

## PRODUCT MONOGRAPH

**PrINVEGA\***

paliperidone

Extended-release Tablets  
3 mg, 6 mg and 9 mg

Antipsychotic Agent

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## **PART I: HEALTH PROFESSIONAL INFORMATION**

### **SUMMARY PRODUCT INFORMATION**

<b>Route of Administration</b>	<b>Dosage Form / Strength</b>	<b>Clinically Relevant Nonmedicinal Ingredients</b>
Oral	Extended-release Tablets/3 mg, 6 mg and 9 mg	Lactose <i>For a complete listing see <b>DOSAGE FORMS, COMPOSITION AND PACKAGING</b> section.</i>

### **INDICATIONS AND CLINICAL USE**

INVEGA (paliperidone) is indicated for the treatment of schizophrenia. In controlled clinical trials, INVEGA was found to improve the symptoms of schizophrenia, including positive and negative symptoms.

#### **Geriatrics (> 65 years of age):**

See **WARNINGS AND PRECAUTIONS, Serious Warnings and Precautions Box** and **Special Populations**.

#### **Pediatrics (< 18 years of age):**

The safety and efficacy of INVEGA in children under the age of 18 have not been established.

### **CONTRAINDICATIONS**

INVEGA is contraindicated in patients who are hypersensitive to paliperidone, risperidone, or to any ingredient in the formulation or component of the container. For a complete listing, see the **DOSAGE FORMS, COMPOSITION AND PACKAGING** section of the Product Monograph.

## WARNINGS AND PRECAUTIONS

### Serious Warnings and Precautions

#### Increased Mortality in Elderly Patients with Dementia

**Elderly patients with dementia treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of thirteen placebo-controlled trials with various atypical antipsychotics (modal duration of 10 weeks) in these patients showed a mean 1.6-fold increase in the death rate in the drug-treated patients. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature (see WARNINGS AND PRECAUTIONS, Special Populations, Use in Geriatric Patients with Dementia).**

#### General

##### **QT Prolongation**

Paliperidone causes a modest increase in the corrected QT (QTc) interval. The use of paliperidone should be avoided in combination with other drugs that are known to prolong QTc including Class 1A (e.g., quinidine, procainamide) or Class III (e.g., amiodarone, sotalol) antiarrhythmic medications, antipsychotic medications (e.g., chlorpromazine, thioridazine), antibiotics (e.g., gatifloxacin, moxifloxacin), or any other class of medications known to prolong the QTc interval. Paliperidone should also be avoided in patients with congenital long QT syndrome and in patients with a history of cardiac arrhythmias.

Certain circumstances may increase the risk of the occurrence of torsades de pointes and/or sudden death in association with the use of drugs that prolong the QTc interval, including (1) bradycardia; (2) hypokalemia or hypomagnesemia; (3) concomitant use of other drugs that prolong the QTc interval; and (4) presence of congenital prolongation of the QT interval.

##### **QT Prolongation Study R076477-SCH-1009**

The effects of paliperidone on the QT interval were evaluated in a double-blind, active-controlled (moxifloxacin 400 mg single dose), multicenter QT study in adults with schizophrenia and schizoaffective disorder. Serial ECG assessments were scheduled at multiple days and multiple timepoints during the day. Least square mean changes from baseline in QTcLD were calculated at each scheduled ECG assessment timepoint and day.

In study R076477-SCH-1009 (n = 141), the 8 mg dose of immediate-release oral paliperidone (n=44) showed a maximal (least square) mean change from baseline in QTcLD of 10.9 msec (90% CI:8.24; 13.62) and was noted on day 8 at 1.5 hours post dose. The mean steady-state peak plasma concentration for this 8 mg dose of paliperidone immediate-release was more than twice the exposure observed with the maximum recommended 12 mg dose of INVEGA ( $C_{\max ss} = 113$  and 45 ng/mL, respectively, when administered with a standard breakfast). In this same study, a 4 mg dose of the immediate-release oral formulation of paliperidone ( $C_{\max ss} = 35$  ng/mL) showed a maximal (least square) mean change from baseline in QTcLD of 9.3 msec (90% CI: 6.56; 11.98) and was noted on day 2 at 1.5 hours post-dose. None of the subjects had a change exceeding 60 msec or a QTcLD exceeding 500 msec at any time during this study.

