person for whom it was not intended.
21. Patients should be informed that, if the patch falls off and accidentally sticks to the skin of another person, they should immediately take the patch off, wash the exposed area with water and seek medical attention for the accidentally exposed individual.

22. When fentanyl transdermal system is no longer needed, the unused patches should be removed from their pouches, folded so that the adhesive side of the patch adheres to itself, and flushed down the toilet.
23. Women of childbearing potential who become, or are planning to become pregnant, should be advised to consult a physician prior to initiating or continuing therapy with fentanyl transdermal system.
24. Patients should be informed that accidental exposure or misuse may lead to death or other serious medical problems.

Drug Interactions

Agents Affecting Cytochrome P450 3A4 Isoenzyme System

Fentanyl is metabolized mainly via the human cytochrome P450 3A4 isoenzyme system (CYP3A4), therefore potential interactions may occur when fentanyl transdermal system is given concomitantly with agents that affect CYP3A4 activity. Concomitant use with agents that induce CYP3A4 activity may reduce the efficacy of fentanyl transdermal system. The concomitant use of transdermal fentanyl with all CYP3A4 inhibitors (such as ritonavir, ketoconazole, itraconazole, itraconazole, clarithromycin, erythromycin, fluconazole, fosamprenavir, amiodarone, ergonovine, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, grapefruit juice, and verapamil) may result in an increase in fentanyl plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression. Patients receiving fentanyl transdermal system and any CYP3A4 inhibitor should be carefully monitored for an extended period of time, and dosage adjustments should be made if warranted (see **BOX WARNING: CLINICAL PHARMACOLOGY, Drug Interactions, WARNINGS, and DOSAGE AND ADMINISTRATION for further information**).

Central Nervous System Depressants

The concomitant use of fentanyl transdermal system with other central nervous system depressants, including but not limited to other opioids, sedatives, hypnotics, tranquilizers (e.g., benzodiazepines, general anesthetics, phenothiazines, skeletal muscle relaxants, and alcohol), may cause respiratory depression, hypotension, and profound sedation, or potentially result in coma or death. When such combined therapy is contemplated, the dose of one or both agents should be significantly reduced.

MAO Inhibitors

Fentanyl transdermal system is not recommended for use in patients who have received MAO within 14 days because severe and unpredictable potentiation by MAO inhibitors has been reported with opioid analgesics.

Carcinogenesis, Mutagenesis, and Impairment of Fertility

In a two-year carcinogenicity study conducted in rats, fentanyl was not associated with an increased incidence of tumors at subcutaneous doses up to 33 mcg/kg/day in males or 100 mcg/kg/day in females (0.16 and 0.39 times the human daily exposure obtained via the 100 mcg/hr patch based on AUC₀₋₂₄ comparison). There was no evidence of mutagenicity in the Ames Salmonella mutagenicity assay, the primary rat hepatocyte unscheduled DNA synthesis assay, the BALB/c 3T3 transformation test, and the human lymphocyte and CHO chromosomal aberration *in vitro* assays.

The potential effects of fentanyl on male and female fertility were examined in the rat model via two separate experiments. In the male fertility study, male rats were treated with fentanyl (0, 0.025, 0.1 or 0.4 mcg/kg/day) via continuous intravenous infusion for 28 days prior to mating. Female rats were not treated. In the female fertility study, female rats were treated with fentanyl (0, 0.025, 0.1 or 0.4 mcg/kg/day) via continuous intravenous infusion for 14 days prior to mating until day 16 of pregnancy; male rats were not treated. Analysis of fertility parameters in both studies indicated that an intravenous dose of fentanyl up to 0.4 mcg/kg/day to either the male or the female alone produced no effects on fertility (this dose is approximately 1.6 times the daily human dose administered by a 100 mcg/hr patch on a mg/m² basis). In a separate study, a single daily bolus dose of fentanyl was shown to impair fertility in rats when given in intravenous doses of 0.3 times the human dose for a period of 12 days.

Pregnancy

Teratogenic Effects. Pregnancy Category C

No epidemiological studies of congenital anomalies in infants born to women treated with fentanyl during pregnancy have been reported.

