

**BUSPAR- buspirone hydrochloride tablet
DIRECT RX**

BUSPIRONE HYDROCHLORIDE

Buspirone hydrochloride tablets, USP are an antianxiety agent that is not chemically or pharmacologically related to the benzodiazepines, barbiturates, or other sedative/anxiolytic drugs.

Buspirone hydrochloride, USP is a white crystalline powder. It is very soluble in water; freely soluble in methanol and in methylene chloride; sparingly soluble in ethanol and in acetonitrile; very slightly soluble in ethyl acetate and practically insoluble in hexanes. Its molecular weight is 422. Chemically, buspirone hydrochloride is 8-[4-[4-(2-pyrimidinyl)-1-piperazinyl]butyl]-8-azaspiro[4.5]decane-7,9-dione monohydrochloride. The molecular formula C₂₁H₃₁N₅O₂•HCl is represented by the following structural formula:

Structural formula

Each buspirone hydrochloride tablet intended for oral administration contains 5 mg or 10 mg or 15 mg or 30 mg buspirone hydrochloride (equivalent to 4.6 mg, 9.1 mg, 13.7 mg, and 27.4 mg of buspirone free base, respectively). In addition, each tablet contains the following inactive ingredients: colloidal silicon dioxide, lactose monohydrate, magnesium stearate, microcrystalline cellulose and sodium starch glycolate. The 5 mg and 10 mg tablets are scored so they can be bisected. Thus, the 5 mg tablet can also provide 2.5 mg dose, and the 10 mg tablet can provide a 5 mg dose. The 15 mg and 30 mg tablets are scored so they can be either bisected or trisected. Thus, a single 15 mg tablet can provide the following doses: 15 mg (entire tablet), 10 mg (two thirds of a tablet), 7.5 mg (one half of a tablet), or 5 mg (one third of a tablet). A single 30 mg tablet can provide the following doses: 30 mg (entire tablet), 20 mg (two thirds of a tablet), 15 mg (one half of a tablet), or 10 mg (one third of a tablet).

The mechanism of action of buspirone is unknown. Buspirone differs from typical benzodiazepine anxiolytics in that it does not exert anticonvulsant or muscle relaxant effects. It also lacks the prominent sedative effect that is associated with more typical anxiolytics. In vitro preclinical studies have shown that buspirone has a high affinity for serotonin (5-HT_{1A}) receptors. Buspirone has no significant affinity for benzodiazepine receptors and does not affect GABA binding in vitro or in vivo when tested in preclinical models.

Buspirone has moderate affinity for brain D₂-dopamine receptors. Some studies do suggest that buspirone may have indirect effects on other neurotransmitter systems.

Buspirone hydrochloride is rapidly absorbed in man and undergoes extensive first-pass metabolism. In a radiolabeled study, unchanged buspirone in the plasma accounted for only about 1% of the radioactivity in the plasma. Following oral administration, plasma concentrations of unchanged buspirone are very low and variable between subjects. Peak plasma levels of 1 ng/mL to 6 ng/mL have been observed 40 to 90 minutes after single oral doses of 20 mg. The single-dose bioavailability of unchanged buspirone when taken as a tablet is on the average about 90% of an equivalent dose of solution, but there is large variability.

The effects of food upon the bioavailability of buspirone hydrochloride tablets have been studied in eight subjects. They were given a 20 mg dose with and without food; the area under the plasma concentration-time curve (AUC) and peak plasma concentration (C_{max}) of unchanged buspirone increased by 84% and 116%, respectively, but the total amount of buspirone immunoreactive material did not change. This suggests that food may decrease the extent of presystemic clearance of buspirone (see DOSAGE AND ADMINISTRATION).

A multiple-dose study conducted in 15 subjects suggests that buspirone has nonlinear pharmacokinetics. Thus, dose increases and repeated dosing may lead to somewhat higher blood levels of unchanged buspirone than would be predicted from results of single-dose studies.

