# Luvox

## (fluvoxamine)

**Luvox** (fluvoxamine); not controlled; brand discontinued, generic only

| Full Prescribing Information | DailyMed Drug Information |
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# Summary

Luvox is a selective serotonin reuptake inhibitor whose only approved use is obsessive-compulsive disorder, indicated down to 8 years of age. The brand is discontinued, and the two generic forms are not interchangeable: the immediate-release tablet holds the pediatric indication, while the extended-release capsule has never been evaluated in children. Potent CYP1A2 inhibition gives it the largest interaction burden of any SSRI here. Not controlled; generic only.

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# Forms & Strengths

- **Immediate-release tablets** (pediatric-indicated, from 8 years): 25 mg, 50 mg, 100 mg
- **Extended-release capsules** (never evaluated in children, adults only): 100 mg, 150 mg
- No oral liquid or chewable form

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# Dosing

- **Age:**
  - Immediate-release tablets, OCD: 8 y/o and older, and adults
  - Extended-release capsules: adults only; never evaluated in pediatric patients
  - Not approved below 8 y/o, or for any indication other than OCD
- **Onset:** 1 to 2 weeks for early effect; 10 weeks for full response
- **Duration:** continuous with daily dosing; half-life 15.6 hours
- **Initial Dose:**
  - 8 to 17 y/o: 25 mg once daily at bedtime
  - Adults: 50 mg once daily at bedtime

- **Titration:**
  - 8 to 17 y/o: 25 mg every 4 to 7 days as tolerated
  - Adults: 50 mg every 4 to 7 days as tolerated
- **Max Dose:**
  - 8 to 11 y/o: 200 mg/day
  - 12 to 17 y/o: 300 mg/day, the adult maximum
  - Adults: 300 mg/day
- **Considerations:** These are immediate-release tablet doses; the extended-release capsule is not pediatric and starts at 100 mg. Split pediatric totals above 50 mg, adult totals above 100 mg, larger dose at bedtime. Titrate a girl more slowly than a boy.

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# Pharmacology

- **Mechanism:** potent serotonin reuptake inhibitor with no significant histaminergic, adrenergic, muscarinic or dopaminergic affinity
- **Delivery / Release:** immediate-release tablet; bioavailability 53%, unaffected by food; half-life 15.6 hours, shortest of the youth SSRIs
- **Metabolism:** hepatic to inactive metabolites; NONLINEAR kinetics over 100 to 300 mg/day. Clearance falls 30% in hepatic dysfunction, rises 25% in smokers.
- **Class Positioning:** enzyme inhibition, not receptor pharmacology, separates it from every other SSRI. A POTENT CYP1A2 inhibitor, it also inhibits CYP2C9, CYP3A4 and CYP2C19.
- **Versus siblings:** four outright drug contraindications no other SSRI carries

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# Indications

- **Obsessive-compulsive disorder** (ICD-10: F42.x): immediate-release tablets, 8 y/o and older, plus adults
- **Obsessive-compulsive disorder, adults only** (ICD-10: F42.x): extended-release capsules, never evaluated in children
- **No other approved indication at any age**; not approved for depression in the United States

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# Off-Label Uses

- **Pediatric anxiety disorders** (ICD-10: F93.0, F40.1, F41.1): CLASS-level support only; AHRQ graded SSRIs moderate to high. (AHRQ 2017)
- **Depression in youth** (ICD-10: F32.x, F33.x), **autism repetitive behaviours** (F84.0), **ADHD** (F90.x), and pediatric use of the extended-release capsule: all insufficient

- **Choosing among pediatric OCD agents:** AACAP makes CBT first line, adding medication for moderate to severe illness, with little evidence separating SSRIs. (AACAP 2011)

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# Contraindications & Warnings

- **Boxed Warning:** Suicidal thoughts and behaviors. Antidepressants increased this risk in children, adolescents and young adults. Observe closely for clinical worsening and suicidality, especially early and at dose changes; the label's stated interval is DAILY family observation with communication to the prescriber. Write the smallest quantity of tablets consistent with good patient management.
- **Contraindicated:**
  - **Tizanidine:** AUC rose about 33-fold, dropping systolic pressure a mean 35 mm Hg.
  - **Thioridazine:** concentrations triple, causing QTc prolongation, torsades and sudden death.
  - **Alosetron:** AUC rose 6-fold. **Pimozide:** QT prolongation and fatal torsades.
  - **MAOIs**, including linezolid and methylene blue: current use or within 14 days, either direction.
- **Use with caution:**
  - Known or suspected bipolar disorder; manic reactions hit 4% in the pediatric OCD trial.
  - Any seizure disorder; avoid in unstable epilepsy, stop if seizures increase.
  - Hyponatremia risk with diuretics; bleeding risk with aspirin, NSAIDs or anticoagulants; untreated narrow angles.
  - Hepatic impairment: lower the start, lengthen the interval.
  - Any narrow-window substrate: warfarin, theophylline, omeprazole, phenytoin.
- **Screen before starting:**
  - The medication list against CYP1A2, CYP3A4, CYP2C9 and CYP2C19 substrates; four agents are contraindicated.
  - Bipolar and seizure history, baseline suicidality, height and weight, and smoking status.
  - Confirmation the prescription reads immediate-release TABLETS, not capsules.