The potential effects of fentanyl on embryo-fetal development were studied in the rat, mouse, and rabbit models. Published literature reports that administration of fentanyl (0, 100, 100, or 500 mcg/kg/day) to pregnant female Sprague-Dawley rats from day 7 to 21 via implanted osmotic minipumps did not produce any evidence of teratogenicity (the high dose is approximately 2 times the daily human dose administered by a 100 mcg/hr patch on a mg/m² basis). In contrast, the intravenous administration of fentanyl (0, 0.01, or 0.03 mcg/kg) to bred female rats from gestation day 6 to 18 suggested evidence of embryotoxicity and a slight increase in mean delivery time in the 0.03 mcg/kg/day group. There was no clear evidence of teratogenicity noted.

Pregnant female New Zealand White rabbits were treated with fentanyl (0, 0.025, 0.1, 0.4 mcg/kg) via intravenous infusion from day 6 to day 18 of pregnancy. Fentanyl produced a slight decrease in the body weight of the live fetuses at the high dose, which may be attributed to maternal toxicity. Under the conditions of the assay, there was no evidence for fentanyl induced adverse effects on embryo-fetal development at doses up to 0.4 mcg/kg (approximately 3 times the daily human dose administered by a 100 mcg/hr patch on a mg/m² basis).

There are no adequate and well-controlled studies in pregnant women. Fentanyl transdermal system should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects

Chronic maternal treatment with fentanyl during pregnancy has been associated with transient respiratory depression, behavioral changes, or seizures characteristic of neonatal abstinence syndrome in newborn infants. Symptoms of neonatal respiratory or neurological depression were no more frequent than expected in most studies of infants born to females treated acutely during labor with intravenous or epidural fentanyl. Transient neonatal muscular rigidity has been observed in infants whose mothers were treated with intravenous fentanyl.

The potential effects of fentanyl on prenatal and postnatal development were examined in the rat model. Female Wistar rats were treated with 0, 0.025, 0.1, or 0.4 mcg/kg/day fentanyl via intravenous infusion from day 6 of pregnancy through 3 weeks of lactation. Fentanyl treatment (0.4 mcg/kg/day) significantly decreased body weight in male and female pups and also decreased survival in pups at day 4. Both the mid-dose and high-dose of fentanyl animals demonstrated alterations in some physical landmarks of development (delayed nipple eruption and eye opening) and transient behavioral development (decreased locomotor activity at day 28 which recovered by day 50). The mid-dose and the high-dose are 0.4 and 1.6 times the daily human dose administered by a 100 mcg/hr patch on a mg/m² basis.

Labor and Delivery

Fentanyl readily passes across the placenta to the fetus, therefore, fentanyl transdermal system is not recommended for analgesia during labor and delivery.

Nursing Mothers

Fentanyl is excreted in human milk, therefore, fentanyl transdermal system is not recommended for use in nursing women because of the possibility of effects in their infants.

Pediatric Use

The safety of fentanyl transdermal system was evaluated in three open-label trials in 291 pediatric patients with chronic pain, 2 years of age through 18 years of age. Starting doses of 25 mcg/hr and higher were used by 181 patients who had been on prior daily opioid doses of at least 45 mcg/day of oral morphine or an equianalgesic dose of another opioid. Initiation of fentanyl transdermal system therapy in pediatric patients taking less than 60 mcg/day of oral morphine or an equianalgesic dose of another opioid has not been evaluated in controlled clinical trials. Approximately 50% of the total daily opioid requirement (fentanyl transdermal system plus rescue medication) was provided by fentanyl transdermal system.

Fentanyl transdermal system was not studied in children under 2 years of age.

Fentanyl transdermal system should be administered to children only if they are opioid-tolerant and 2 years of age or older (see **DOSAGE AND ADMINISTRATION and BOX WARNING**).

To guard against accidental ingestion by children, use caution when choosing the application site for fentanyl transdermal system (see **DOSAGE AND ADMINISTRATION**) and monitor adhesion of the system closely.

Geriatric Use

Data from intravenous studies with fentanyl suggest that the elderly patients may have reduced clearance and a prolonged half-life. Moreover, elderly patients may be more sensitive to the acute substance than younger patients. A study conducted with the fentanyl transdermal system in elderly patients demonstrated that fentanyl pharmacokinetics did not differ significantly from young adult subjects, although peak serum concentrations tended to be lower and mean half-life values were prolonged to approximately 34 hours.

Respiratory depression is the chief hazard in elderly or debilitated patients, usually following large initial doses in non-tolerant patients or when opioids are given in conjunction with other agents that depress respiration.