An in vitro protein binding study indicated that approximately 86% of buspirone is bound to plasma proteins. It was also observed that aspirin increased the plasma levels of free buspirone by 23%, while flurazepam decreased the plasma levels of free buspirone by 20%. However, it is not known whether these drugs cause similar effects on plasma levels of free buspirone *in vivo*, or whether such changes, if they do occur, cause clinically significant differences in treatment outcome. An in vitro study indicated that buspirone did not displace highly protein-bound drugs such as phenytoin, warfarin, and propranolol from plasma protein, and that buspirone may displace digoxin.

Buspirone is metabolized primarily by oxidation, which *in vitro* has been shown to be mediated by cytochrome P450 3A4 (CYP3A4) (see PRECAUTIONS, Drug Interactions). Several hydroxylated derivatives and a pharmacologically active metabolite, 1-pyrimidinylpiperazine (1-PP), are produced. In animal models predictive of anxiolytic potential, 1-PP has about one quarter of the activity of buspirone, but is present in up to 20-fold greater amounts. However, this is probably not important in humans: blood samples from humans chronically exposed to buspirone hydrochloride do not exhibit high levels of 1-PP; mean values are approximately 3 ng/mL and the highest human blood level recorded among 108 chronically dosed patients was 17 ng/mL, less than 1/200th of 1-PP levels found in animals given large doses of buspirone without signs of toxicity.

In a single-dose study using ¹⁴C-labeled buspirone, 29% to 63% of the dose was excreted in the urine within 24 hours, primarily as metabolites; fecal excretion accounted for 18% to 38% of the dose. The average elimination half-life of unchanged buspirone after single doses of 10 mg to 40 mg is about 2 to 3 hours.

Special Populations:

Age and Gender Effects:

After single or multiple doses in adults, no significant differences in buspirone pharmacokinetics (AUC and C_{max}) were observed between elderly and younger subjects or between men and women.

Hepatic Impairment:

After multiple-dose administration of buspirone to patients with hepatic impairment, steady-state AUC of buspirone increased 13-fold compared with healthy subjects (see PRECAUTIONS).

Renal Impairment:

After multiple-dose administration of buspirone to renally impaired (Clcr = 10 to 70 mL/min/1.73 m²) patients, steady-state AUC of buspirone increased 4-fold compared with healthy (Clcr ≥ 80 mL/min/1.73 m²) subjects (see PRECAUTIONS).

Race Effects:

The effects of race on the pharmacokinetics of buspirone have not been studied.

Buspirone hydrochloride tablets are indicated for the management of anxiety disorders or the short-term relief of the symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic.

The efficacy of buspirone hydrochloride tablets have been demonstrated in controlled clinical trials of outpatients whose diagnosis roughly corresponds to Generalized Anxiety Disorder (GAD). Many of the patients enrolled in these studies also had coexisting depressive symptoms and buspirone hydrochloride tablets relieved anxiety in the presence of these coexisting depressive symptoms. The patients evaluated in these studies had experienced symptoms for periods of 1 month to over 1 year prior to the study, with an average symptom duration of 6 months. Generalized Anxiety Disorder (300.02) is described in the American Psychiatric Association's Diagnostic and Statistical Manual, III-1 as follows:

Generalized, persistent anxiety (of at least 1 month continual duration), manifested by symptoms from three of the four following categories:

1. Motor tension:

Shakiness, jitteriness, jumpiness, trembling, tension, muscle aches, fatigability, inability to relax, eyelid twitch, furrowed brow, strained face, fidgeting, restlessness, easy startle.

2. Autonomic hyperactivity:

Sweating, heart pounding or racing, cold, clammy hands, dry mouth, dizziness, lightheadedness, paresthesias (tingling in hands or feet), upset stomach, hot or cold spells, frequent urination, diarrhea, discomfort in the pit of the stomach, lump in the throat, flushing, pallor, high resting pulse and respiration rate.