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# Drug Interactions

- **Contraindicated:** tizanidine, thioridazine, alosetron, pimozide, and MAOIs within 14 days. Choose another agent.
- **Potent CYP1A2 inhibition is the defining hazard.** Review the medication list for substrates before writing it and at every visit.
- **Viloxazine** (Qelbree): the likeliest collision in an ADHD practice; itself a strong CYP1A2 inhibitor, so combining stacks two potent inhibitors.

- **Ramelteon** AUC rose 190-fold; do not combine. **Theophylline:** cut to one third, monitor levels.
- **Warfarin** rose 98%; **tricyclics**, **carbamazepine**, **clozapine**, **propranolol** and **methadone** rise. Monitor levels; adjust methadone when fluvoxamine starts AND stops.
- **Benzodiazepines:** halve the alprazolam start, avoid diazepam; lorazepam and oxazepam are unaffected.
- **Other serotonergic drugs** (SNRIs, triptans, opioids, lithium, amphetamines): additive serotonin syndrome risk. Quitting smoking raises levels.

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# Administration

- Give at bedtime as one dose while the total is 50 mg or less in a child, 100 mg or less in an adult.
- Above those thresholds divide into two doses, the larger at bedtime. Give with or without food.
- Tablets must be swallowed; the 25 mg is unscored, thinly stocked.
- Never substitute extended-release capsules under 18: never evaluated in children, and its lowest strength, 100 mg, is four times the pediatric start.
- Titrate a girl more slowly than a boy the same age; girls reach benefit at lower doses.
- Missed dose: same day only, never doubled. Never stop abruptly.

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# Side Effects

- **Common:** nausea at about 40%, the commonest reason a child stops early, plus headache, somnolence, insomnia, dry mouth, nervousness, diarrhea and tremor; in children also emotional lability, hyperkinesia, ecchymosis and epistaxis
- **Serious:**
  - Suicidal thoughts and behavior: the boxed warning. Reassess early and at each dose change.
  - Serotonin syndrome: stop fluvoxamine and every serotonergic drug immediately.
  - Manic or hypomanic switch, 4% in the pediatric OCD trial: stop rather than titrating through.
  - Seizures, hyponatremia as SIADH, bleeding up to life-threatening haemorrhage.
  - Angle closure glaucoma, priapism, sexual dysfunction, weight loss. Ask directly and plot growth.

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# Monitoring & Labs

- **Suicidality:** daily family observation, plus clinician assessment of ideation and behaviour at every contact for 3 months and at every dose change.
- **Medication reconciliation:** recheck the full list at EVERY visit against CYP1A2, CYP3A4, CYP2C9 and CYP2C19 substrates. The highest-yield task.
- **Activation and mania:** ask during titration and every 3 months once stable about reduced sleep need, pressured speech and hyperactivity.
- **Growth:** height and weight charted at baseline, quarterly for a year, then twice yearly.
- **Sodium, bleeding, seizures:** check sodium for new headache or confusion; ask about bruising, nosebleeds and convulsions.
- **Interacting-drug levels:** check any narrow-window co-drug at baseline and 1 week post-change.
- **Response:** reassess with the same instrument at 10 weeks.

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# Discontinuation & Taper

- Do not stop abruptly; reduce gradually and monitor for discontinuation symptoms.
- Discontinuation syndrome: dysphoric mood, irritability, agitation, dizziness, electric shock sensations, headache, insomnia.
- Taper matters more here than for most SSRIs. Slow it as the dose gets small.
- If intolerable symptoms follow a decrease, resume the previous dose and go slower. Exception: emergent suicidality, where the label directs tapering as fast as feasible.
- Adjust methadone when fluvoxamine comes off. No drug holidays.

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# Pregnancy & Lactation

- **Pregnancy:** observational data show no clear risk of major birth defects or miscarriage. Risks: persistent pulmonary hypertension of the newborn, poor neonatal adaptation, a less than 2-fold rise in postpartum hemorrhage.
- **Fertility:** animal findings suggest impaired fertility on treatment. Weigh risk against relapse.
- **Lactation:** relative infant dose roughly 1%; maternal doses up to 300 mg daily are not expected to cause adverse effects, and not a reason to stop nursing. (LactMed 2026)
- **Infant monitoring:** watch for diarrhea, vomiting, poor sleep and agitation. (LactMed 2026)
- **Exposure Registry:** National Pregnancy Registry for Antidepressants, 1-844-405-6185, womensmentalhealth.org

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# Counseling Points

- **Counsel the family on:**
  - The tablet and the capsule not being the same medicine. If the pharmacy hands over capsules, call first.
  - Nausea being the commonest problem, worst in the first two weeks; food and slower titration, not stopping.
  - Bedtime dosing at 50 mg or less, splitting above that with the larger half at bedtime.
  - Bringing every new medicine to you first, over-the-counter included; this one changes how the body handles others.
  - Watching daily, early and after dose changes, for agitation, emotional swings or self-harm talk; never stopping abruptly; 10 weeks being the decision point.
- **Advise them to call for:**
  - New or worsening self-harm talk, or a sudden mood or behaviour change.
  - Several nights of almost no sleep, or pressured speech.
  - Agitation with fever, shivering, twitching or stiffness; same-day call.
  - Nosebleeds that will not stop, unusual bruising, or blood in vomit or stool.
  - Headache with confusion or unsteadiness, which can be low sodium.
  - A seizure, an erection over 4 hours, or sudden eye pain.

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