

## HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use UNITHROID safely and effectively. See full prescribing information for UNITHROID.

UNITHROID® (levothyroxine sodium) tablets, for oral use

Initial U.S. Approval: 2001

### WARNING: NOT FOR TREATMENT OF OBESITY OR FOR WEIGHT LOSS

See full prescribing information for complete boxed warning.

- Thyroid hormones, including UNITHROID, should not be used for the treatment of obesity or for weight loss.
- Doses beyond the range of daily hormonal requirements may produce serious or even life-threatening manifestations of toxicity (6, 10).

### INDICATIONS AND USAGE

UNITHROID is L-thyroxine (T4) indicated in pediatric and adult patients for:

- Hypothyroidism: As replacement in primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism. (1)
- Pituitary Thyrotropin (Thyroid-Stimulating Hormone, TSH) Suppression: As an adjunct to surgery and radioliodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer. (1)

Limitations of Use:

- Not indicated for suppression of benign thyroid nodules and nontoxic diffuse goiter in iodine-sufficient patients. (1)
- Not indicated for treatment of hypothyroidism during the recovery phase of subacute thyroiditis. (1)

### DOSAGE AND ADMINISTRATION

- Administer once daily, on an empty stomach, one-half to one hour before breakfast with a full glass of water. (2.1)
- Administer at least 4 hours before or after drugs that are known to interfere with absorption. (2.1)
- Evaluate the need for dose adjustments when regularly administering within one hour of certain foods that may affect absorption. (2.1)
- Starting dose depends on a variety of factors, including age, body weight, cardiovascular status, concomitant medical conditions (including pregnancy), concomitant medications, co-administered food, and the specific nature of the condition being treated. Peak therapeutic effect may not be attained for 4 to 6 weeks. (2.2)
- See full prescribing information for dosing in specific patient populations. (2.3)
- Adequacy of therapy determined with periodic monitoring of TSH and/or T4 as well as clinical status. (2.4)

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## FULL PRESCRIBING INFORMATION

### WARNING: NOT FOR TREATMENT OF OBESITY OR FOR WEIGHT LOSS

- Thyroid hormones, including UNITHROID, either alone or with other therapeutic agents, should not be used for the treatment of obesity or for weight loss.
- In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction.
- Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for their anorectic effects [see Adverse Reactions (6), Drug Interactions (7.7), Overdosage (10)].

#### 1 INDICATIONS AND USAGE

##### Hypothyroidism

UNITHROID is indicated in pediatric and adult patients as a replacement therapy in primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism.

##### Pituitary Thyrotropin (Thyroid-Stimulating Hormone, TSH) Suppression

UNITHROID is indicated in pediatric and adult patients as an adjunct to surgery and radioliodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer.

Limitations of Use:

- UNITHROID is not indicated for suppression of benign thyroid nodules and nontoxic diffuse goiter in iodine-sufficient patients as there are no clinical benefits and overtreatment with UNITHROID may induce hypothyroidism [see Warnings and Precautions (5.4)].
- UNITHROID is not indicated for treatment of hypothyroidism during the recovery phase of subacute thyroiditis.

#### 2 DOSAGE AND ADMINISTRATION

##### 2.1 General Administration Information

Administer UNITHROID tablets orally as a single daily dose, on an empty stomach, one-half to one hour before breakfast.

Administer UNITHROID at least 4 hours before or after drugs that are known to interfere with UNITHROID absorption [see Drug Interactions (7.1)].

Evaluate the need for dose adjustments when regularly administering within one hour of certain foods that may affect UNITHROID absorption [see Drug Interactions (7.9), Clinical Pharmacology (12.3)].

Administer UNITHROID to infants and children who cannot swallow intact tablets by crushing the tablet, suspending the freshly crushed tablet in a small amount (5 mL to 10 mL or 1 teaspoon to 2 teaspoons) of water and immediately administering the suspension by spoon or dropper. Do not store the suspension. Do not administer in foods

### DOSAGE FORMS AND STRENGTHS

Tablets: 25 mcg, 50 mcg, 75 mcg, 88 mcg, 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 300 mcg (3)

### CONTRAINDICATIONS

- Uncorrected adrenal insufficiency (4)

### WARNINGS AND PRECAUTIONS

- Cardiac adverse reactions in the elderly and in patients with underlying cardiovascular disease: Initiate UNITHROID at less than the full replacement dose because of the increased risk of cardiac adverse reactions, including atrial fibrillation. (2.3, 5.1, 8.5)
- Myxedema coma: Do not use oral thyroid hormone drug products to treat myxedema coma. (5.2)
- Acute adrenal crisis in patients with concomitant adrenal insufficiency: Treat with replacement glucocorticoids prior to initiation of UNITHROID treatment. (5.3)
- Prevention of hypertthyroidism or incomplete treatment of hypothyroidism: Proper dose titration and careful monitoring is critical to prevent the persistence of hypothyroidism or the development of hypertthyroidism. (5.4)
- Worsening of diabetic control: Therapy in patients with diabetes mellitus may worsen glycemic control and result in increased antidiabetic agent or insulin requirements. Carefully monitor glycemic control after starting, changing, or discontinuing thyroid hormone therapy. (5.5)
- Decreased bone mineral density associated with thyroid hormone over-replacement: Over-replacement can increase bone resorption and decrease bone mineral density. Give the lowest effective dose. (5.6)