3. Apprehensive expectation:

Anxiety, worry, fear, rumination, and anticipation of misfortune to self or others.

4. Vigilance and scanning:

Hyperattentiveness resulting in distractibility, difficulty in concentrating, insomnia, feeling "on edge," irritability, impatience.

The above symptoms would not be due to another mental disorder, such as a depressive disorder or schizophrenia. However, mild depressive symptoms are common in GAD.

The effectiveness of buspirone hydrochloride tablets in long-term use, that is, for more than 3 to 4 weeks, has not been demonstrated in controlled trials. There is no body of evidence available that systematically addresses the appropriate duration of treatment for GAD. However, in a study of long-term use, 264 patients were treated with buspirone hydrochloride tablets for 1 year without ill effect. Therefore, the physician who elects to use buspirone hydrochloride tablets for extended periods should periodically reassess the usefulness of the drug for the individual patient.

Buspirone hydrochloride tablets are contraindicated in patients hypersensitive to buspirone hydrochloride.

The administration of buspirone hydrochloride tablets to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. There have been reports of the occurrence of elevated blood pressure when buspirone hydrochloride tablets have been added to a regimen including an MAOI. Therefore, it is recommended that buspirone hydrochloride tablets not be used concomitantly with an MAOI.

Because buspirone hydrochloride tablets have no established antipsychotic activity, it should not be employed in lieu of appropriate antipsychotic treatment.

General:

Interference with Cognitive and Motor Performance:

Studies indicate that buspirone hydrochloride tablets are less sedating than other anxiolytics and that it does not produce significant functional impairment. However, its CNS effects in any individual patient may not be predictable. Therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone treatment does not affect them adversely.

While formal studies of the interaction of buspirone hydrochloride with alcohol indicate that buspirone does not increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use of alcohol and buspirone.

Potential for Withdrawal Reactions in Sedative/Hypnotic/Anxiolytic Drug-Dependent Patients:

Because buspirone hydrochloride tablets do not exhibit cross-tolerance with benzodiazepines and other common sedative/hypnotic drugs, it will not block the withdrawal syndrome often seen with cessation of therapy with these drugs. Therefore, before starting therapy with buspirone hydrochloride tablets, it is advisable to withdraw patients gradually, especially patients who have been using a CNS-depressant drug chronically, from their prior treatment. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug, and its effective half-life of elimination.

The syndrome of withdrawal from sedative/hypnotic/anxiolytic drugs can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

Possible Concerns Related to Buspirone's Binding to Dopamine Receptors:

Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine-mediated neurological function (e.g., dystonia, pseudo-parkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported in some small fraction of buspirone-treated patients. The syndrome may be explained in several ways. For example, buspirone may increase central noradrenergic activity; alternatively, the effect may be attributable to dopaminergic effects (i.e., represent akathisia). See ADVERSE REACTIONS: Postmarketing Experience.

Information for Patients:

To assure safe and effective use of buspirone hydrochloride tablets, the following information and instructions should be given to patients:

Inform your physician about any medications, prescription or non-prescription, alcohol, or drugs that you are now taking or plan to take during your treatment with buspirone hydrochloride tablets.

Inform your physician if you are pregnant, or if you are planning to become pregnant, or if you become pregnant while you are taking buspirone hydrochloride tablets.

Inform your physician if you are breastfeeding an infant.

Until you experience how this medication affects you, do not drive a car or operate potentially dangerous machinery.

You should take buspirone hydrochloride consistently, either always with or always without food.

During your treatment with buspirone hydrochloride tablets, avoid drinking large amounts of grapefruit juice.

Laboratory Tests:

There are no specific laboratory tests recommended.

Drug Interactions:

Psychotropic Agents:

MAO inhibitors:

It is recommended that buspirone hydrochloride tablets not be used concomitantly with MAO inhibitors (see WARNINGS).