Also, in this study, a 400 mg dose of moxifloxacin (n=58) showed a maximal least square mean change from baseline in QTcLD of 6.1 msec (90% CI: 3.64; 8.53) and was noted on day 8 at 3 hours post-dose. Placebo (n=58) showed a maximal least square mean change from baseline in QTcLD of 3.5 msec (90% CI: 1.05; 5.95) and was noted on day 2 at 30 minutes post-dose.

### **Concomitant Use of INVEGA with Oral Risperidone**

Since paliperidone (9-hydroxy-risperidone) is the major active metabolite of risperidone, concomitant use of INVEGA with oral risperidone is not recommended since the combination of the two will lead to additive paliperidone exposure.

### **Body Temperature Regulation**

Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing INVEGA to patients who will be experiencing conditions which may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration.

### **Carcinogenesis and Mutagenesis**

For animal data, see *Product Monograph Part II: TOXICOLOGY*.

### **Cardiovascular**

#### **Orthostatic Hypotension**

Paliperidone may induce orthostatic hypotension in some patients based on its alpha-blocking activity. Based on pooled data from the three placebo-controlled, 6-week, fixed-dose trials with INVEGA (3, 6, 9 and 12 mg), orthostatic hypotension was reported by 2.5% of subjects treated with INVEGA compared with 0.8% of subjects treated with placebo.

INVEGA should be used with caution in patients with known cardiovascular disease (e.g., heart failure, myocardial infarction or ischemia, conduction abnormalities), cerebrovascular disease or conditions that predispose the patient to hypotension such as dehydration and hypovolemia. Special care should be taken to avoid hypotension in patients with a history of cerebrovascular insufficiency or ischemic heart disease, and in patients taking medications to lower blood pressure.

### **Endocrine and Metabolism**

#### **Hyperglycemia**

Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with all atypical antipsychotics. These cases were, for the most part, seen in post-marketing clinical use and epidemiologic studies, and not in clinical trials.

In clinical trials, there have been few reports of glucose-related adverse events (e.g., hyperglycemia) in subjects treated with INVEGA.

Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies, which did not include INVEGA, suggest an increased risk of treatment-emergent hyperglycemia-related adverse

events in patients treated with the atypical antipsychotics. Because INVEGA was not marketed at the time these studies were performed, it is not known if INVEGA is associated with this increased risk. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available.

Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of antidiabetic treatment despite discontinuation of the suspect drug. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control.

### **Hyperprolactinemia**

As with other atypical antipsychotics that antagonize dopamine D<sub>2</sub> receptors, paliperidone elevates prolactin levels and the elevation persists during chronic administration. Paliperidone has a prolactin-elevating effect similar to that seen with risperidone.

Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent in vitro, a factor of potential importance if the prescription of these drugs is considered in a patient with previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported with prolactin-elevating compounds, the clinical significance of elevated serum prolactin levels is unknown for most patients. As is common with dopamine D<sub>2</sub> antagonists, prolonged administration of risperidone in rodent carcinogenicity studies resulted in an increase in the incidence of pituitary gland, mammary gland, and endocrine pancreas hyperplasia and/or tumours (see **WARNINGS AND PRECAUTIONS: Carcinogenesis and Mutagenesis**). However, neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive at this time. The carcinogenic potential of paliperidone, an active metabolite of risperidone, was assessed based on studies with risperidone conducted in mice and rats.

In the three placebo-controlled, 6-week, fixed-dose trials with INVEGA (3, 6, 9, and 12 mg), the proportion of subjects who experienced potentially prolactin-related adverse events was similar for the placebo (1%) and INVEGA (1-2%) groups.

### **Gastrointestinal**

#### **Potential For Gastrointestinal Obstruction**

Because the INVEGA tablet is nondeformable and does not appreciably change in shape in the GI tract, INVEGA should not be administered to patients with pre-existing severe gastrointestinal narrowing (pathologic or iatrogenic, for example: esophageal motility disorders, small bowel inflammatory disease, “short gut” syndrome due to adhesions or decreased transit time, past history of peritonitis, cystic fibrosis, chronic intestinal pseudo-obstruction, or Meckel’s diverticulum) or in patients with dysphagia or significant difficulty in swallowing tablets. There have been rare reports of obstructive symptoms in patients with known strictures in association

with the ingestion of drugs in non-deformable controlled-release formulations. Due to the controlled-release design of the tablet, INVEGA should only be used in patients who are able to swallow the tablet whole (see **DOSAGE AND ADMINISTRATION, Dosing Considerations**).

