Skeletal Muscle Relaxants
Therapeutic Class Review (TCR)

December 3, 2012

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**FDA-APPROVED INDICATIONS**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Manufacturer</th>
<th>Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>baclofen (Fleqsuvy™)†</td>
<td>Azurity</td>
<td>For the treatment of spasticity resulting from multiple sclerosis (MS), particularly for the relief of flexor spasms and concomitant pain, clonus, and muscular rigidity. May also be of some value in patients with spinal cord injuries and other spinal cord diseases.</td>
</tr>
<tr>
<td>baclofen (Lioresal®)2</td>
<td>generic</td>
<td>For the alleviation of signs and symptoms of spasticity resulting from MS, particularly for the relief of flexor spasms, concomitant pain, clonus, and muscular rigidity.</td>
</tr>
<tr>
<td>baclofen (Lyvispah™)†</td>
<td>Saol</td>
<td>For the treatment of spasticity resulting from MS, particularly for the relief of flexor spasms and concomitant pain, clonus, and muscular rigidity. May also be of some value in patients with spinal cord injuries and other spinal cord diseases.</td>
</tr>
<tr>
<td>baclofen (Ozobax™)4</td>
<td>Metacel</td>
<td>For the treatment of spasticity resulting from MS, particularly for the relief of flexor spasms and concomitant pain, clonus, and muscular rigidity. May also be of some value in patients with spinal cord injuries and other spinal cord diseases.</td>
</tr>
<tr>
<td>carisoprodol (Soma®)5</td>
<td>generic, Meda</td>
<td></td>
</tr>
<tr>
<td>carisoprodol compound or carisoprodol and aspirin6</td>
<td>generic</td>
<td>As an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.</td>
</tr>
<tr>
<td>chlorzoxazone7 (Parafon Forte® DSC)</td>
<td>generic</td>
<td></td>
</tr>
<tr>
<td>chlorzoxazone8 (Lorzone™)</td>
<td>Vertical</td>
<td></td>
</tr>
<tr>
<td>cyclobenzaprine (Flexeril®)9</td>
<td>generic</td>
<td>Hudson Scientific, Casper</td>
</tr>
<tr>
<td>cyclobenzaprine (Cyclotens™, Fexmid®)10, 11, 12</td>
<td>generic</td>
<td></td>
</tr>
<tr>
<td>dantrolene sodium (Dantrium®)*14</td>
<td>generic</td>
<td>For the control of clinical spasticity resulting from upper motor neuron disorders such as spinal cord injury, stroke, cerebral palsy, or multiple sclerosis.</td>
</tr>
<tr>
<td>metaxalone (Skelaxin®)15</td>
<td>generic</td>
<td>As an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.</td>
</tr>
<tr>
<td>methocarbamol (Robaxin®)16</td>
<td>generic</td>
<td>As an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.</td>
</tr>
<tr>
<td>methocarbamol/aspirin17</td>
<td>generic</td>
<td>As an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.</td>
</tr>
<tr>
<td>orphenadrine citrate18</td>
<td>generic</td>
<td>As an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.</td>
</tr>
<tr>
<td>orphenadrine compound or orphenadrine/aspirin/caffeine (Norgesic Forte)19, 20</td>
<td>generic, Poly Pharmaceuticals</td>
<td>Symptomatic relief of mild to moderate pain of acute musculoskeletal disorders.</td>
</tr>
<tr>
<td>tizanidine (Zanaflex®)21</td>
<td>generic, Acor da/Covis</td>
<td>For the acute and intermittent management of increased muscle tone associated with spasticity.</td>
</tr>
</tbody>
</table>

† Fleqsuvy, Lyvispah, and Ozobax are not indicated in the treatment of skeletal muscle spasm resulting from rheumatic disorders.
* Oral Dantrium is also indicated preoperatively to prevent or attenuate the development of signs of malignant hyperthermia in known, or strongly suspect, malignant hyperthermia susceptible patients who require anesthesia and/or surgery.

**OVERVIEW**

Skeletal muscle relaxants are FDA-approved to treat two different types of conditions: muscular pain or spasms from peripheral musculoskeletal conditions and spasticity from upper motor neuron syndromes. Both conditions affect patients' mobility and affect independence in activities of daily living and work.

Spasticity is a condition in which muscles are continuously contracted causing stiffness or tightness which may interfere with movement and speech. It is usually caused by damage to the portion of the brain or spinal cord that controls voluntary movement. Spasticity is a major health concern and can be associated with a number of disease entities such as spinal cord injury, multiple sclerosis, traumatic brain injury, cerebral palsy, and stroke. Symptoms may include hypertonicity, clonus, exaggerated deep tendon reflexes, muscle spasms, scissoring, and fixed joints. The degree of spasticity varies from mild muscle stiffness to severe, painful, and uncontrolable muscle spasms. Spasticity may cause decreased range of motion, contractures, sleep disorders, and impaired ambulation.