### ADVERSE REACTIONS

Common adverse reactions for UNITHROID are primarily those of hyperthyroidism due to therapeutic overdosage: arrhythmias, myocardial infarction, dyspnea, muscle spasm, headache, nervousness, irritability, insomnia, tremors, muscle weakness, increased appetite, weight loss, diarrhea, heat intolerance, menstrual irregularities, and skin rash (6)

To report SUSPECTED ADVERSE REACTIONS, contact Anneal Pharmaceuticals at 1-877-835-5472 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

### DRUG INTERACTIONS

See full prescribing information for drugs that affect thyroid hormone pharmacokinetics and metabolism (e.g., absorption, synthesis, secretion, catabolism, protein binding, and target tissue response) and may alter the therapeutic response to UNITHROID (7)

### USE IN SPECIFIC POPULATIONS

Pregnancy may require the use of higher doses of levothyroxine (2.3, 8.1)

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that decrease absorption of UNITHROID, such as soybean-based infant formula [see Drug Interactions (7.9)].

#### 2.2 General Principles of Dosing

The dose of UNITHROID for hypothyroidism or pituitary TSH suppression depends on a variety of factors including: the patient's age, body weight, cardiovascular status, concomitant medical conditions (including pregnancy), concomitant medications, co-administered food and the specific nature of the condition being treated [see Dosage and Administration (2.3), Warnings and Precautions (5), Drug Interactions (7)]. Dosing must be individualized to account for these factors and dose adjustments made based on periodic assessment of the patient's clinical response and laboratory parameters [see Dosage and Administration (2.4)].

The peak therapeutic effect of a given dose of UNITHROID may not be attained for 4 to 6 weeks.

#### 2.3 Dosing in Specific Populations

##### Primary Hypothyroidism in Adults and in Adolescents in Whom Growth and Puberty Are Complete

Start UNITHROID at the full replacement dose in otherwise healthy, non-elderly individuals who have been hypothyroid for only a short time (such as a few months). The average full replacement dose of UNITHROID is approximately 1.6 mcg per kg per day (for example: 100 mcg per day to 125 mcg per day for a 70 kg adult).

Adjust the dose by 12.5 mcg to 25 mcg increments every 4 to 6 weeks until the patient is clinically euthyroid and the serum TSH returns to normal. Doses greater than 200 mcg per day are seldom required. An inadequate response to daily doses of greater than 300 mcg per day is rare and may indicate poor compliance, malabsorption, drug interactions, or a combination of these factors.

For elderly patients or patients with underlying cardiac disease, start with a dose of 12.5 mcg to 25 mcg per day. Increase the dose every 6 to 8 weeks, as needed until the patient is clinically euthyroid and the serum TSH returns to normal. The full replacement dose of UNITHROID may be less than 1 mcg per kg per day in elderly patients.

In patients with severe longstanding hypothyroidism, start with a dose of 12.5 mcg to 25 mcg per day. Adjust the dose in 12.5 mcg to 25 mcg increments every 2 to 4 weeks until the patient is clinically euthyroid and the serum TSH level is normalized.

##### Secondary or Tertiary Hypothyroidism

Start UNITHROID at the full replacement dose in otherwise healthy, non-elderly individuals who have been hypothyroid for only a short time, patients with underlying cardiovascular disease or patients with severe longstanding hypothyroidism as described above. Serum TSH is not a reliable measure of UNITHROID dose adequacy in patients with secondary or tertiary hypothyroidism and should not be used to monitor therapy. Use the serum free-T4 level to monitor adequacy of therapy in this patient population. Titrate UNITHROID dosing per above instructions until the patient is clinically euthyroid and the serum free-T4 level is restored to the upper half of the normal range.

### Pediatric Dosage - Congenital or Acquired Hypothyroidism

The recommended daily dose of UNITHROID in pediatric patients with hypothyroidism is based on body weight and changes with age as described in Table 1. Start UNITHROID at the full daily dose in most pediatric patients. Start at a lower starting dose in newborns (0 to 3 months) at risk for cardiac failure and in children at risk for hyperactivity (see below). Monitor for clinical and laboratory response [see Dosage and Administration (2.4)].

#### Table 1: UNITHROID Dosing Guidelines for Pediatric Hypothyroidism

Age	Daily Dose Per Kg Body Weight <sup>a</sup>
0 to 3 months	10 mcg/kg daily to 15 mcg/kg daily
3 to 6 months	8 mcg/kg daily to 10 mcg/kg daily
6 to 12 months	6 mcg/kg daily to 8 mcg/kg daily
1 to 5 years	5 mcg/kg to 6 mcg/kg daily
6 to 12 years	4 mcg/kg to 5 mcg/kg daily
Greater than 12 years but growth and puberty incomplete	2 mcg/kg to 3 mcg/kg daily
Growth and puberty complete	1.6 mcg/kg daily

<sup>a</sup> - The dose should be adjusted based on clinical response and laboratory parameters [see Warnings and Precautions (5.4), Drug Interactions (7.10)]. Use In Specific Populations (8.4).

#### Newborns (0 to 3 months) at Risk for Cardiac Failure:

Consider a lower starting dose in newborns at risk for cardiac failure. Increase the dose every 4 to 6 weeks as needed based on clinical and laboratory response.