Fentanyl transdermal system should be used with caution in elderly, cachectic, or debilitated patients as they may have altered pharmacokinetics due to poor fat stores, muscle wasting or altered clearance (see **DOSAGE AND ADMINISTRATION**).

ADVERSE REACTIONS

In post-marketing experience, deaths from hypoventilation due to use of fentanyl transdermal system have been reported (see **BOX WARNING and CONTRAINDICATIONS**).

Pre-Marketing Clinical Trial Experience

Although fentanyl transdermal system use in post-operative or acute pain and in patients who are not opioid-tolerant is CONTRAINDICATED, the safety of fentanyl transdermal system was originally evaluated in 257 post-operative adult patients for 1 to 3 days and 153 cancer patients for a total of 510 patients. The duration of fentanyl transdermal system use varied in cancer patients, 50% of patients used fentanyl transdermal system for over 30 days, 28% continued treatment for more than 4 months, and 10% used fentanyl transdermal system for more than 1 year.

Hypoventilation was the most serious adverse reaction observed in 13 (4%) post-operative patients and in 3 (2%) of the cancer patients. Hypotension and hypertension were observed in 11 (3%) and 4 (1%) of the opioid-naïve patients.

Various adverse events were reported, a causal relationship to fentanyl transdermal system was not always determined. The frequencies presented here reflect the actual frequency of each adverse effect in patients who received fentanyl transdermal system. There has been no attempt to correct for a placebo effect, concomitant use of other opioids, or to subtract the frequencies reported by placebo-treated patients in controlled trials.

Adverse reactions reported in 153 cancer patients at a frequency of 1% or greater are presented in Table 1. Similar reactions were seen in the 257 post-operative patients.

In the pediatric population, the safety of fentanyl transdermal system has been evaluated in 291 patients with chronic pain 2 to 18 years of age. The duration of fentanyl transdermal system use varied; 20% of pediatric patients were treated for > 15 days, 46% for 16 to 30 days, 16% for 31 to 60 days, and 17% for at least 61 days. Twenty-five patients were treated with fentanyl transdermal system for at least 4 months and 9 patients for more than 9 months.

There was no apparent pediatric-specific risk associated with fentanyl transdermal system use in children as young as 2 years old when used as directed. The most common adverse events were fever (35%), vomiting (33%), and nausea (24%).

Adverse events reported in pediatric patients at a rate of > 1% are presented in Table 1.

TABLE 1: ADVERSE EVENTS (at rate of $\geq 1\%$)

Study System	Adults (N=380)	Pediatric (N=291)
Body as a Whole	Abdominal pain, backache, fatigue, loss of pain, fever, influenza like symptoms, headache, respiratory signs	Fatigue, headache, fever, chills, chest pain, allergic reaction, feeling hot
Cardiovascular	Hypertension, hypotension	Hypertension, hypotension
Digestive	Nausea, vomiting, constipation, dry mouth, anorexia, diarrhea, dyspepsia, flatulence	Nausea, vomiting, constipation, dry mouth, diarrhea
Nervous	Dizziness, somnolence, confusion, euphoria, sedation, depression, anxiety, nervousness, headache, tremor, abnormal coordination, weakness, abnormal thinking, abnormal gait, abnormal dreams, apathy, paresthesia, amnesia, vertigo, stupor, hypotonia, hyperreflexia, rigidity	Dizziness, somnolence, confusion, euphoria, sedation, depression, anxiety, nervousness, headache, tremor, abnormal coordination, weakness, abnormal thinking, abnormal gait, abnormal dreams, apathy, paresthesia, amnesia, vertigo, stupor, hypotonia, hyperreflexia, rigidity
Respiratory	Chronic hypoventilation, apnea, hyperreflexia, pharyngitis, hoarseness, dyspnea, asthma, acute, acute respiratory distress syndrome, respiratory depression, rhinitis, coughing	Dyspnea, respiratory depression, rhinitis, coughing
Skin and Appendages	Swelling, pruritus, rash, application site reactions, erythema, pruritus, itching, edema	Pruritus, application site reactions, swelling, redness, rash, rash aggravated, skin reactions localized
Urogenital	Urinary retention, micturition, dysuria	Urinary retention

^a Reactions occurring in 3% to 10% of fentanyl transdermal system patients.
^b Reactions occurring in 10% or more of fentanyl transdermal system patients.