Common musculoskeletal conditions associated with muscle spasms include low back pain, neck pain, tension headaches, and myofascial pain syndrome. Hypertonicity and hyperreflexia are not present as with upper motor neuron syndromes. These conditions can cause significant disability and pain.

The 2005 Multiple Sclerosis Council for Clinical Practice Guidelines for spasticity management in multiple sclerosis included the oral skeletal muscle relaxant agents baclofen and tizanidine, as effective first-line treatment options. Generally, skeletal muscle relaxants are administered orally. Baclofen can be administered intrathecally, and orphenadrine can be administered either intravenously (IV) or intramuscularly (IM). Only the oral agents are included in this review.
## PHARMACOLOGY

<table>
<thead>
<tr>
<th><strong>Drug</strong></th>
<th><strong>Mechanism of Action</strong></th>
</tr>
</thead>
</table>
| baclofen (Fleqsyv, Lioresal, Lyvispa, Ozobax) | - Inhibits monosynaptic and polysynaptic reflexes at the spinal level by hyperpolarization of afferent terminals  
- Additionally acts at supraspinal sites  
- Has general central nervous system (CNS) depressant properties |
| carisoprodol (Soma) | - In animals, it produces muscle relaxation by blocking interneuronal activity in the descending reticular formation and spinal cord. |
| carisoprodol compound or carisoprodol and aspirin | - Carisoprodol, in animals, produces muscle relaxation by blocking interneuronal activity in the descending reticular formation and spinal cord.  
- Aspirin is a non-narcotic analgesic with anti-inflammatory activity. Inhibition of prostaglandin biosynthesis appears to account for most of its anti-inflammatory and for at least part of its analgesic properties. |
| chlorzoxazone | - Acts primarily at the spinal cord level and subcortical areas of the brain, inhibiting multisynaptic reflex arcs involved in producing and maintaining skeletal muscle spasm of varied etiology |
| cyclobenzaprine (Flexeril, Fexmid) | - Relieves skeletal muscle spasm of local origin without interfering with muscle function  
- Ineffective in muscle spasm due to CNS disease |
| dantrolene sodium (Dantrium) | - In isolated nerve-muscle preparation, dantrolene produced relaxation by affecting contractile response of the skeletal muscle at a site beyond the myoneural junction and directly on the muscle itself.  
- In skeletal muscle, dantrolene dissociates the excitation-contraction coupling, probably by interfering with the release of calcium from the sarcoplasmic reticulum.  
- Does not appear to directly affect the CNS; the extent of its indirect effect is unknown |
| methocarbamol (Robaxin) | - May be caused by general CNS depression  
- The drug has no direct action on the contractile mechanism of striated muscle, the motor endplate, or the nerve fiber. |
| methocarbamol/aspirin | - May be caused by general CNS depression  
- Methocarbamol has no direct action on the contractile mechanism of striated muscle, the motor endplate, or the nerve fiber.  
- Aspirin is a non-narcotic analgesic with anti-inflammatory activity. Inhibition of prostaglandin biosynthesis appears to account for most of its anti-inflammatory and for at least part of its analgesic properties. |
| orphenadrine citrate | - Acts centrally at the brain stem  
- Does not directly relax tense skeletal muscles  
- Possesses anticholinergic actions |
| orphenadrine compound or orphenadrine/aspirin/caffeine (Norgesic Forte) | - Orphenadrine acts centrally at the brain stem.  
- Orphenadrine does not directly relax tense skeletal muscles.  
- Orphenadrine possesses anticholinergic actions.  
- Aspirin is a non-narcotic analgesic with anti-inflammatory activity. Inhibition of prostaglandin biosynthesis appears to account for most of its anti-inflammatory and for at least part of its analgesic properties.  
- Caffeine increases levels of intracellular cyclic-AMP. |
| tizanidine (Zanaflex) | - Agonist at alpha₂-adrenergic receptor sites  
- Reduces spasticity by increasing presynaptic inhibition of motor neurons |
### PHARMACOKINETICS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Half-Life (hours)</th>
<th>Metabolites</th>
<th>Major Route of Elimination</th>
</tr>
</thead>
<tbody>
<tr>
<td>baclofen (Fleqsuvy)</td>
<td>5.6</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>baclofen (Lioresal)</td>
<td>2 - 4</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>baclofen (Lyvispah)</td>
<td>5.5</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>baclofen (Ozobax)</td>
<td>5.7</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>carisoprodol (Soma)</td>
<td>1</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>carisoprodol/aspirin (Soma Compound)</td>
<td>15.5</td>
<td>3-7 hours (several metabolites)</td>
<td>kidney and liver</td>
</tr>
<tr>
<td>chlorzoxazone (Parafon Forte DSC, Lorzone)</td>
<td>1</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>cyclobenzaprine (Flexeril, Fexmid)</td>
<td>18</td>
<td>several metabolites</td>
<td>kidney</td>
</tr>
<tr>
<td>cyclobenzaprine ER (Amrix)</td>
<td>32</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>dantrolene sodium (Dantrium)</td>
<td>8.7</td>
<td>5-hydroxy dantrolene acetylamino</td>
<td>kidney</td>
</tr>
<tr>
<td>metaxalone (Skelaxin)</td>
<td>8-9</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>methocarbamol (Robaxin)</td>
<td>1-2</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>methocarbamol/aspirin</td>
<td>1-2 (methocarbamol)</td>
<td>--</td>
<td>kidney</td>
</tr>
<tr>
<td>orphenadrine citrate</td>
<td>14-16 (orphenadrine)</td>
<td>8 metabolites</td>
<td>kidney</td>
</tr>
<tr>
<td>orphenadrine/aspirin/caffeine (Norgesic Forte)</td>
<td>15.5</td>
<td>3-7 hours (several metabolites)</td>
<td>kidney, liver and kidney</td>
</tr>
<tr>
<td>tizanidine (Zanaflex)</td>
<td>2.5</td>
<td>--</td>
<td>kidney</td>
</tr>
</tbody>
</table>