Amitriptyline:

After addition of buspirone to the amitriptyline dose regimen, no statistically significant differences in the steady-state pharmacokinetic parameters (Cmax, AUC, and Cmin) of amitriptyline or its metabolite nortriptyline were observed.

Diazepam:

After addition of buspirone to the diazepam dose regimen, no statistically significant differences in the steady-state pharmacokinetic parameters (Cmax, AUC, and Cmin) were observed for diazepam, but increases of about 15% were seen for nordiazepam, and minor adverse clinical effects (dizziness, headache, and nausea) were observed.

Haloperidol:

In a study in normal volunteers, concomitant administration of buspirone and haloperidol resulted in increased serum haloperidol concentrations. The clinical significance of this finding is not clear.

Nefazodone:

[see Inhibitors and Inducers of Cytochrome P450 3A4 (CYP3A4)].

Trazodone:

There is one report suggesting that the concomitant use of Desyrel®# (trazodone hydrochloride) and buspirone may have caused 3- to 6-fold elevations on SGPT (ALT) in a few patients. In a similar study attempting to replicate this finding, no interactive effect on hepatic transaminases was identified.

Triazolam/Flurazepam:

Coadministration of buspirone with either triazolam or flurazepam did not appear to prolong or intensify the sedative effects of either benzodiazepine.

Other Psychotropics:

Because the effects of concomitant administration of buspirone with most other psychotropic drugs have not been studied, the concomitant use of buspirone with other CNS-active drugs should be approached with caution.

Inhibitors and Inducers of Cytochrome P450 3A4 (CYP3A4):

Buspirone has been shown in vitro to be metabolized by CYP3A4. This finding is consistent with the in vivo interactions observed between buspirone and the following:

Diltiazem and Verapamil:

In a study of nine healthy volunteers, coadministration of buspirone (10 mg as a single dose) with verapamil (80 mg t.i.d.) or diltiazem (60 mg t.i.d.) increased plasma buspirone concentrations (verapamil increased AUC and Cmax of buspirone 3.4-fold while diltiazem increased AUC and Cmax 5.5-fold and 4-fold, respectively.) Adverse events attributable to buspirone may be more likely during concomitant administration with either diltiazem or verapamil. Subsequent dose adjustment may be necessary and should be based on clinical assessment.

Erythromycin:

In a study in healthy volunteers, coadministration of buspirone (10 mg as a single dose) with erythromycin (1.5 g/day for 4 days) increased plasma buspirone concentrations (5-fold increase in Cmax and 6-fold increase in AUC). These pharmacokinetic interactions were accompanied by an increased incidence of side effects attributable to buspirone. If the two drugs are to be used in combination, a low dose of buspirone (e.g., 2.5 mg b.i.d.) is recommended. Subsequent dose adjustment of either drug should be based on clinical assessment.

Grapefruit Juice:

In a study in healthy volunteers, coadministration of buspirone (10 mg as a single dose) with grapefruit juice (200 mL double-strength t.i.d. for 2 days) increased plasma buspirone concentrations (4.3-fold increase in Cmax; 9.2-fold increase in AUC). Patients receiving buspirone should be advised to avoid drinking such large amounts of grapefruit juice.

Itraconazole:

In a study in healthy volunteers, coadministration of buspirone (10 mg as a single dose) with itraconazole (200 mg/day for 4 days) increased plasma buspirone concentrations (13-fold increase in Cmax and 19-fold increase in AUC). These pharmacokinetic interactions were accompanied by an increased incidence of side effects attributable to buspirone. If the two drugs are to be used in combination, a low dose of buspirone (e.g., 2.5 mg q.d.) is recommended. Subsequent dose adjustment of either drug should be based on clinical assessment.