The following adverse effects have been reported in less than 1% of the 510 adult post-operative and cancer patients studied:

- Cardiovascular:** bradycardia
- Digestive:** abdominal distention
- Nervous:** dizziness, hyperreflexia, vertigo, stupor, hypotonia, depersonalization, hostility
- Respiratory:** stridorous breathing, asthma, respiratory disorder
- Skin and Appendages, General:** exfoliative dermatitis, pustules
- Special Senses:** amblyopia
- Urogenital:** bladder pain, oliguria, urinary frequency

Post-Marketing Experience - Adults

The following adverse reactions have been reported in association with the use of fentanyl transdermal system and not reported in the pre-marketing adverse reactions section above:

- Body as a Whole:** edema
- Cardiovascular:** tachycardia
- Metabolic and Nutritional:** weight loss
- Special Senses:** blurred vision
- Urogenital:** decreased libido, anorgasmia, ejaculatory difficulty

DRUG ABUSE AND ADDICTION

Fentanyl transdermal system contains a high concentration of fentanyl, a potent Schedule I opioid agonist. Schedule II opioid substances, which include hydromorphone, methadone, morphine, oxycodone, and oxycodone, have the highest potential for abuse and risk of fatal overdose due to respiratory depression. Fentanyl, like morphine and other opioids used in analgesia, can be abused and is subject to criminal diversion.

The high contents of fentanyl in the patches (fentanyl transdermal system) may be a particular target for abuse and diversion.

Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use; compulsive use, continued use despite harm; and craving. Drug addiction is a treatable disease, utilizing a multidisciplinary approach, but relapse is common.

"Drug seeking" behavior is very common in addicts and drug abusers. Drug seeking tactics include emergency calls or visits near the end of office hours, refusal to undergo appropriate examination, testing or referral, repeated "loss" of prescriptions, tampering with prescriptions and reluctance to provide prior medical records or contact information for other treating physician(s). "Doctor shopping" to obtain additional prescriptions is common among drug abusers and patients suffering from untreated addiction.

Abuse and addiction are separate and distinct from physical dependence and tolerance. Physicians should be aware that addiction may be accompanied by concurrent tolerance and symptoms of physical dependence. In addition, abuse of opioids can occur in the absence of true addiction and is characterized by misuse for non-medical purposes, often in combination with other psychoactive substances. Since fentanyl transdermal system may be diverted for non-medical use, careful record keeping of prescribing information, including quantity, frequency, and renewal requests is strongly advised.

Proper assessment of the patient, proper prescribing practices, periodic re-evaluation of therapy, and proper dispensing and storage are appropriate measures that help to limit abuse of opioid drugs.

Fentanyl transdermal systems are intended for transdermal use (to be applied on the skin). Only do not use a fentanyl transdermal system if the pouch seal is broken or the patch is out, damaged, or changed in any way.

OVERDOSAGE

Clinical Presentation

The manifestations of fentanyl overdosage are an extension of its pharmacologic actions with the most serious significant effect being hypoventilation.

Treatment

For the management of hypoventilation, immediate countermeasures include removing the fentanyl transdermal system and physically or verbally stimulating the patient. These actions can be followed by administration of a specific narcotic antagonist such as naloxone. The duration of hypoventilation following an overdose may be longer than the effects of the narcotic antagonist's action (the half-life of naloxone ranges from 30 to 81 minutes). The interval between N antagonist doses should be carefully chosen because of the possibility of re-narcotization after system removal, repeated administration of naloxone may be necessary. Reversal of the narcotic effect may result in acute onset of pain and the release of catecholamines.

Always ensure a patent airway is established and maintained, administer oxygen and assist or control respiration as indicated and use an oropharyngeal airway or endotracheal tube if necessary. Adequate body temperature and fluid intake should be maintained.

If severe or persistent hypotension occurs, the possibility of hypovolemia should be considered and managed with appropriate parenteral fluid therapy.

DOSAGE AND ADMINISTRATION

Special Precautions

Fentanyl transdermal system contains a high concentration of a potent Schedule II opioid agonist, fentanyl. Schedule II opioid substances which include fentanyl, hydromorphone, methadone, morphine, oxycodone, and oxycodone have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression. Fentanyl can be abused and is subject to criminal diversion. The high content of fentanyl in the patches (fentanyl transdermal system) may be a particular target for abuse and diversion.