### CONTRAINDICATIONS/WARNINGS

Dantrolene (Dantrium) labeling has a black box warning regarding a potential for hepatotoxicity. The incidence of symptomatic hepatitis (fatal and nonfatal) reported in patients taking up to 400 mg per day is much lower than in those taking ≥ 800 mg per day. Even sporadic short courses of the higher dose levels within a treatment regimen markedly increased the risk of serious hepatic injury. Liver dysfunction, as evidenced by liver enzyme elevations, has been observed in patients exposed to the drug for varying periods of time. Overt hepatitis has been most frequently observed between the third and twelfth months of therapy. Risk of hepatic injury appears to be greater in females, in patients >35
years of age, and in patients taking other medications in addition to dantrolene. If no observable benefit is derived from therapy after 45 days, discontinue use.

Dantrolene is not for use where spasticity is utilized to sustain upright balance/posture in ambulation or when spasticity is utilized to obtain or maintain increased function.

Baclofen (Fleqsuvy, Lyvispah, Ozobax) is contraindicated in patients with hypersensitivity to baclofen. Baclofen (Fleqsuvy, Lioresal, Lyvispah, Ozobax) dose should be reduced slowly when discontinuing, as hallucinations and seizures have occurred on abrupt withdrawal of the drug. In patients with epilepsy, the clinical state and electroencephalogram (EEG) should be monitored at regular intervals, since deterioration in seizure control and EEG have been reported occasionally in patients taking baclofen. Infants born to mothers who received oral baclofen during pregnancy have experienced neonatal withdrawal symptoms (e.g., tremor, jitteriness, seizure) hours to days following birth; if required during pregnancy, decrease the dose slowly and discontinue prior to delivery. Due to the potential for drowsiness and sedation, patients should not operate automobiles or machinery until the effects of baclofen are known; CNS depression can be additive if taken concurrently with alcohol or other CNS depressants. Baclofen has the potential to cause exacerbations of psychotic disorders, schizophrenia, and confusional states; it also can exacerbate autonomic dysreflexia. It is poorly tolerated in stroke patients and should be used with caution in patients where spasticity is used to maintain upright posture and balance or to increase function. Ovarian cysts have occurred in MS patients receiving baclofen; in most patients, the cysts spontaneously resolved during continued use of baclofen.

Carisoprodol containing products are contraindicated in patients with a history of acute intermittent porphyria. The active metabolite of carisoprodol is meprobamate, a controlled substance. Post marketing cases of dependence, withdrawal, and abuse have been reported with prolonged usage. Carisoprodol has sedative effects which may impair the mental and/or physical abilities needed for the performance of potentially hazardous tasks, and there have been post-marketing reports of motor vehicle accidents associated with its use.

Rare but serious hepatocellular toxicity has been reported with the use of chlorzoxazone.