### **Antiemetic Effect**

An antiemetic effect was observed in preclinical studies with paliperidone. This effect, if it occurs in humans, may mask the signs and symptoms of overdose with certain drugs or of conditions such as intestinal obstruction, Reye's syndrome, and brain tumour.

### **Genitourinary**

#### **Priapism**

Drugs with alpha-adrenergic blocking effects have been reported to induce priapism. Priapism has been reported with INVEGA during post-marketing surveillance (see **ADVERSE REACTIONS, Post-Market Adverse Drug Reactions**).

### **Hepatic/Biliary/Pancreatic**

Paliperidone is not extensively metabolized in the liver. In a study in subjects with moderate hepatic impairment (Child-Pugh class B), the plasma concentrations of unbound paliperidone were similar to those of healthy subjects. No dose adjustment is required in patients with mild to moderate hepatic impairment. The effect of severe hepatic impairment is unknown.

### **Neurologic**

#### **Neuroleptic Malignant Syndrome (NMS)**

Neuroleptic malignant syndrome is a potentially fatal symptom complex that has been reported in association with antipsychotic drugs, including paliperidone.

Clinical manifestations of NMS are hyperthermia, muscle rigidity, altered mental status (including catatonic signs) and evidence of autonomic instability (irregular blood pressure, tachycardia, cardiac arrhythmias, and diaphoresis). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure.

In arriving at a diagnosis, it is important to identify cases in which the clinical presentation includes both serious medical illness (e.g., pneumonia, systemic infection, etc.) and untreated or inadequately treated extrapyramidal signs and symptoms. Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever, and primary central nervous system pathology.

The management of NMS should include: (1) immediate discontinuation of antipsychotic drugs including INVEGA, and other drugs not essential to concurrent therapy; (2) intensive symptomatic treatment and medical monitoring; and (3) treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for uncomplicated NMS.

If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrence of NMS has been reported.

### **Tardive Dyskinesia (TD)**

A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Although TD appears to be most prevalent in the elderly, especially elderly females, it is impossible to predict at the onset of treatment which patients are likely to develop TD. It has been suggested that the occurrence of parkinsonian side effects is a predictor for the development of TD.

The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. There is no known treatment for established cases of TD. The syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. However, antipsychotic treatment itself may suppress the signs and symptoms of TD, thereby masking the underlying process. The effect of symptom suppression upon the long-term course of TD is unknown.

In view of these considerations, INVEGA should be prescribed in a manner that is most likely to minimize the risk of TD. As with any antipsychotic, INVEGA should generally be reserved for patients who appear to be obtaining substantial benefit from the drug. In such patients, the smallest dose and the shortest duration of treatment should be sought. The need for continued treatment should be reassessed periodically.

If signs and symptoms of TD develop during treatment with INVEGA, withdrawal of the drug should be considered. However, some patients may require treatment with INVEGA despite the presence of the syndrome.

### **Potential Effect on Cognitive and Motor Performance**

Somnolence, sedation and blurred vision were reported in subjects treated with INVEGA (see **ADVERSE REACTIONS**). Antipsychotics, including INVEGA, have the potential to impair judgment, thinking, or motor skills. Patients should be cautioned about performing activities requiring mental alertness, such as operating hazardous machinery or operating a motor vehicle, until they are reasonably certain that paliperidone therapy does not adversely affect them.

### **Seizures**

Antipsychotic drugs are known to lower the seizure threshold. During premarketing clinical trials (the three placebo-controlled, 6-week, fixed-dose studies and a study conducted in elderly schizophrenic subjects), the number of reports of seizures was similar between subjects treated with INVEGA (3, 6, 9, 12 mg, 0.22%) and subjects treated with placebo (0.25%). As with other antipsychotic drugs, INVEGA should be used cautiously in patients with a history of seizures or other conditions that potentially lower the seizure threshold.

### **Parkinson's Disease and Dementia with Lewy Bodies**

Physicians should weigh the risks versus the benefits when prescribing antipsychotic drugs, including INVEGA, to patients with Parkinson's disease or dementia with Lewy bodies (DLB) since both groups may be at increased risk of neuroleptic malignant syndrome as well as having an increased sensitivity to antipsychotic medications. Manifestation of this increased sensitivity can include confusion, obtundation, postural instability with frequent falls, in addition to extrapyramidal symptoms.