Fentanyl transdermal systems are intended for transdermal use (on intact skin) only. The fentanyl transdermal system should not be used if the pouch seal is broken, or the patch is out, damaged, or changed in any way.

Each fentanyl transdermal system may be worn continuously for 72 hours. The next patch should be applied to a different skin site after removal of the previous transdermal system.

If problems with adhesion of the fentanyl transdermal system occur, the edges of the patch may be taped with first aid tape. If problems with adhesion persist, the patch may be overlaid with a transparent adhesive film dressing (e.g., BioCryl™ or Tegaderm™).

If the patch falls off before 72 hours, dispose of it by folding in half and flushing down the toilet. A new patch may be applied to a different skin site.

Fentanyl transdermal system is ONLY for use in patients who are already tolerant to opioid therapy of comparable potency. Use in non-opioid tolerant patients may lead to fatal respiratory depression. Overestimating the fentanyl transdermal system dose when converting patients from another opioid medication can result in fatal overdose with the first dose. Due to the mean half-life of approximately 17 hours, patients who are thought to have had a serious adverse event, including overdose, will require monitoring and treatment for at least 24 hours.

The concomitant use of fentanyl transdermal system with all cytochrome P450 3A4 inhibitors (such as ritonavir, ketoconazole, itraconazole, itraconazole, clarithromycin, nefazodone, nefazodone, amiodarone, aprepitant, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, fosamprenavir, grapefruit juice, and verapamil) may result in an increase in fentanyl plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression. Patients receiving fentanyl transdermal system and any CYP3A4 inhibitor should be carefully monitored for an extended period of time and dosage adjustments should be made if warranted (see **BOX WARNING: CLINICAL PHARMACOLOGY, Drug Interactions, WARNINGS, and PRECAUTIONS for further information**).

Pediatric patients converting to fentanyl transdermal system with a 25 mcg/hr patch should be opioid-tolerant and receiving at least 60 mg of oral morphine or the equivalent per day. The dose conversion schedule described in Table C, and method of titration described below, are recommended in opioid-tolerant pediatric patients over 2 years of age with chronic pain (see **PRECAUTIONS, Pediatric Use**).

Respiratory depression is the chief hazard in elderly or debilitated patients, usually following large initial doses in non-tolerant patients, or when opioids are given in conjunction with other agents that depress respiration.

Fentanyl transdermal system should be used with caution in elderly, cachectic, or debilitated patients as they may have altered pharmacokinetics due to poor fat stores, muscle wasting, or altered clearance (see **CLINICAL PHARMACOLOGY, Special Populations, Geriatric Use**).

General Principles

Fentanyl transdermal system is indicated for management of persistent, moderate to severe chronic pain that:

- requires continuous, around-the-clock opioid administration for an extended period of time
- cannot be managed by other means such as non-steroidal analgesics, opioid combination products, or immediate-release opioids.

Fentanyl transdermal system should ONLY be used in patients who are already receiving opioid therapy who have demonstrated opioid tolerance, and who require a total daily dose at least equivalent to fentanyl transdermal system 25 mcg/hr. Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg oral hydromorphone daily, or an equianalgesic dose of another opioid.

Because serious or life-threatening hypoventilation could occur, fentanyl transdermal system is contraindicated:

- in patients who are not opioid-tolerant
- in the management of acute pain or in patients who require opioid analgesia for a short period of time
- in the management of post-operative pain, including use after out-patient or day surgeries (e.g., tonsillectomy)
- in the management of mild pain
- in the management of intermittent pain (e.g., use on an as needed basis [prn])

(see **CONTRAINDICATIONS for further information**).

Safety of fentanyl transdermal system has not been established in children under 2 years of age. Fentanyl transdermal system should be administered to children only if they are opioid-tolerant and 2 years of age or older (see **PRECAUTIONS, Pediatric Use**).

Prescribers should individualize treatment using a progressive plan of pain management such as outlined by the World Health Organization, the Agency for Health Research and Quality, the Federation of State Medical Boards Model Policy, or the American Pain Society.

With all opioids, the safety of patients using the products is dependent on healthcare practitioners prescribing them in strict conformity with their approved labeling with respect to patient selection, dosing, and proper conditions for use.