Cyclobenzaprine (Flexeril, Fexmid, Amrix) is contraindicated in patients with hyperthyroidism, congestive heart failure, during the acute recovery phase of myocardial infarction, and in patients with arrhythmias and heart block conduction disturbances. Incidences of hyperpyretic crisis seizures and deaths have occurred in patients receiving cyclobenzaprine concomitantly with monoamine oxidase (MAO) inhibitors. Use of cyclobenzaprine in patients with moderate to severe hepatic function impairment is not recommended. Cyclobenzaprine ER capsules (Amrix) should not be used in the elderly or in patients with hepatic impairment. Because of its atropine-like action, use cyclobenzaprine with caution in patients with a history of urinary retention, angle-closure glaucoma or increased intraocular pressure, and in patients taking anticholinergic medication. Because of its atropine-like action, use cyclobenzaprine with caution in patients with a history of urinary retention, angle-closure glaucoma or increased intraocular pressure, and in patients taking anticholinergic medication. 71

Metaxalone (Skelaxin) is contraindicated in drug-induced, hemolytic or other anemias, and in significantly impaired renal or hepatic function.

Orphenadrine-containing products (Norgesic Forte) are contraindicated in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy or obstruction of the bladder neck, and myasthenia gravis.
Aspirin is contraindicated in patients who are hypersensitive to salicylates or nonsteroidal anti-inflammatory drugs (NSAIDs), children or teenagers with influenza, chickenpox, or an acute febrile illness due to possible development of Reye's syndrome, and bleeding disorders. Aspirin is also contraindicated in patients with a serious GI complication (e.g., bleeding, perforations, obstruction) due to aspirin use or aspirin induced asthma.

Tizanidine (Zanaflex) is primarily metabolized by CYP1A2; therefore, concomitant use with ciprofloxacin (Cipro®) or fluvoxamine is contraindicated. Tizanidine occasionally causes liver injury, most often hepatocellular in type. In controlled clinical studies, approximately five percent of patients treated with tizanidine had elevations of liver function tests [alanine aminotransferase (ALT), aspartate aminotransferase (AST)] to greater than three times the upper limit of normal (or two times if baseline levels were elevated), compared with 0.4 percent in control patients. Most cases resolved rapidly upon drug withdrawal, with no reported residual problems. Tizanidine use has been associated with hallucinations. Upon discontinuation, especially in patients who have been receiving high doses for long periods, decrease the dose slowly to minimize the risk of withdrawal and rebound hypertension, tachycardia, and hypertonia.

**DRUG INTERACTIONS**

Caution should be used with all skeletal muscle relaxants when used concurrently with other CNS depressants, barbiturates, or alcohol since the sedative effects may be additive.

Cyclobenzaprine (Flexeril, Fexmid, Amrix) may have life-threatening interactions with MAO inhibitors. MAO inhibitor should be discontinued at least 14 days before starting cyclobenzaprine. Cyclobenzaprine may enhance the seizure risk in patients taking tramadol.

Concomitant use of carisoprodol containing products with CYP2C19 inhibitors, omeprazole or fluvoxamine (Luvox®, Luvox® CR), may increase carisoprodol levels and decrease those of the active metabolite, meprobamate. The impact of these drug interactions is unknown. Coadministration of CYP2C19 inducers, such as rifampin or St. John's wort, with carisoprodol-containing products could result in decreased exposure of carisoprodol and increased exposure of meprobamate.

While a definite drug interaction has not yet been established, caution should be observed if dantrolene is given concomitantly with estrogen. Hepatotoxicity has occurred more often in women over 35 years of age receiving concomitant estrogen therapy. Also, plasma protein binding of dantrolene may be reduced in patients taking warfarin.

Methocarbamol may inhibit the effect of pyridostigmine bromide. Use with caution in patients with myasthenia gravis receiving anticholinesterase agents.

Concurrent use of orphenadrine and amantadine has been shown to increase the effect of amantadine. Therapeutic effects of haloperidol and phenothiazines have been decreased with the use of orphenadrine.