Nefazodone:

In a study of steady-state pharmacokinetics in healthy volunteers, coadministration of buspirone (2.5 or 5 mg b.i.d.) with nefazodone (250 mg b.i.d.) resulted in marked increases in plasma buspirone concentrations (increases up to 20-fold in Cmax and up to 50-fold in AUC) and statistically significant

decreases (about 50%) in plasma concentrations of the buspirone metabolite 1-PP. With 5 mg b.i.d. doses of buspirone, slight increases in AUC were observed for nefazodone (23%) and its metabolites hydroxynefazodone (HO-NEF) (17%) and meta-chlorophenylpiperazine (9%). Slight increases in Cmax were observed for nefazodone (8%) and its metabolite HO-NEF (11%).

Subjects receiving buspirone 5 mg b.i.d. and nefazodone 250 mg b.i.d experienced lightheadedness, asthenia, dizziness, and somnolence, adverse events also observed with either drug alone. If the two drugs are to be used in combination, a low dose of buspirone (e.g., 2.5 mg q.d.) is recommended. Subsequent dose adjustment of either drug should be based on clinical assessment.

Rifampin:

In a study in healthy volunteers, coadministration of buspirone (30 mg as a single dose) with rifampin (600 mg/day for 5 days) decreased the plasma concentrations (83.7% decrease in Cmax; 89.6% decrease in AUC) and pharmacodynamic effects of buspirone. If the two drugs are to be used in combination, the dosage of buspirone may need adjusting to maintain anxiolytic effect.

Other Inhibitors and Inducers of CYP3A4:

Substances that inhibit CYP3A4, such as ketoconazole or ritonavir, may inhibit buspirone metabolism and increase plasma concentrations of buspirone while substances that induce CYP3A4, such as dexamethasone, or certain anticonvulsants (phenytoin, phenobarbital, carbamazepine), may increase the rate of buspirone metabolism. If a patient has been titrated to a stable dosage on buspirone, a dose adjustment of buspirone may be necessary to avoid adverse events attributable to buspirone or diminished anxiolytic activity. Consequently, when administered with a potent inhibitor of CYP3A4, a low dose of buspirone used cautiously is recommended. When used in combination with a potent inducer of CYP3A4 the dosage of buspirone may need adjusting to maintain anxiolytic effect.

Other Drugs:

Cimetidine:

Coadministration of buspirone with cimetidine was found to increase Cmax (40%) and T_{max} (2-fold), but had minimal effects on the AUC of buspirone.

Protein Binding:

In vitro, buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins. However, there has been one report of prolonged prothrombin time when buspirone was added to the regimen of a patient treated with warfarin. The patient was also chronically receiving phenytoin, phenobarbital, digoxin, and Synthroid®*. In vitro, buspirone may displace less firmly bound drugs like digoxin. The clinical significance of this property is unknown.

Therapeutic levels of aspirin, desipramine, diazepam, flurazepam, ibuprofen, propranolol, thioridazine, and tolbutamide had only a limited effect on the extent of binding of buspirone to plasma proteins (see CLINICAL PHARMACOLOGY).

Drug/Laboratory Test Interactions:

Buspirone hydrochloride may interfere with the urinary metanephrite/catecholamine assay. It has been mistakenly read as metanephrite during routine assay testing for pheochromocytoma, resulting in a false positive laboratory result. Buspirone hydrochloride should therefore be discontinued for at least 48 hours prior to undergoing a urine collection for catecholamines.

Carcinogenesis, Mutagenesis, Impairment of Fertility:

No evidence of carcinogenic potential was observed in rats during a 24 month study at approximately 133 times the maximum recommended human oral dose; or in mice, during an 18 month study at approximately 167 times the maximum recommended human oral dose.

With or without metabolic activation, buspirone did not induce point mutations in five strains of *Salmonella typhimurium* (Ames Test) or mouse lymphoma L5178YTK+ cell cultures, nor was DNA

damage observed with buspirone in Wi-38 human cells. Chromosomal aberrations or abnormalities did not occur in bone marrow cells of mice given one or five daily doses of buspirone.