As with all opioids, dosage should be individualized. The most important factor to be considered in determining the appropriate dose is the extent of pre-existing opioid-tolerance (see **BOX WARNING** and **CONTRAINDICATIONS**). Initial doses should be reduced in elderly or debilitated patients (see **PRECAUTIONS**).

Fentanyl transdermal system should be applied to intact, non-irritated, and non-radiated skin on a flat surface such as the chest, back, flank, or upper arm. In young children and persons with cognitive impairment, adhesion should be monitored and the upper back is the preferred location to minimize the potential of inappropriate patch removal. Hair at the application site should be clipped (not shaved) prior to system application. If the site of fentanyl transdermal system application must be cleaned prior to application of the patch, do so with clear water. Do not use soaps, oils, lotions, alcohol, or any other agents that might irritate the skin or alter its characteristics. Allow the skin to dry completely prior to patch application.

Fentanyl transdermal system should be applied immediately upon removal from the sealed package. Do not use if the pouch seal is broken. Do not alter the patch (e.g., cut in any way) prior to application and do not use out of or damaged patches.

The transdermal system should be pressed firmly in place with the palm of the hand for 30 seconds, making sure the contact is complete, especially around the edges.

Fentanyl transdermal system should be kept out of the reach of children. Used patches should be folded so that the adhesive side of the patch adheres to itself, then the patch should be flushed down the toilet immediately upon removal. Patients should dispose of any patches remaining from a prescription as soon as they are no longer needed. Unused patches should be removed from their pouches, folded so that the adhesive side of the patch adheres to itself, and flushed down the toilet.

Dose Selection

Doses must be individualized based upon the status of each patient and should be assessed at regular intervals after fentanyl transdermal system application. Reduced doses of fentanyl transdermal system are suggested for the elderly and other groups discussed in **PRECAUTIONS**.

Fentanyl transdermal system is **ONLY** for use in patients who are already tolerant to opioid therapy of comparable potency. Use in non-opioid tolerant patients may lead to fatal respiratory depression.

In selecting an initial fentanyl transdermal system dose, attention should be given to 1) the daily dose, potency, and characteristics of the opioid the patient has been taking previously (e.g., whether it is a pure agonist or mixed agonist/antagonist), 2) the reliability of the relative potency estimates used to calculate the fentanyl transdermal system dose needed (potency estimates may vary with the route of administration), 3) the degree of opioid tolerance and 4) the general condition and medical status of the patient. Each patient should be maintained at the lowest dose providing acceptable pain control.

Initial Fentanyl Transdermal System Dose Selection

Overestimating the fentanyl transdermal system dose when converting patients from another opioid medication can result in fatal overdose with the first dose. Due to the mean half-life of approximately 17 hours, patients who are thought to have had a serious adverse event, including overdose, will require monitoring and treatment for at least 24 hours.

There has been no systematic evaluation of fentanyl transdermal system as an initial opioid analgesic in the management of chronic pain, since most patients in the clinical trials were converted to fentanyl transdermal system from other narcotics. The efficacy of fentanyl transdermal system 12 mcg/hr as an initiating dose has not been determined. In addition, patients who are not opioid-tolerant have experienced hyperventilation and death during use of fentanyl transdermal system. Therefore, fentanyl transdermal system should be used only in patients who are opioid-tolerant.

To convert patients from oral or parenteral opioids to fentanyl transdermal system, use **Table C**.

Alternatively, for adult and pediatric patients taking opioids or doses not listed in **Table C**, use the following methodology:

1. Calculate the previous 24-hour analgesic requirement.
2. Convert this amount to the equianalgesic oral morphine dose using **Table D**.
3. **Table E** displays the range of 24-hour oral morphine doses that are recommended for conversion to each fentanyl transdermal system dose. Use this table to find the calculated 24-hour morphine dose and the corresponding fentanyl transdermal system dose. Initiate fentanyl transdermal system treatment using the recommended dose and titrate patients upwards (no more frequently than every 3 days after the initial dose or than every 6 days thereafter) until analgesic efficacy is attained. The recommended starting dose when converting from other opioids to fentanyl transdermal system is likely too low for 50% of patients. This starting dose is recommended to minimize the potential for overdosing patients with the first dose. For delivery rates in excess of 100 mcg/hr, multiple systems may be used.