Concomitant use of tizanidine with fluvoxamine or ciprofloxacin, potent inhibitors of CYP1A2, is contraindicated due to significant alterations of pharmacokinetic parameters of tizanidine including increased AUC, half-life, Cmax, increased oral bioavailability, and decreased plasma clearance. Because of potential drug interactions, concomitant use of tizanidine with other CYP1A2 inhibitors, such as zileuton, other fluoroquinolones, antiarrhythmic agents (amiodarone, mexiletine, propafenone, and verapamil), cimetidine, famotidine, acyclovir, and ticlopidine should be avoided. Retrospective analysis
of population pharmacokinetic data following single and multiple dose administration of 4 mg
tizanidine, however, showed that women concurrently taking oral contraceptives had 50 percent lower
clearance of tizanidine compared to women not on oral contraceptives.81

**ADVERSE EFFECTS**

All skeletal muscle relaxants have a similar adverse effect profile with somnolence, dizziness, dry
mouth, and asthenia being some of the most commonly reported effects. Each individual agent may
also have additional adverse events based on its structure and mechanism of action.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Asthenia (%)</th>
<th>Dizziness (%)</th>
<th>Dry Mouth (%)</th>
<th>Somnolence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>baclofen (Fleqsuvy, Lioresal, Lyvispah, Ozobax) 82, 83, 84, 85</td>
<td>5-15</td>
<td>5-15</td>
<td>reported</td>
<td>10-63</td>
</tr>
<tr>
<td>carisoprodol (Soma) 86</td>
<td>nr</td>
<td>7-8</td>
<td>nr</td>
<td>13-17</td>
</tr>
<tr>
<td>carisoprodol / aspirin (Soma Compound) 87</td>
<td>nr</td>
<td>reported</td>
<td>nr</td>
<td>reported</td>
</tr>
<tr>
<td>chlorzoxazone (Parafon Forte DSC, Lorzone) 88, 89</td>
<td>nr</td>
<td>reported</td>
<td>nr</td>
<td>reported</td>
</tr>
<tr>
<td>Cyclobenzaprine (Flexeril, Fexmid) 90, 91</td>
<td>reported</td>
<td>19</td>
<td>21-32</td>
<td>39</td>
</tr>
<tr>
<td>cyclobenzaprine ER (Amrix) 92</td>
<td>reported</td>
<td>3-6</td>
<td>6-14</td>
<td>1-2</td>
</tr>
<tr>
<td>dantrolene (Dantrium) 93</td>
<td>reported</td>
<td>reported</td>
<td>nr</td>
<td>reported</td>
</tr>
<tr>
<td>metaxalone (Skelaxin) 94</td>
<td>nr</td>
<td>reported</td>
<td>nr</td>
<td>reported</td>
</tr>
<tr>
<td>methocarbamol (Robaxin) 95</td>
<td>reported</td>
<td>reported</td>
<td>nr</td>
<td>reported</td>
</tr>
<tr>
<td>methocarbamol/aspirin 96</td>
<td>reported</td>
<td>reported</td>
<td>nr</td>
<td>reported</td>
</tr>
<tr>
<td>orphenadrine citrate 97</td>
<td>nr</td>
<td>reported</td>
<td>nr</td>
<td>reported</td>
</tr>
<tr>
<td>orphenadrine / aspirin / caffeine (Norgesic Forte) 98, 99</td>
<td>nr</td>
<td>reported</td>
<td>nr</td>
<td>reported</td>
</tr>
<tr>
<td>tizanidine (Zanaflex) 100</td>
<td>78</td>
<td>16-45</td>
<td>88</td>
<td>92</td>
</tr>
</tbody>
</table>

Adverse effects data are obtained from product package information and therefore, should not be considered comparative or all inclusive. nr = not reported

Tizanidine (Zanaflex) had a 5% incidence in clinical trials of causing increased liver enzymes 3-times the upper limit of normal.101 There have also been 3 deaths from hepatocellular injury in postmarketing reports.

**SPECIAL POPULATIONS**102

**Pediatrics**

Safety and efficacy of carisoprodol-containing products and oral methocarbamol (Robaxin) in pediatric patients < 16 years of age have not been established.103, 104

Safety and efficacy of cyclobenzaprine (Flexeril, Fexmid) in pediatric patients < 15 years of age have not been established.105, 106

Metaxalone (Skelaxin) and baclofen (Fleqsuvy, Lioresal, Lyvispah, Ozobax) use in pediatric patients < 12 years of age have not been established.107, 108, 109, 110, 111, 112
Safety and efficacy of dantrolene sodium (Dantrium) in pediatric patients < 5 years of age have not been established.  

There are no well-controlled studies of safety and efficacy of tizanidine (Zanaflex), cyclobenzaprine ER (Amrix), chlorzoxazone, or orphenadrine-containing products (Norgesic Forte) in children. 

Aspirin-containing products are contraindicated in children or teenagers with influenza, chickenpox, or an acute febrile illness due to possible development of Reye's syndrome. 