Pregnancy

Teratogenic Effects:

Pregnancy Category B:

No fertility impairment or fetal damage was observed in reproduction studies performed in rats and rabbits at buspirone doses of approximately 30 times the maximum recommended human dose. In humans, however, adequate and well-controlled studies during pregnancy have not been performed. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Labor and Delivery:

The effect of buspirone hydrochloride on labor and delivery in women is unknown. No adverse effects were noted in reproduction studies in rats.

Nursing Mothers:

The extent of the excretion in human milk of buspirone or its metabolites is not known. In rats, however, buspirone and its metabolites are excreted in milk. Buspirone hydrochloride tablets administration to nursing women should be avoided if clinically possible.

Pediatric Use:

The safety and effectiveness of buspirone were evaluated in two placebo-controlled 6 week trials involving a total of 559 pediatric patients (ranging from 6 to 17 years of age) with GAD. Doses studied were 7.5 mg to 30 mg b.i.d. (15 to 60 mg/day). There were no significant differences between buspirone and placebo with regard to the symptoms of GAD following doses recommended for the treatment of GAD in adults. Pharmacokinetic studies have shown that, for identical doses, plasma exposure to buspirone and its active metabolite, 1-PP, are equal to or higher in pediatric patients than adults. No unexpected safety findings were associated with buspirone in these trials. There are no long-term safety or efficacy data in this population.

Geriatric Use:

In one study of 6632 patients who received buspirone for the treatment of anxiety, 605 patients were \geq 65 years old and 41 were \geq 75 years old; the safety and efficacy profiles for these 605 elderly patients (mean age = 70.8 years) were similar to those in the younger population (mean age = 43.3 years). Review of spontaneously reported adverse clinical events has not identified differences between elderly and younger patients, but greater sensitivity of some older patients cannot be ruled out.

There were no effects of age on the pharmacokinetics of buspirone (see CLINICAL PHARMACOLOGY, Special Populations).

Use in Patients With Impaired Hepatic or Renal Function:

Buspirone is metabolized by the liver and excreted by the kidneys. A pharmacokinetic study in patients with impaired hepatic or renal function demonstrated increased plasma levels and a lengthened half-life of buspirone. Therefore, the administration of buspirone hydrochloride tablets to patients with severe hepatic or renal impairment cannot be recommended (see CLINICAL PHARMACOLOGY).

Controlled Substance Class:

Buspirone hydrochloride is not a controlled substance.

Physical and Psychological Dependence:

In human and animal studies, buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. Human volunteers

with a history of recreational drug or alcohol usage were studied in two doubleblind clinical investigations. None of the subjects were able to distinguish between buspirone hydrochloride tablets and placebo. By contrast, subjects showed a statistically significant preference for methaqualone and diazepam. Studies in monkeys, mice, and rats have indicated that buspirone lacks potential for abuse.

Following chronic administration in the rat, abrupt withdrawal of buspirone did not result in the loss of body weight commonly observed with substances that cause physical dependency.

Although there is no direct evidence that buspirone hydrochloride tablets causes physical dependence or drug-seeking behavior, it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone hydrochloride tablets misuse or abuse (e.g., development of tolerance, incrementation of dose, drug-seeking behavior).

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The recommended initial dose is 15 mg daily (7.5 mg b.i.d.). To achieve an optimal therapeutic response, at intervals of 2 to 3 days the dosage may be increased 5 mg per day, as needed. The maximum daily dosage should not exceed 60 mg per day. In clinical trials allowing dose titration, divided doses of 20 mg to 30 mg per day were commonly employed.

The bioavailability of buspirone is increased when given with food as compared to the fasted state (see CLINICAL PHARMACOLOGY). Consequently, patients should take buspirone in a consistent manner with regard to the timing of dosing; either always with or always without food.

When buspirone is to be given with a potent inhibitor of CYP3A4, the dosage recommendations described in the PRECAUTIONS: Drug Interactionssection should be followed.