#### Pediatric Patients at Risk for Hyperactivity:

To minimize the risk of hyperactivity in pediatric patients, start at one-fourth the recommended full replacement dose, and increase on a weekly basis by one-fourth the full recommended replacement dose until the full recommended replacement dose is reached.

#### Pregnancy

Pre-existing Hypothyroidism: UNITHROID dose requirements may increase during pregnancy. Measure serum TSH and free-T4 as soon as pregnancy is confirmed, and, at minimum, during each trimester of pregnancy. In patients with primary hypothyroidism, maintain serum TSH in the trimester-specific reference range. For patients with serum TSH above the normal trimester-specific range, increase the dose of UNITHROID by 12.5 mcg daily to 25 mcg daily and measure TSH every 4 weeks until a stable UNITHROID dose is reached and serum TSH is within the normal trimester-specific range. Reduce UNITHROID dosage to pre-pregnancy levels immediately after delivery and measure serum TSH levels 4 to 8 weeks postpartum to ensure UNITHROID dose is appropriate.

New Onset Hypothyroidism: Normalize thyroid function as rapidly as possible. In patients with moderate to severe signs and symptoms of hypothyroidism, start UNITHROID at the full replacement dose (1.6 mcg per kg body weight per day). In patients with mild hypothyroidism (TSH less than 10 mIU per liter) start UNITHROID at 1 mcg per kg body weight per day. Evaluate serum TSH every 4 weeks and adjust UNITHROID dosage until a serum TSH is within the normal trimester specific range [see Use in Specific Populations (8.1)].

#### TSH Suppression in Well-Differentiated Thyroid Cancer

The dose of UNITHROID should target TSH levels within the desired therapeutic range. This may require a UNITHROID dose of greater than 2 mcg per kg per day, depending on the target level for TSH suppression.

#### 2.4 Monitoring TSH and/or Thyroxine (T4) Levels

Assess the adequacy of therapy by periodic assessment of laboratory tests and clinical evaluation. Persistent clinical and laboratory evidence of hypothyroidism despite an apparent adequate replacement dose of UNITHROID may be evidence of inadequate absorption, poor compliance, drug interactions, or a combination of these factors.

#### Adults

In adult patients with primary hypothyroidism, monitor serum TSH levels after an interval of 6 to 8 weeks after any change in dose. In patients on a stable and appropriate replacement dose, evaluate clinical and biochemical response every 6 to 12 months and whenever there is a change in the patient's clinical status.

#### Pediatrics

In patients with congenital hypothyroidism, assess the adequacy of replacement therapy by measuring both serum TSH and total or free-T. Monitor TSH and total or free-T4 in children as follows: 2 and 4 weeks after the initiation of treatment, 2 weeks after any change in dosage, and then every 3 to 12 months thereafter following dose stabilization until growth is completed. Poor compliance or abnormal values may necessitate more frequent monitoring. Perform routine clinical examination, including assessment of development, mental and physical growth, and bone maturation, at regular intervals.

While the general aim of therapy is to normalize the serum TSH level, TSH may not normalize in some patients due to *in utero* hypothyroidism causing a resetting of pituitary-thyroid feedback. Failure of the serum T4 to increase into the upper half of the normal range within 2 weeks of initiation of UNITHROID therapy and/or of the serum TSH to decrease below 20 mIU per liter within 4 weeks may indicate the child is not receiving adequate therapy. Assess compliance, dose of medication administered, and method of administration prior to increasing the dose of UNITHROID [see Warnings and Precautions (5.1), Use in Specific Populations (8.4)].

#### Secondary and Tertiary Hypothyroidism

Monitor serum free-T4 levels and maintain in the upper half of the normal range in these patients.

### DOSAGE FORMS AND STRENGTHS

UNITHROID tablets are round and color-coded available as follows:

Strength (mcg)	Color	Tablet Markings
25	Peach	JSP / 513
50	White	JSP / 514
75	Purple	JSP / 515
88	Olive	JSP / 561
100	Yellow	JSP / 516
112	Rose	JSP / 562
125	Tan	JSP / 519
137	Blue	JSP / 564
150	Light Blue	JSP / 520
175	Lilac	JSP / 563
200	Pink	JSP / 522
300	Green	JSP / 523

### 4 CONTRAINDICATIONS

UNITHROID is contraindicated in patients with uncorrected adrenal insufficiency [see Warnings and Precautions (5.3)].

### 5 WARNINGS AND PRECAUTIONS

#### 5.1 Cardiac Adverse Reactions in the Elderly and in Patients with Underlying Cardiovascular Disease

Overtreatment with levothyroxine may cause an increase in heart rate, cardiac wall thickness, and cardiac contractility and may precipitate angina or arrhythmias, particularly in patients with cardiovascular disease and in elderly patients. Initiate UNITHROID therapy in this population at lower doses than those recommended in younger individuals or in patients without cardiac disease [see Dosage and Administration (2.3), Use in Specific Populations (8.5)].

Monitor for cardiac arrhythmias during surgical procedures in patients with coronary artery disease receiving suppressive UNITHROID therapy. Monitor patients receiving concomitant UNITHROID and sympathomimetic agents for signs and symptoms of coronary insufficiency. If cardiovascular symptoms develop or worsen, reduce or withhold the UNITHROID dose for one week and restart at a lower dose.

#### 5.2 Myxedema Coma

Myxedema coma is a life-threatening emergency characterized by poor circulation and hypometabolism, and may result in unpredictable absorption of levothyroxine sodium from the gastrointestinal tract. Use of oral thyroid hormone drug products is not recommended to treat myxedema coma. Administer thyroid hormone products formulated for intravenous administration to treat myxedema coma.