**Pregnancy**

Cyclobenzaprine is Pregnancy Category B while baclofen, carisoprodol, chlorzoxazone, dantrolene, orphenadrine, and tizanidine are Pregnancy Category C. Product labeling for the baclofen oral solution (Ozobax), baclofen oral suspension (Fleqsuvy), and baclofen oral granules (Lyvispah) complies with the Pregnancy and Lactation Labeling Rule (PLLR) and does not provide a Pregnancy Category but instead includes descriptive text regarding the risk in pregnant women; there are insufficient data to determine the developmental risk for major birth defects, miscarriages, or other maternal adverse outcomes for Ozobax, Fleqsuvy, or Lyvispah. 

Safety of metaxalone has not been established with regard to possible adverse reactions on fetal development. 

Aspirin is Pregnancy Category D. Avoid aspirin use one week prior to and during labor and delivery because it can result in excessive blood loss at delivery. Prolonged gestation and prolonged labor due to prostaglandin inhibition have been reported.

**DOSAGES**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Initial Dose</th>
<th>Maximum Daily Dose</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>baclofen (Fleqsuvy, Lioresal, Lyvispah, Ozobax)*</td>
<td>5 mg three times daily; may be increased by 5 mg/dose every three days as needed to a max of 80 mg/day</td>
<td>80 mg</td>
<td>10 mg, 20 mg tablets (Lioresal, generic); 5 mg/5 mL oral solution (Ozobax, generic); 25 mg/5 mL oral suspension (Fleqsuvy); 5 mg, 10 mg, 20 mg granule packets (Lyvispah)</td>
</tr>
<tr>
<td>carisoprodol (Soma)†</td>
<td>250 mg to 350 mg three or four times daily; take the last dose at bedtime</td>
<td>1,400 mg</td>
<td>250 mg, 350 mg tablets†</td>
</tr>
<tr>
<td>carisoprodol / aspirin (Soma Compound)†</td>
<td>200 mg/325 mg four times daily</td>
<td>1,600 mg/2,600 mg</td>
<td>200 mg/325 mg tablets</td>
</tr>
<tr>
<td>chlorzoxazone (Parafon Forte DSC, Lorzone)</td>
<td>250 mg to 750 mg three or four times daily (generic, Parafon Forte DSC); 375 mg to 750 mg three or four times daily (Lorzone)</td>
<td>750 mg three or four times daily</td>
<td>500 mg tablets (generic, Parafon Forte DSC); 375 mg, 750 mg (Lorzone)</td>
</tr>
</tbody>
</table>
### Dosages (continued)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Initial Dose</th>
<th>Maximum Daily Dose</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>cyclobenzaprine (Cyclotens, Flexeril)†</td>
<td>5 mg three times daily, may increase to 10 mg three times daily</td>
<td>30 mg</td>
<td>5 mg, 10 mg tablets; Cyclotens Starter Pak contains cyclobenzaprine 10 mg tablets (30 count), a TENS unit, and TENS replacement pads (10 count); Cyclotens Refill Pak contains cyclobenzaprine 10 mg tablets (30 count) and TENS replacement pads (10 count)</td>
</tr>
<tr>
<td>cyclobenzaprine (Fexmid)†</td>
<td>7.5 mg three times daily</td>
<td>--</td>
<td>7.5 mg tablet</td>
</tr>
<tr>
<td>cyclobenzaprine ER (Amrix)†</td>
<td>15 mg daily , may increase to 30 mg daily</td>
<td>--</td>
<td>15 mg, 30 mg capsules</td>
</tr>
<tr>
<td>dantrolene (Dantrium)</td>
<td>Initial dose 25 mg every day; increase at 4 to 7 day intervals to 25 mg twice daily to 4 times daily, up to max 100 mg twice daily to 4 times daily if necessary. Maintain each dosage level for four to seven days to determine response.</td>
<td>400 mg</td>
<td>25 mg, 50 mg, 100 mg capsules</td>
</tr>
<tr>
<td>metaxalone (Skelaxin)</td>
<td>800 mg three or four times daily</td>
<td>--</td>
<td>800 mg tablet</td>
</tr>
<tr>
<td>methocarbamol (Robaxin)</td>
<td>Initial dosage: 3 tablets four times a day. Maintenance dosage: 2 tablets four times a day. Methocarbamol 750 mg tablets: Initial dosage: 2 tablets four times a day. Maintenance dosage: 1 tablet every 4 hours or 2 tablets three times a day.</td>
<td>8 g</td>
<td>500 mg, 750 mg tablets</td>
</tr>
<tr>
<td>methocarbamol/ aspirin</td>
<td>two tablets four times daily</td>
<td>12 tablets</td>
<td>325 mg/400 mg tablets</td>
</tr>
<tr>
<td>orphenadrine citrate</td>
<td>100 mg twice daily</td>
<td>--</td>
<td>100 mg, 100 mg ER tablets</td>
</tr>
<tr>
<td>orphenadrine / aspirin / caffeine (Norgesic Forte)</td>
<td>low strength: one to two tablets three to four times daily high strength: a half or whole tablet three to four times daily</td>
<td>--</td>
<td>25/385/30 mg (generic only), 50/770/60 mg orphenadrine/aspirin/caffeine tablets</td>
</tr>
<tr>
<td>tizanidine (Zanaflex)</td>
<td>4 mg daily, increase dose by 2-4 mg gradually, repeat dose every six to eight hours. Target dose is 8 mg three times daily.</td>
<td>36 mg</td>
<td>4 mg tablets; 2 mg, 4 mg, 6 mg capsules</td>
</tr>
</tbody>
</table>