Buspirone Hydrochloride Tablets USP, 5 mg are white to off-white, capsule-shaped, flat-faced, beveled-edge tablets debossed with bisect on one side; one side of bisect is debossed with 'ZE' and another is debossed with '36' and other side is plain

Patient Instruction Sheet

Buspirone Hydrochloride Tablets, USP

HOW TO USE

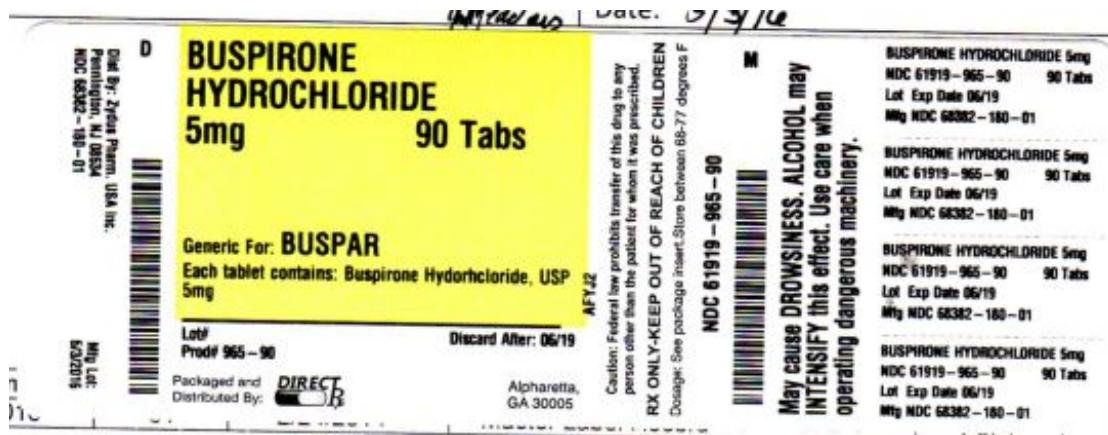
For 15 mg and 30 mg tablets

Response to buspirone varies among individuals. Your physician may find it necessary to adjust your dosage to obtain the proper response.

Each tablet is scored and can be broken accurately to provide any of the following dosages.
Figure

To break a tablet accurately and easily, hold the tablet between your thumbs and index fingers close to the appropriate tablet score (groove) as shown in the photo. Then, with the tablet score facing you, apply pressure and snap the tablet segments apart (segments breaking incorrectly should not be used). figure

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.



BUSPAR

buspirone hydrochloride tablet

Product Information

Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:61919-965(NDC:68382-180)
Route of Administration	ORAL		

Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
BUSPIRONE HYDRO CHLORIDE (UNII: 207LT9J9OC) (BUSPIRONE - UNII:TK65WKS8HL)	BUSPIRONE HYDRO CHLORIDE	5 mg

Inactive Ingredients

Ingredient Name	Strength
LACTOSE MONOHYDRATE (UNII: EWQ57Q8I5X)	
CELLULOSE, MICROCRYSTALLINE (UNII: OP1R32D61U)	
SILICON DIOXIDE (UNII: ETJ7Z6XBU4)	
SODIUM STARCH GLYCOLATE TYPE A POTATO (UNII: 5856J3G2A2)	
MAGNESIUM STEARATE (UNII: 70097M6I30)	

Product Characteristics

Color	white (WHITE (WHITE TO OFF WHITE))	Score	2 pieces
Shape	CAPSULE (CAPSULE (CAPSULE))	Size	8mm
Flavor		Imprint Code	ZE;36
Contains			

Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:61919-965-90	90 in 1 BOTTLE; Type 0: Not a Combination Product	05/03/2016	

Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA078888	05/03/2016	

Labeler - DIRECT RX (079254320)

Establishment

Name	Address	ID/FEI	Business Operations
DIRECT RX		079254320	repack(61919-965)

Revised: 5/2016

DIRECT RX