#### 5.3 Acute Adrenal Crisis in Patients with Concomitant Adrenal Insufficiency

Thyroid hormone increases metabolic clearance of glucocorticoids. Initiation of thyroid hormone therapy prior to initiating glucocorticoid therapy may precipitate an acute adrenal crisis in patients with adrenal insufficiency. Treat patients with adrenal insufficiency with replacement glucocorticoids prior to initiating treatment with UNITHROID [see Contraindications (4)].

#### 5.4 Prevention of Hypertthyroidism or Incomplete Treatment of Hypothyroidism

UNITHROID has a narrow therapeutic index. Over- or under-treatment with UNITHROID may have negative effects on growth and development, cardiovascular function, bone metabolism, reproductive function, cognitive function, emotional state, gastrointestinal function, and on glucose and lipid metabolism. Titrate the dose of UNITHROID carefully and monitor response to titration to avoid these effects [see Dosage and Administration (2.4)]. Monitor for the presence of drug or food interactions when using UNITHROID and adjust the dose as necessary [see Drug Interactions (7), Clinical Pharmacology (12.3)].

#### 5.5 Worsening of Diabetic Control

Addition of levothyroxine therapy in patients with diabetes mellitus may worsen glycemic control and result in increased antidiabetic agent or insulin requirements. Carefully monitor glycemic control after starting, changing, or discontinuing UNITHROID [see Drug Interactions (7.2)].

#### 5.6 Decreased Bone Mineral Density Associated with Thyroid Hormone Over-Replacement

Increased bone resorption and decreased bone mineral density may occur as a result of levothyroxine over-replacement, particularly in post-menopausal women. The increased bone resorption may be associated with increased serum levels and urinary excretion of calcium and phosphorus, elevations in bone alkaline phosphatase, and suppressed serum parathyroid hormone levels. Administer the minimum dose of UNITHROID that achieves the desired clinical and biochemical response to mitigate against this risk.

### 6 ADVERSE REACTIONS

Common adverse reactions with UNITHROID therapy are primarily those of hyperthyroidism due to therapeutic overdosage [see Warnings and Precautions (5.4), Overdosage (10)]. They include the following:

**General:** fatigue, increased appetite, weight loss, heat intolerance, fever, excessive sweating

**Central nervous system:** headache, hyperactivity, nervousness, anxiety, irritability, emotional lability, insomnia

**Musculoskeletal:** tremors, muscle weakness and cramps

**Cardiovascular:** palpitations, tachycardia, arrhythmias, increased pulse and blood pressure, heart failure, angina, myocardial infarction, cardiac arrest

**Respiratory:** dyspnea

**Gastrointestinal:** diarrhea, vomiting, abdominal cramps, elevations in liver function tests

**Dermatologic:** hair loss, flushing

**Endocrine:** decreased bone mineral density

**Reproductive:** menstrual irregularities, impaired fertility

Seizures have been reported rarely with levothyroxine therapy.

**Adverse Reactions in Pediatric Patients**

Pseudotumor cerebri and slipped capital femoral epiphysis have been reported in pediatric patients receiving levothyroxine therapy. Overtreatment may result in craniosynostosis in infants and premature closure of the epiphyses in pediatric patients with resultant compromised adult height.

#### Hypersensitivity Reactions

Hypersensitivity reactions to inactive ingredients have occurred in patients treated with thyroid hormone products. These include urticaria, pruritus, skin rash, flushing, angioedema, various gastrointestinal symptoms (abdominal pain, nausea, vomiting and diarrhea), fever, arthralgia, serum sickness and wheezing. Hypersensitivity to levothyroxine itself is not known to occur.

### 7 DRUG INTERACTIONS

**7.1 Drugs Known to Affect Thyroid Hormone Pharmacokinetics**  
Many drugs can exert effects on thyroid hormone pharmacokinetics (e.g., absorption, synthesis, secretion, catabolism, protein binding, and target tissue response) and may alter the therapeutic response to UNITHROID (see Tables 2 - 5).

#### Table 2: Drugs That May Decrease T4 Absorption (Hypothyroidism)

Potential impact: Concurrent use may reduce the efficacy of UNITHROID by binding and delaying or preventing absorption, potentially resulting in hypothyroidism.

Drug or Drug Class	Effect
Calcium Carbonate Ferrous Sulfate	Calcium carbonate may form an insoluble chelate with levothyroxine, and ferrous sulfate likely forms a ferric-thyroxine complex. Administer UNITHROID at least 4 hours apart from these agents.
Orlistat	Monitor patients treated concomitantly with orlistat and UNITHROID for changes in thyroid function.
Bile Acid Sequestrants - Colesevelam - Cholestyramine - Colestipol Ion Exchange Resins - Kayexalate - Sevelamer	Bile acid sequestrants and ion exchange resins are known to decrease levothyroxine absorption. Administer UNITHROID at least 4 hours prior to these drugs or monitor thyrotropin-stimulating hormone (TSH) levels.
Other drugs: Proton Pump Inhibitors Succralfate Antacids - Aluminum & Magnesium Hydroxides - Simethicone	Gastric acidity is an essential requirement for adequate absorption of levothyroxine. Succralfate, antacids and proton pump inhibitors may cause hypochlorhydria, affect intragastric pH, and reduce levothyroxine absorption. Monitor patients appropriately.