* Empty Lyvispah packet(s) into the mouth (granules dissolve or can be swallowed) or take with liquids, soft foods, or via feeding tube, as needed*

†Recommended for short-term usage (2 to 4 weeks) because of the lack of evidence of effectiveness for long-term usage.

‡ A generic carisoprodol 350 mg tablet is also available under the trade name Vanadom.
CLINICAL TRIALS

Search Strategy

Articles were identified through searches performed on PubMed and review of information sent by manufacturers. Search strategy included the FDA-approved use of all drugs in this class. Randomized, controlled, comparative trials published in the last 20 years are considered the most relevant in this category. Studies included for analysis in the review were published in English, performed with human participants, and randomly allocated participants to comparison groups. In addition, studies must contain clearly stated, predetermined outcome measure(s) of known or probable clinical importance, use data analysis techniques consistent with the study question, and include follow-up (endpoint assessment) of at least 80 percent of participants entering the investigation. Despite some inherent bias found in all studies including those sponsored and/or funded by pharmaceutical manufacturers, the studies in this therapeutic class review were determined to have results or conclusions that do not suggest systematic error in their experimental study design. While the potential influence of manufacturer sponsorship/funding must be considered, the studies in this review have also been evaluated for validity and importance.

Two consistent limitations appear throughout the controlled studies that have been conducted: the lack of quantitative and sensitive functional assessment and the lack of comparative trials between different agents. In the majority of trials in which meaningful functional assessment was included, the study drug failed to improve function, even though the antispastic action was significant. Placebo-controlled trials of virtually all major centrally acting antispastic agents have shown that sedation, reduction of global performance, and muscle weakness are frequent adverse effects.

No clinical trials were performed for chlorzoxazone (Lorzone). Approval of baclofen oral solution (Ozobax) was based on a bioavailability study conducted in healthy subjects that compared the solution to baclofen oral tablets. Similarly, approval of baclofen oral suspension (Flequvy) and baclofen oral granules (Lyvispah) were based on bioavailability studies performed in healthy subjects that compared the suspension or granules to baclofen oral tablets.

carisoprodol (Soma) and placebo

In a double-blind, multicenter, randomized, placebo-controlled trial, 562 patients were evaluated for efficacy and safety of carisoprodol in the treatment of acute lower back muscle spasm for seven days. Patients were given carisoprodol (n=277) 250 mg three times daily and at bedtime for seven days or placebo (n=285). Carisoprodol was significantly more effective than placebo for patient-rated global impression of change (2.24 versus 1.70; p<0.0001) and patient-rated relief from starting backache (1.83 versus 1.12; p<0.0001). Patients experienced clinical improvement with or without sedation. Onset of moderate or marked improvement was three days with carisoprodol compared to six days with placebo (p<0.0001). No patient discontinued treatment with carisoprodol because of drowsiness. No serious adverse events or clinically significant effects on laboratory values or vital signs were seen in either group.

cyclobenzaprine (Flexeril) and placebo

In two double-blind, placebo-controlled trials, adult patients with acute painful muscle spasm of the lumbar or cervical region were randomized to receive cyclobenzaprine 2.5 mg, 5 mg, 10 mg, or placebo for a total of seven days. Study 1 used cyclobenzaprine 5 mg, 10 mg, or placebo, and study 2 used
cyclobenzaprine 2.5 mg, 5 mg, or placebo. A total of 1,405 patients with a mean age of 42 years were treated. Approximately 89 percent of patients were Caucasian. A total of 737 patients had low back pain, and 668 patients had neck pain. On day seven, significantly more patients receiving cyclobenzaprine 5 mg and 10 mg three times a day had higher mean efficacy score compared with placebo, while cyclobenzaprine 2.5 mg three times a day was not significantly more effective than placebo. Cyclobenzaprine 5 mg was as effective as cyclobenzaprine 10 mg but was associated with less sedation.