TABLE C*
DOSE CONVERSION GUIDELINES

Current Analgesic	Daily Dosage (mg/d)			
Oral morphine	60-134	129-224	225-314	315-404
IM/IV morphine	10-22	23-37	38-52	53-67
Oral oxycodone	30-67	67.5-112	112.5-157	157.5-202
IM/IV oxycodone	15-33	33.5-56	56.5-78	78.5-101
Oral codeine	110-447	448-747	748-1047	1048-1347
Oral hydromorphone	8-17	17.1-29	29.1-39	39.1-51
IV hydromorphone	1.5-3.4	3.5-6.6	6.7-9.9	9.9-13
IM meperidine	75-165	166-278	279-390	391-503
Oral methadone	20-44	45-74	75-104	105-134
IM methadone	10-22	23-37	38-52	53-67
Recommended Fentanyl Transdermal System Dose	12 mcg/hr	16 mcg/hr	24 mcg/hr	36 mcg/hr

Alternatively, for adult and pediatric patients taking opioids or doses not listed in **Table C**, use the conversion methodology outlined above with **Table D**.

* **Table C** should not be used to convert from fentanyl transdermal system to other therapies because this conversion to fentanyl transdermal system is conservative. Use of **Table C** for conversion to other analgesic therapies can overestimate the dose of the new agent. Overdosage of the new analgesic agent is possible (see **DOSAGE AND ADMINISTRATION**, **Discontinuation of Fentanyl Transdermal System**).

TABLE D*†
EQUIANALGESIC POTENCY CONVERSION

Name	Equianalgesic Dose (mg IM)†	PO
Morphine	10	60 (PO)†
Hydromorphone (Dilaudid)†	1.5	7.5
Methadone (Dolophine)†	10	30
Oxycodone	15	30
Levo-Dromoran (Lavo-Dromoran)†	2	4
Oxymorphone (Numorphan)†	1	10 (PR)
Meperidine (Demerol)†	75	—
Codeine	100	200

Dilaudid is a registered trademark of Purdue Pharma L.P.
Dolophine is a registered trademark of Roxane Laboratories, Inc.
Lavo-Dromoran is a registered trademark of Valeant Pharmaceuticals North America.
Numorphan is a registered trademark of Endo Pharmaceuticals, Inc.
Demerol is a registered trademark of Sandoz-Aventis U.S. LLC.

* **Table D** should not be used to convert from fentanyl transdermal system to other therapies because this conversion to fentanyl transdermal system is conservative. Use of **Table D** for conversion to other analgesic therapies can overestimate the dose of the new agent. Overdosage of the new analgesic agent is possible (see **DOSAGE AND ADMINISTRATION**, **Discontinuation of Fentanyl Transdermal System**).

† All IM and PO doses in this chart are considered equivalent to 10 mg of IM morphine in analgesic effect. IM denotes intramuscular; PO oral; and PR rectal.

‡ Based on single-dose studies in which an intramuscular dose of each drug listed was compared with morphine to establish the relative potency. Oral doses are those recommended when changing from parenteral to an oral route. Reference: Foley, K.M. (1985) The treatment of cancer pain. *NEJM* 313:284-95.

§ Although controlled studies are not available, in clinical practice it is customary to consider the doses of opioid given IM, IV, or subcutaneously to be equivalent. There may be some differences in pharmacokinetic parameters such as $t_{1/2}$ and $T_{1/2}$.

¶ The conversion ratio of 10 mg parenteral morphine = 30 mg oral morphine is based on clinical experience in patients with chronic pain. The conversion ratio of 10 mg parenteral morphine = 60 mg oral morphine is based on a potency study in acute pain. Reference: Asbjorn and Lipman (1993) Management of pain in the cancer patient. *Anesth Analg* 76:402-416.

TABLE E*
RECOMMENDED INITIAL FENTANYL TRANSDERMAL SYSTEM DOSE BASED UPON DAILY ORAL MORPHINE DOSE

Oral 24-hour Morphine (mg/day)	Fentanyl Transdermal System Dose (mcg/hr)
60-134	25
135-224	50
225-314	75
315-404	100
405-494	125
495-584	150
585-674	175
675-764	200
765-854	225
855-944	250
945-1034	275
1035-1124	300

NOTE: In clinical trials, these ranges of daily oral morphine doses were used as a basis for conversion to fentanyl transdermal system.