**Table 3: Drugs That May Alter T and Triiodothyronine (T3) Serum Transport Without Affecting Free Thyroxine (FT4) Concentration (Euthyroidism)**

Drug or Drug Class	Effect
Clofibrate Estrogen-containing oral contraceptives Estrogens (oral) Heroin / Methadone 5-Fluorouracil Mitotane Tamoxifen	These drugs may increase serum thyroxine-binding globulin (TBG) concentration.
Androgens / Anabolic Steroids Asparaginase Glucocorticoids Slow-Release Nicotinic Acid	These drugs may decrease serum TBG concentration.

Potential impact (below): Administration of these agents with UNITHROID results in an initial transient increase in FT4. Continued administration results in a decrease in serum T4 and normal FT4 and TSH concentrations.

Salicylates (>2 g/day)	Salicylates inhibit binding of T4 and T3 to TBG and transthyretin. An initial increase in serum FT4 is followed by return of FT4 to normal levels with sustained therapeutic serum salicylate concentrations, although total T4 levels may decrease by as much as 30%.
Other drugs: Carbamazepine Furosemide (>80 mg IV) Heparin Hydantoin Non-Steroidal Anti-inflammatory Drugs - Fenamates	These drugs may cause protein-binding site displacement. Furosemide has been shown to inhibit the protein binding of T4 to TBG and albumin, causing an increased free-T4 fraction in serum. Furosemide competes for T4-binding sites on TBG, prealbumin, and albumin, so that a single high dose can acutely lower the total T4 level. Phenytoin and carbamazepine reduce serum protein binding of levothyroxine, and total and FT4 may be reduced by 20% to 40%, but most patients have normal serum TSH levels and are clinically euthyroid. Closely monitor thyroid hormone parameters.

**Table 4: Drugs That May Alter Hepatic Metabolism of T4 (Hypothyroidism)**

Potential impact: Stimulation of hepatic microsomal drug-metabolizing enzyme activity may cause increased hepatic degradation of levothyroxine, resulting in increased UNITHROID requirements.

Drug or Drug Class	Effect
Phenobarbital Rifampin	Phenobarbital has been shown to reduce the response to thyroxine. Phenobarbital increases L-thyroxine metabolism by inducing uridine 5'-diphospho-glucuronosyltransferase (UGT) and leads to a lower T4 serum levels. Changes in thyroid status may occur if barbiturates are added or withdrawn from patients being treated for hypothyroidism. Rifampin has been shown to accelerate the metabolism of levothyroxine.

**Table 5: Drugs That May Decrease Conversion of T4 to T3**

Potential impact: Administration of these enzyme inhibitors decreases the peripheral conversion of T4 to T3, leading to decreased T3 levels. However, serum T4 levels are usually normal but may occasionally be slightly increased.

Drug or Drug Class	Effect
Beta-adrenergic antagonists (e.g., Propranolol >160 mg/day)	In patients treated with large doses of propranolol (>160 mg/day), T3 and T4 levels change slightly. TSH levels remain normal, and patients are clinically euthyroid. It should be noted that actions of particular beta-adrenergic antagonists may be impaired when the hypothyroid patient is converted to the euthyroid state.
Glucocorticoids (e.g., Dexamethasone ≥4 mg/day)	Short-term administration of large doses of glucocorticoids may decrease serum T3 concentrations by 30% with minimal change in serum T4 levels. However, long-term glucocorticoid therapy may result in slightly decreased T3 and T4 levels due to decreased TBG production (see above).
Other: Amiodarone	Amiodarone inhibits peripheral conversion of levothyroxine (T4) to triiodothyronine (T3) and may cause isolated biochemical changes (increase in serum free-T4, and decreased or normal free-T3) in clinically euthyroid patients.

## 7.2 Antidiabetic Therapy

Addition of UNITHROID therapy in patients with diabetes mellitus may worsen glycemic control and result in increased antidiabetic agent or insulin requirements. Carefully monitor glycemic control, especially when UNITHROID is started, changed, or discontinued [see *Warnings and Precautions (5.5)*].

## 7.3 Oral Anticoagulants

UNITHROID increases the response to oral anticoagulant therapy. Therefore, a decrease in the dose of anticoagulant may be warranted with correction of the hypothyroid state or when the UNITHROID dose is increased. Closely monitor coagulation tests to permit appropriate and timely dosage adjustments.

## 7.4 Digitalis Glycosides

UNITHROID may reduce the therapeutic effects of digitalis glycosides. Serum digitalis glycoside levels may be decreased when a hypothyroid patient becomes euthyroid, necessitating an increase in the dose of digitalis glycosides.

## 7.5 Antidepressant Therapy

Concurrent use of tricyclic (e.g., amitriptyline) or tetracyclic (e.g., maprotiline) antidepressants and UNITHROID may increase the therapeutic and toxic effects of both drugs, possibly due to increased receptor sensitivity to catecholamines. Toxic effects may include increased risk of cardiac arrhythmias and central nervous system stimulation. UNITHROID may accelerate the onset of action of tricyclics. Administration of sertraline in patients stabilized on UNITHROID may result in increased UNITHROID requirements.

## 7.6 Ketamine

Concurrent use of ketamine and UNITHROID may produce marked hypertension and tachycardia. Closely monitor blood pressure and heart rate in these patients.