**tizanidine (Zanaflex) and baclofen (Lioresal)**

An early double-blind trial compared tizanidine with baclofen in 40 patients with severe disabilities related to multiple sclerosis. Patients were randomized to either treatment for six weeks. The mean dose was 23 mg for tizanidine and 59 mg for baclofen. Similar antispastic effects were observed between the two treatments. Adverse effects of both drugs included sleepiness, muscular weakness, and dry mouth. Sudden discontinuations of either drug resulted in a transient increase in spasticity in approximately half of the patients.

A double-blind study enrolled 100 patients with multiple sclerosis with chronic spasticity to compare the effectiveness of tizanidine and baclofen. Patients were randomized to daily doses of tizanidine 6 mg or baclofen 15 mg. Doses were titrated upward during the first two weeks of therapy to a daily maximum of tizanidine 24 mg or baclofen 60 mg. Optimal doses were administered for six weeks. Efficacy and tolerability were evaluated after two and eight weeks. Both drugs improved functional status of patients in 80 percent (tizanidine) and 76 percent (baclofen) of patients (p=NS). The antispastic efficacy of tizanidine was greater after eight weeks than after two weeks, whereas the efficacy of baclofen decreased slightly with time. Both drugs showed good overall tolerability in more than 60 percent of patients.

Thirty patients with spasticity due to cerebrovascular lesions were enrolled in a double-blind study to compare the efficacy and tolerability of tizanidine and baclofen. Titration occurred over a two-week period for each patient. Maximum doses were tizanidine 20 mg per day and baclofen 50 mg per day. Efficacy and tolerability were assessed monthly, initially, then bimonthly during the 50-week maintenance phase. Both drugs improved the symptoms of spasticity with 87 percent of patients showing an improvement in excessive muscle tone (p<0.01) in the tizanidine group and 79 percent of patients in the baclofen group (p<0.01). Adverse effects were mild and transient with tizanidine, and no patients discontinued therapy. Three patients discontinued baclofen due to severe adverse effects. There were no statistically significant differences between the two drugs.

**META-ANALYSIS**

A comprehensive comparative systematic review of the skeletal muscle relaxants was completed in 2004. A total of 101 randomized trials were included from MEDLINE, Cochrane Library, and Embase searches through January 2003. The purpose of the meta-analysis was to determine if there was evidence that one or more skeletal muscle relaxants is superior to others in efficacy or safety. Of all the randomized trials, none were rated good quality; all studies were poor to fair quality. Populations included adults and pediatric patients with spasticity or a musculoskeletal syndrome. It included the following oral drugs classified as skeletal muscle relaxants: baclofen, carisoprodol (Soma), chlorzoxazone, cyclobenzaprine, dantrolene (Dantrium), metaxalone (Skelaxin), methocarbamol (Robaxin), orphenadrine, and tizanidine (Zanaflex). There is fair evidence that baclofen, tizanidine, and...
dantrolene are effective compared to placebo in patients with spasticity (primarily multiple sclerosis). There is fair evidence that baclofen and tizanidine are roughly equivalent for efficacy in patients with spasticity, but insufficient evidence to determine the efficacy of dantrolene compared to baclofen or tizanidine. Also, fair evidence supports that the overall rate of adverse effects between tizanidine and baclofen are similar. However, tizanidine is associated with more dry mouth, and baclofen is associated with more weakness. Furthermore, there is fair evidence that cyclobenzaprine, carisoprodol, orphenadrine, and tizanidine are effective compared to placebo in patients with musculoskeletal conditions (primarily acute back or neck pain). The review concluded that there was insufficient evidence to determine the relative efficacy or safety of cyclobenzaprine, carisoprodol, orphenadrine, tizanidine, metaxalone, methocarbamol, and chlorzoxazone.

**SUMMARY**

Skeletal muscle relaxants consist of antispasticity and antispasmodic agents, a distinction often overlooked. The antispasticity agents, such as baclofen, tizanidine, and dantrolene, aid in reducing muscle hypertonicity and involuntary jerks. Antispasmodic agents, such as carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol are primarily used to treat musculoskeletal conditions.

Very few comparative studies are available for the skeletal muscle relaxants. Studies are generally not considered of good quality. Overall, there are not enough data to support that the skeletal muscle relaxants have different efficacy or safety. For these agents, the efficacy of the skeletal muscle relaxants is often impacted by the level of adverse effects; therefore, agents must be titrated to produce acceptable benefits while minimizing adverse effects.

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