* **Table E** should not be used to convert from fentanyl transdermal system to other therapies because this conversion to fentanyl transdermal system is conservative. Use of **Table E** for conversion to other analgesic therapies can overestimate the dose of the new agent. Overdosage of the new analgesic agent is possible (see **DOSAGE AND ADMINISTRATION**, **Discontinuation of Fentanyl Transdermal System**).

The majority of patients are adequately maintained with fentanyl transdermal system administered every 72 hours. Some patients may not achieve adequate analgesia using this dosing interval and may require systems to be applied every 48 hours rather than every 72 hours. An increase in the fentanyl transdermal system dose should be evaluated before changing dosing intervals in order to maintain patients on a 72-hour regimen. Dosing intervals less than every 72 hours were not studied in children and adolescents and are not recommended.

Because of the increase in serum fentanyl concentration over the first 24 hours following initial system application, the initial evaluation of the maximum analgesic effect of fentanyl transdermal system cannot be made before 24 hours of wearing. The initial fentanyl transdermal system dose may be increased after 3 days (see **DOSAGE AND ADMINISTRATION**, **Dose Titration**).

During the initial application of fentanyl transdermal system, patients should use short-acting analgesics as needed until analgesic efficacy with fentanyl transdermal system is attained. Thereafter, some patients still may require periodic supplemental doses of other short-acting analgesics for "breakthrough" pain.

Dose Titration

The recommended initial fentanyl transdermal system dose based upon the daily oral morphine dose is conservative, and 50% of patients are likely to require a dose increase after initial application of fentanyl transdermal system. The initial fentanyl transdermal system dose may be increased after 3 days based on the daily dose of supplemental opioid analgesics required by the patient in the second or third day of the initial application.

Physicians are advised that it may take up to 6 days after increasing the dose of fentanyl transdermal system for the patient to reach equilibrium on the new dose (see graph in **CLINICAL PHARMACOLOGY**). Therefore, patients should wear a higher dose through two applications before any further increase in dosage is made on the basis of the average daily use of a supplemental analgesic.

Appropriate dosage increments should be based on the daily dose of supplementary opioids, using the ratio of 45 mg/24 hours of oral morphine to a 12.5 mcg/hr increase in fentanyl transdermal system dose.

Discontinuation of Fentanyl Transdermal System

To convert patients to another opioid, remove fentanyl transdermal system and titrate the dose of the new analgesic based upon the patient's report of pain until adequate analgesia has been attained. Upon system removal, 17 hours or more are required for a 50% decrease in serum fentanyl concentrations. Opioid withdrawal symptoms (such as nausea, vomiting, diarrhea, anxiety, and shivering) are possible in some patients after conversion or dose adjustment. For patients requiring discontinuation of opioids, a gradual downward titration is recommended since it is not known at what dose level the opioid may be discontinued without producing the signs and symptoms of abrupt withdrawal.

Tables C, D, and E should not be used to convert from fentanyl transdermal system to other therapies. Because the conversion to fentanyl transdermal system is conservative, use of **Tables C, D, and E** for conversion to other analgesic therapies can overestimate the dose of the new agent. Overdosage of the new analgesic agent is possible.

HOW SUPPLIED

Fentanyl transdermal system is supplied in cartons containing 5 individually packaged systems. See chart for information regarding individual systems.

Fentanyl Transdermal System Dose (mcg/hr)	System Size (cm ²)	Fentanyl Content (mcg)	NDC Number
Fentanyl transdermal system-25	7.8	2.75	0406-9025-76
Fentanyl transdermal system-50	15.6	5.50	0406-9050-76
Fentanyl transdermal system-75	23.4	8.25	0406-9075-76
Fentanyl transdermal system-100	31.2	11.0	0406-9000-76

Safety and Handling

Fentanyl transdermal system is supplied in sealed transdermal systems which pose little risk of exposure to healthcare workers. Do not use a fentanyl transdermal system if the pouch seal is broken or the patch is cut, damaged, or changed in any way.

KEEP FENTANYL TRANSDERMAL SYSTEM OUT OF THE REACH OF CHILDREN AND PETS.

Store in original unopened pouch. Store up to 25°C (77°F); excursions permitted to 15-30°C (59-86°F). Apply immediately after removal from individually sealed pouch. Do not use if the pouch seal is broken. For transdermal use only.

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A Schedule II narcotic. DEA order form required.

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