## 7.7 Sympathomimetics

Concurrent use of sympathomimetics and UNITHROID may increase the effects of sympathomimetics or thyroid hormone. Thyroid hormones may increase the risk of coronary insufficiency when sympathomimetic agents are administered to patients with coronary artery disease.

## 7.8 Tyrosine-Kinase Inhibitors

Concurrent use of tyrosine-kinase inhibitors such as imatinib may cause hypothyroidism. Closely monitor TSH levels in these patients.

## 7.9 Drug-Food Interactions

Consumption of certain foods may affect UNITHROID absorption thereby necessitating adjustments in dosing [see *Dosage and Administration (2.1)*]. Soybean flour (infant formula), cotton seed meal, walnuts, and dietary fiber may bind and decrease the absorption of UNITHROID from the GI tract. Grapefruit juice may delay the absorption of levothyroxine and reduce its bioavailability.

## 7.10 Drug-Laboratory Test Interactions

Consider changes in TBG concentration when interpreting T4 and T3 values. Measure and evaluate unbound (free) hormone and/or determine the free T4 index (FT4I) in this circumstance. Pregnancy, infectious hepatitis, estrogens, estrogen-containing oral contraceptives, and acute intermittent porphyria increase TBG concentrations. Nephrosis, severe hypoproteinemia, severe liver disease, acromegaly, androgens and corticosteroids decrease TBG concentration. Familial hyper- or hypo-thyroxine binding globulinemias have been described, with the incidence of TBG deficiency approximating 1 in 9000.

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

#### Risk Summary

Experience with levothyroxine use in pregnant women, including data from post-marketing studies, have not reported increased rates of major birth defects or miscarriages (see *Data*). There are risks to the mother and fetus associated with untreated hypothyroidism in pregnancy. Since thyroid-stimulating hormone (TSH) levels may increase during pregnancy, TSH should be monitored and UNITHROID dosage adjusted during pregnancy (see *Clinical Considerations*). There are no animal studies conducted with levothyroxine during pregnancy. UNITHROID should not be discontinued during pregnancy and hypothyroidism diagnosed during pregnancy should be promptly treated.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively.

#### Clinical Considerations

##### Disease-Associated Maternal and/or Embryo/Fetal Risk

Maternal hypothyroidism during pregnancy is associated with a higher rate of complications, including spontaneous abortion, gestational hypertension, pre-eclampsia, stillbirth, and premature delivery. Untreated maternal hypothyroidism may have an adverse effect on fetal neurocognitive development.

##### Dose Adjustments During Pregnancy and the Postpartum Period

Pregnancy may increase UNITHROID requirements. Serum TSH level should be monitored and the UNITHROID dosage adjusted during pregnancy. Since postpartum TSH levels are similar to preconception values, the UNITHROID dosage should return to the pre-pregnancy dose immediately after delivery [see *Dosage and Administration (2.3)*].

#### Data

##### Human Data

Levothyroxine is approved for use as a replacement therapy for hypothyroidism. There is a long experience of levothyroxine use in pregnant women, including data from post-marketing studies that have not reported increased rates of fetal malformations, miscarriages or other adverse maternal or fetal outcomes associated with levothyroxine use in pregnant women.

## 8.2 Lactation

#### Risk Summary

Limited published studies report that levothyroxine is present in human milk. However, there is insufficient information to determine the effects of levothyroxine on the breastfed infant and no available information on the effects of levothyroxine on milk production. Adequate levothyroxine treatment during lactation may normalize milk production in hypothyroid lactating mothers. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for UNITHROID and any potential adverse effects on the breastfed infant from UNITHROID or from the underlying maternal condition.

## 8.4 Pediatric Use

The initial dose of UNITHROID varies with age and body weight. Dosing adjustments are based on an assessment of the individual patient's clinical and laboratory parameters [see *Dosage and Administration (2.3, 2.4)*].

In children in whom a diagnosis of permanent hypothyroidism has not been established, discontinue UNITHROID for a trial period, but only after the child is at least 3 years of age. Obtain serum T4 and TSH levels at the end of the trial period, and use laboratory test results and clinical assessments to guide diagnosis and treatment, if warranted.

### Congenital Hypothyroidism [see *Dosage and Administration (2.3, 2.4)*]

Rapid restoration of normal serum T4 concentrations is essential for preventing the adverse effects of congenital hypothyroidism on intellectual development as well as on overall physical growth and maturation. Therefore, initiate UNITHROID therapy immediately upon diagnosis. Levothyroxine is generally continued for life in these patients.

Closely monitor infants during the first 2 weeks of UNITHROID therapy for cardiac overload, arrhythmias, and aspiration from avid suckling.

Closely monitor patients to avoid undertreatment or overtreatment. Undertreatment may have deleterious effects on intellectual development and linear growth. Overtreatment is associated with craniosynostosis in infants, may adversely affect the tempo of brain maturation, and may accelerate the bone age and result in premature epiphyseal closure and compromised adult stature.

### Acquired Hypothyroidism in Pediatric Patients

Closely monitor patients to avoid undertreatment and overtreatment. Undertreatment may result in poor school performance due to impaired concentration and slowed mentation and in reduced adult height. Overtreatment may accelerate the bone age and result in premature epiphyseal closure and compromised adult stature.

Treated children may manifest a period of catch-up growth, which may be adequate in some cases to normalize adult height. In children with severe or prolonged hypothyroidism, catch-up growth may not be adequate to normalize adult height.

