

## SEROQUEL-Use During Pregnancy and Nursing

### Prescribing Information<sup>1</sup>

SEROQUEL is a psychotropic agent belonging to the dibenzothiazepine chemical class.

#### Indications

SEROQUEL is indicated:

For the short-term treatment of acute manic episodes associated with bipolar I disorder, as either monotherapy or adjunct therapy to lithium or divalproex

For the treatment of schizophrenia

SEROQUEL has been designated a Pregnancy Category C drug by the FDA, indicating that evidence of embryo/fetal toxicity was found in experimental animal models. There are no adequate and well-controlled studies in pregnant women, and quetiapine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Therefore, patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy.

There was no evidence of teratogenicity detected in rats or rabbits when dosed at 0.6-1.8 times the maximum human dose during the period of organogenesis. There was, however, evidence of embryo/fetal toxicity. For complete details, please refer to the enclosed prescribing information.

The effect of quetiapine on labor and delivery in humans is unknown.

Quetiapine was excreted in the milk of treated animals during lactation. It is not known if quetiapine is excreted in human milk. Therefore, patients should be advised not to breast feed if they are taking quetiapine.

Please see the enclosed SEROQUEL Prescribing Information for complete product information.

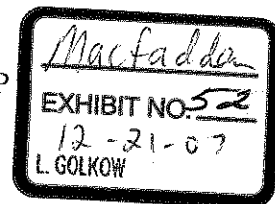
#### **Clinical Data**

It is AstraZeneca policy to provide adverse event information, including information on drug use in pregnancy, primarily from the Prescribing Information and the published literature for our marketed products. We do not provide specific adverse event information from the AstraZeneca Safety database because of the inherent limitations of spontaneous reports. Such limitations include adverse event recognition, underreporting, biases, estimation of patient exposure, report quality, and the lack of established causality of these events.

A search of our internal database of published medical literature identified several case reports pertaining to the use of quetiapine in a pregnant patient with schizophrenia. These cases are summarized below.

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Balke<sup>2</sup> described the case of a 24-year-old woman with a 7-year history of bipolar affective disorder with acute manic episodes, whose disorder only remitted when she complied with her regimen of lithium 1500 mg/day. Because of the associated risk of birth defects, lithium was discontinued when the patient conceived and was replaced with quetiapine 25 mg at bedtime. The patient remained on this low dose throughout her pregnancy with no significant side effects and no deterioration of her condition. Delivery of her baby was uneventful and the baby had no evidence of birth defects. Because of the high rate of relapse in the first month post-partum, the patient was advised to resume taking lithium. However, she chose to continue quetiapine treatment and to breast-feed her baby, despite the lack of information on the secretion of quetiapine in breast milk. The author provided no further information regarding effects in the baby during breast-feeding. The quetiapine dose was increased to 50 mg/day and at the time of this report (6 weeks post-partum), the baby was doing well. The author concluded that while this report of the successful use of quetiapine during pregnancy is encouraging, further studies are necessary to establish the safety and efficacy of quetiapine during pregnancy.

Tenyi and colleagues<sup>3</sup> described the case of a 38-year-old woman with paranoid-type schizophrenia treated with quetiapine 300 mg/day as monotherapy. The patient's pregnancy was discovered at week 17; she was taking quetiapine when her baby was conceived. Because her symptoms had improved significantly, the quetiapine dose was decreased to 200 mg bid at week 20 and further reduced to 150 mg bid at week 22. She was in remission during her pregnancy and experienced no side effects of quetiapine. She gave birth to a healthy boy at week 38 (baby's weight, 3120 g; height, 48 cm). The baby's Apgar score was 9 in the first minute and 10 at 5 minutes. The patient continued taking her medication and did not breastfeed. At time of discharge, the patient and baby were free of neuropsychiatric and perinatal complications. The baby's development was intact during the first 6 months of his life. Please note, the authors stated that the patient's quetiapine dose was 300 mg/day when her pregnancy was discovered and that the dose was later decreased to 200 mg bid and 150 mg bid. There appears to be a potential error in the reporting of the baseline quetiapine dose, since the dose reductions listed were actually dose increases instead of decreases (given a baseline dose of 300 mg/day). A correction has not been published by the journal.

Taylor and colleagues<sup>4</sup> reported the case of a 33-year-old woman who was treated with quetiapine during her pregnancy. The patient experienced a first episode of psychosis, which was treated with risperidone 4 mg/day. However, because of high prolactin levels (1997 mU/l; <550 is normal maximum), her medication was switched to quetiapine 2 weeks later. The patient conceived despite hyperprolactinemia and pregnancy was diagnosed during week 4 of gestation, 2 weeks after starting quetiapine treatment. A collaborative decision was made to have the patient continue taking quetiapine throughout pregnancy because of the level of risk and family history of psychosis. Clinical improvement was monitored using various rating scales, including the Brief Psychiatric Rating Scale (BPRS) and Global Assessment Scale (GAS), at baseline and after 6 weeks, 3 months, and 9 months. BPRS and GAS scores improved, and side effects were negligible. The patient's initial quetiapine maintenance dose was 300 mg/day, which was switched to 200 mg/day at week 21. Four weeks prior to the patient's due date, the dose was decreased by 50 mg/day each week to enable breastfeeding. The patient remained in remission throughout her pregnancy and gave birth to a healthy baby girl (wt=3.61 kg). The

baby's Apgar score was 8 in the first minute and 9 after 5 minutes. No problems developed in the first postpartum month and the patient was able to successfully breastfeed her baby. In addition, there was no exacerbation of psychosis.

Enclosure(s):

- SEROQUEL Prescribing Information

Reference(s):

1. SEROQUEL Prescribing Information
2. Balke LD. Quetiapine is effective in the treatment of bipolar affective disorder during pregnancy [poster]. Presented at: the 7<sup>th</sup> World Congress of Biological Psychiatry; July 1-6, 2001; Berlin, Germany.
3. Tényi T, Trixler M, Keresztes Z. Quetiapine and pregnancy. *Am J Psychiatry* 2002; 159:674.
4. Taylor TM, O'Toole MS, Ohlsen RI, et al. Safety of quetiapine during pregnancy. *Am J Psychiatry*. 2003; 160:3.