## **Psychiatric**

### **Suicide**

The possibility of suicide or attempted suicide is inherent in psychosis, and thus, close supervision and appropriate clinical management of high-risk patients should accompany drug therapy.

### **Renal**

The dose should be reduced in patients with moderate to severe renal impairment (see **DOSAGE AND ADMINISTRATION**). The disposition of paliperidone was studied in subjects with varying degrees of renal function. Elimination of paliperidone decreased with decreasing creatinine clearance. Total clearance of paliperidone was reduced in subjects with impaired renal function by 32% in mild (CrCl = 50 to < 80 mL/min), 64% in moderate (CrCl = 30 to < 50 mL/min), and 71% in severe (CrCl = 10 to < 30 mL/min) renal impairment. The mean terminal elimination half-life of paliperidone was 24, 40, and 51 hours in subjects with mild, moderate, and severe renal impairment, respectively, compared with 23 hours in subjects with normal renal function (CrCl ≥ 80 mL/min). INVEGA has not been studied in subjects with creatinine clearance < 10mL/min.

### **Special Populations**

**Pregnant Women:** The safety of INVEGA during pregnancy has not been established. No teratogenic effect was noted in any animal study. Laboratory animals treated with a high dose of paliperidone showed a slight increase in fetal deaths. This high dose was toxic to the mothers. The offspring were not affected at exposures 20- to 34-fold the maximum human exposure. INVEGA should only be used if the benefits outweigh the risks. The effect of INVEGA on labour and delivery in humans is unknown.

Use of antipsychotic drugs during the last trimester of pregnancy has been associated with reversible extrapyramidal symptoms in the neonate.

**Nursing Women:** In animal studies with paliperidone and in human studies with risperidone, paliperidone was excreted in the milk. Patients should be advised not to breast-feed an infant if they are taking INVEGA.

**Pediatrics (< 18 years of age):** The safety and efficacy of INVEGA in children under the age of 18 years have not been established.

**Geriatrics (> 65 years of age):** The number of patients 65 years of age or older exposed to INVEGA during a placebo-controlled clinical trial in elderly subjects receiving flexible doses (3 – 12 mg/day) was limited (n=76). In general, the types and frequencies of adverse events reported in these subjects in this study were similar to those reported in the younger population of adult subjects studied in three placebo-controlled, 6-week, fixed-dose trials. Based on the limited data and consistent with general clinical practice, a greater sensitivity of older individuals to adverse events, including cardiac events, cannot be ruled out.

Because elderly subjects may have diminished renal function, dose adjustments may be required according to their renal function status (see **Renal** above and **DOSAGE AND ADMINISTRATION**).

## **Use in Geriatric Patients with Dementia**

### Overall Mortality

In a meta-analysis of 13 controlled clinical trials, elderly patients with dementia treated with other atypical antipsychotic drugs had an increased risk of mortality compared to placebo. INVEGA is not indicated for the treatment of elderly patients with dementia.

### Cerebrovascular Adverse Events (CVAEs) in Elderly Patients With Dementia

In placebo-controlled trials in elderly patients with dementia treated with some atypical antipsychotic drugs, including risperidone and olanzapine, there was a higher incidence of cerebrovascular adverse events (cerebrovascular accidents and transient ischemic attacks) including fatalities compared to placebo. INVEGA is not indicated for the treatment of elderly patients with dementia.

### Dysphagia

Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in patients with advanced Alzheimer's dementia. INVEGA and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

## **ADVERSE REACTIONS**

### **Clinical Trial Adverse Drug Reactions**

*Because clinical trials are conducted under very specific conditions the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.*

### **Short-Term, Placebo-Controlled, Fixed-Dose Studies**

The information presented in this section was derived from pooled data from three placebo-controlled, 6-week, fixed-dose studies conducted in non-elderly (mean age 38 years) patients with schizophrenia. The doses studied among these three trials included 3, 6, 9, 12, and 15 mg/day (see **Product Monograph Part II: CLINICAL TRIALS**). Body systems and adverse event/adverse drug reaction (ADR) terms are based on the MedDRA dictionary.