## 8.5 Geriatric Use

Because of the increased prevalence of cardiovascular disease among the elderly, initiate UNITHROID at less than the full replacement dose [see *Dosage and Administration (2.3)*, *Warnings and Precautions (5.1)*]. Atrial arrhythmias can occur in elderly patients. Atrial fibrillation is the most common of the arrhythmias observed with levothyroxine overtreatment in the elderly.

## 10 OVERDOSAGE

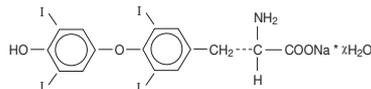
The signs and symptoms of overdosage are those of hyperthyroidism [see *Warnings and Precautions (5.4)*, *Adverse Reactions (6)*]. In addition, confusion and disorientation may occur. Cerebral embolism, shock, coma, and death have been reported. Seizures occurred in a 5-year-old child ingesting 3.6 mg of levothyroxine. Symptoms may not necessarily be evident or may not appear until several days after ingestion of levothyroxine sodium.

Reduce the UNITHROID dose or temporarily discontinue if signs or symptoms of overdosage occur. Initiate appropriate supportive treatment as dictated by the patient's medical status.

For current information on the management of poisoning or overdosage, contact the National Poison Control Center at 1-800-222-1222 or www.poisson.org.

## 11 DESCRIPTION

UNITHROID contains the active ingredient, levothyroxine, a synthetic crystalline levothyroxine (T4) in sodium salt form. It is chemically designated as L-3,3',5,5'-tetraiodothyronine monosodium hydrate. Synthetic T4 is identical in chemical structure to the T4 produced in the human thyroid gland. Levothyroxine sodium has an empirical formula of C<sub>15</sub>H<sub>11</sub>I<sub>4</sub>N<sub>2</sub>O<sub>4</sub> • H<sub>2</sub>O, molecular weight of 798.85 g/mol (anhydrous), and structural formula as shown:



UNITHROID tablets for oral administration are supplied in the following strengths: 25 mcg, 50 mcg, 75 mcg, 88 mcg, 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg and 300 mcg.

### Inactive Ingredients

Acacia, colloidal silicon dioxide, corn starch, lactose, magnesium stearate, microcrystalline cellulose, and sodium starch glycolate. The following are the coloring additives per tablet strength:

Strength (mcg)	Color additive(s)
25	FD&C Yellow No. 6 Aluminum Lake
50	None
75	FD&C Red No. 40 Aluminum Lake, FD&C Blue No. 2 Aluminum Lake
88	D&C Yellow No. 10 Aluminum Lake, FD&C Yellow No. 6 Aluminum Lake, FD&C Blue No. 1 Aluminum Lake
100	D&C Yellow No. 10 Aluminum Lake, FD&C Yellow No. 6 Aluminum Lake
112	D&C Red No. 27 Aluminum Lake
125	FD&C Yellow No. 6 Aluminum Lake, FD&C Red No. 40 Aluminum Lake, FD&C Blue No. 1 Aluminum Lake
137	FD&C Blue No. 1 Aluminum Lake
150	FD&C Blue No. 2 Aluminum Lake
175	FD&C Blue No. 10 Aluminum Lake, D&C Red No. 27 Aluminum Lake
200	FD&C Red No. 40 Aluminum Lake
300	FD&C Yellow No. 10 Aluminum Lake, FD&C Yellow No. 6 Aluminum Lake, FD&C Blue No. 1 Aluminum Lake

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Thyroid hormones exert their physiologic actions through control of DNA transcription and protein synthesis. Triiodothyronine (T3) and L-thyroxine (T4) diffuse into the cell nucleus and bind to thyroid receptor proteins attached to DNA. This nuclear hormone receptor complex activates gene transcription and synthesis of messenger RNA and cytoplasmic proteins.

The physiological actions of thyroid hormones are produced predominantly by T3, the majority of which (approximately 80%) is derived from T4 by deiodination in peripheral tissues.

### 12.2 Pharmacodynamics

Oral levothyroxine sodium is a synthetic T4 hormone that exerts the same physiologic effect as endogenous T4, thereby maintaining normal T4 levels when a deficiency is present.

### 12.3 Pharmacokinetics

#### Absorption

Absorption of orally administered T4 from the gastrointestinal tract ranges from 40% to 90%. The majority of the levothyroxine dose is absorbed from the jejunum and upper ileum. The relative bioavailability of UNITHROID tablets, compared to an equal nominal dose of oral levothyroxine sodium solution, is approximately 97 to 99%. T4 absorption is increased by fasting, and decreased in malabsorption syndromes and by certain foods such as soybeans. Dietary fiber decreases bioavailability of T4. Absorption may also decrease with age. In addition, many drugs and foods affect T4 absorption [see *Drug Interactions (7)*].

#### Distribution

Circulating thyroid hormones are greater than 99% bound to plasma proteins, including thyroxine-binding globulin (TBG), thyroxine-binding prealbumin (TBPA), and thyroxine-binding albumin (TBA), whose capacities and affinities vary for each hormone. The higher affinity of both TBG and TBPA for T4 partially explains the higher serum levels, slower metabolic clearance, and longer half-life of T4 compared to T3. Protein-bound thyroid hormones exist in reverse equilibrium with small amounts of free hormone. Only unbound hormone is metabolically active. Many drugs and physiologic conditions affect the binding of thyroid hormones to serum proteins [see *Drug Interactions (7)*]. Thyroid hormones do not readily cross the placental barrier [see *Use in Specific Populations (8.1)*].

#### Elimination

##### Metabolism

T4 is slowly eliminated (Table 6). The major pathway of thyroid hormone metabolism is through sequential deiodination. Approximately 80% of circulating T3 is derived from peripheral T4 by monodeiodination. The liver is the major site of degradation for both T4 and T3, with T4 deiodination also occurring at a number of additional sites, including the kidney and other tissues. Approximately 80% of the daily dose of T4 is deiodinated to yield equal amounts of T3 and reverse T3 (rT3). T3 and rT3 are further deiodinated to diiodothyronine. Thyroid hormones are also metabolized via conjugation with glucuronides and sulfates and excreted directly into the bile and gut where they undergo enterohepatic recirculation.

##### Excretion

Thyroid hormones are primarily eliminated by the kidneys. A portion of the conjugated hormone reaches the colon unchanged and is eliminated in the feces. Approximately 20% of T4 is eliminated in the stool. Urinary excretion of T4 decreases with age.

**Table 6: Pharmacokinetic Parameters of Thyroid Hormones in Euthyroid Patients**

Hormone	Ratio in Thyroglobulin	Biologic Potency	t½ (days)	Protein Binding (%) <sup>2</sup>
Levothyroxine (T4)	10-20	1	6-7 <sup>1</sup>	99.96
Liothyronine (T3)	1	4	≤ 2	99.5

<sup>1</sup> 3 to 4 days in hyperthyroidism, 9 to 10 days in hypothyroidism

<sup>2</sup> Includes TBG, TBPA, and TBA

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Animal studies have not been performed to evaluate the carcinogenic potential, mutagenic potential or effects on fertility of levothyroxine sodium.

## 16 HOW SUPPLIED/STORAGE AND HANDLING

UNITHROID (levothyroxine sodium) tablets are round and color-coded available as follows:

Strength (mcg)	Color	Tablet Markings	NDC - bottles of 100
25	Peach	JSP / 513	NDC 60846-801-01
50	White	JSP / 514	NDC 60846-802-01
75	Purple	JSP / 515	NDC 60846-803-01
88	Olive	JSP / 561	NDC 60846-804-01
100	Yellow	JSP / 516	NDC 60846-805-01
112	Rose	JSP / 562	NDC 60846-806-01
125	Tan	JSP / 519	NDC 60846-807-01
137	Blue	JSP / 564	NDC 60846-808-01
150	Light Blue	JSP / 520	NDC 60846-809-01
175	Lilac	JSP / 563	NDC 60846-810-01
200	Pink	JSP / 522	NDC 60846-811-01
300	Green	JSP / 523	NDC 60846-812-01

### STORAGE CONDITIONS

Store between 20°C-25°C (68°F-77°F) with excursions permitted between 15°C-30°C (59°F-86°F).

## 17 PATIENT COUNSELING INFORMATION

### Dosing and Administration

- Instruct patients to take UNITHROID only as directed by their healthcare provider.
- Instruct patients to take UNITHROID as a single dose, preferably on an empty stomach, one-half to one hour before breakfast with a full glass of water to avoid choking or gagging.
- Inform patients that agents such as iron and calcium supplements and antacids can decrease the absorption of levothyroxine. Instruct patients not to take UNITHROID tablets within 4 hours of these agents.
- Instruct patients to notify their healthcare provider should they become pregnant or breastfeeding or are thinking of becoming pregnant, while taking UNITHROID.

### Important Information

- Inform patients that it may take several weeks before they notice an improvement in symptoms.
- Inform patients that the levothyroxine in UNITHROID is intended to replace a hormone that is normally produced by the thyroid gland. Generally, replacement therapy is to be taken for life.
- Inform patients that UNITHROID should not be used as a primary or adjunctive therapy in a weight control program.
- Instruct patients to notify their healthcare provider if they are taking any other medications, including prescription and over-the-counter preparations.
- Instruct patients to notify their healthcare provider of any other medical conditions you may have, particularly heart disease, diabetes, clotting disorders, and adrenal or pituitary gland problems as the dose of medications used to control these other conditions may need to be adjusted while taking UNITHROID. If you have diabetes, instruct patients to monitor their blood and/or urinary glucose levels as directed by their physician and immediately report any changes to their physician. If patients are taking anticoagulants, their clotting status should be checked frequently.
- Instruct patients to notify their physician or dentist if they are taking UNITHROID prior to any surgery.

### Adverse Reactions

- Instruct patients to notify their healthcare provider if they experience any of the following symptoms: rapid or irregular heartbeat, chest pain, shortness of breath, leg cramps, headache, nervousness, irritability, sleeplessness, tremors, change in appetite, weight gain or loss, vomiting, diarrhea, excessive sweating, heat intolerance, fever, changes in menstrual periods, hives or skin rash, or any other unusual medical event.
- Inform patients that partial hair loss may occur rarely during the first few months of UNITHROID therapy; this is usually temporary.

Manufactured by:

**Jerome Stevens Pharmaceuticals, Inc.**

Bohemia, NY 11716

Distributed by:

**Anneal Specialty, a division of Anneal Pharmaceuticals LLC**

Bridgewater, NJ 08807

Revised: 06/2019