### Adverse Events Associated with Discontinuation of Treatment

Overall, there was no difference in the incidence of discontinuation due to adverse events between patients who received INVEGA (5%) and placebo-treated patients (5%). The types of adverse events that led to discontinuation were similar between patients treated with INVEGA and placebo-treated patients, except for Nervous System Disorders (2% and 0%, respectively) and Gastrointestinal Disorders (1% and 0%, respectively) which were of greater incidence among patients treated with INVEGA than placebo-treated patients, and Psychiatric Disorders which were of greater incidence among placebo-treated patients than patients treated with INVEGA (3% and 1%, respectively).

Commonly Observed Adverse Drug Reactions

Table 1.1 enumerates all treatment-emergent adverse events, regardless of causality, reported at an incidence of  $\geq 1\%$  of patients treated with INVEGA in these studies, and for which the incidence in patients treated with INVEGA was greater than the incidence in patients treated with placebo.

The most frequently reported ADRs, reported by  $\geq 2\%$  of patients treated with INVEGA, included: headache (13.2%; placebo 11.8%), tachycardia (6.6%; placebo 2.8%), akathisia (6.5%; placebo 3.9%), sinus tachycardia (5.5%; placebo 4.2%), extrapyramidal disorder (5.4%; placebo 2.3%), somnolence (4.9%; placebo 3.4%), dizziness (4.8%; placebo 3.9%), sedation (4.2%; placebo 3.7%), tremor (3.4%; placebo 3.4%), hypertonia (2.8%; placebo 1.1%), dystonia (2.6%; placebo 0.6%), orthostatic hypotension (2.5%; placebo 0.8%), and dry mouth (2.4%; placebo 0.6%).

**Table 1.1:** Treatment-Emergent Adverse Events, Regardless of Causality, Reported by  $\geq 1\%$  of Patients with Schizophrenia in Any INVEGA Group and Which Occurred at Greater Incidence Than in the Placebo Group in the Three Placebo-Controlled, 6-Week, Double-Blind, Fixed-Dose Clinical Trials. (Safety Analysis Set)

Body System or Organ Class Dictionary-derived Term	INVEGA				
	Placebo (N=355) %	3 mg (N=127) %	6 mg (N=235) %	9 mg (N=246) %	12 mg (N=242) %
<b>Cardiac disorders</b>					
Atrioventricular block first degree	1	2	0	2	1
Bradycardia	1	0	1	1	2
Bundle branch block	2	3	1	3	<1
Palpitations	0	2	1	0	1
Sinus arrhythmia	0	2	1	1	<1
Sinus tachycardia	4	9	4	4	7
Tachycardia	3	2	7	7	7
<b>Eye disorders</b>					
Dry eye	0	2	0	<1	<1
Oculogyration	0	0	0	2	0
Vision blurred	1	1	<1	0	2
<b>Gastrointestinal disorders</b>					
Abdominal pain	1	0	2	1	1
Abdominal pain upper	1	1	3	2	2
Diarrhea	2	1	1	1	2
Dry mouth	1	2	3	1	3
Dyspepsia	4	2	3	2	5
Nausea	5	6	4	4	4
Salivary hypersecretion	<1	0	<1	1	4
Stomach discomfort	<1	2	1	<1	1
Toothache	1	2	2	2	2
Vomiting	5	2	3	4	5
<b>General disorders and administration site conditions</b>					
Asthenia	1	2	<1	2	2
Fatigue	1	2	1	2	2

**Table 1.1:** Treatment-Emergent Adverse Events, Regardless of Causality, Reported by  $\geq 1\%$  of Patients with Schizophrenia in Any INVEGA Group and Which Occurred at Greater Incidence Than in the Placebo Group in the Three Placebo-Controlled, 6-Week, Double-Blind, Fixed-Dose Clinical Trials(continued) (Safety Analysis Set)

Body System or Organ Class Dictionary-derived Term	Placebo (N=355) %	3 mg (N=127) %	INVEGA		
			6 mg (N=235) %	9 mg (N=246) %	12 mg (N=242) %
<b>General disorders and administration site conditions (continued)</b>					
Pyrexia	1	1	<1	2	2
<b>Infections and infestations</b>					
Bronchitis	<1	0	1	<1	1
Nasopharyngitis	3	3	2	2	2
Rhinitis	<1	0	1	0	<1
Upper respiratory tract infection	1	1	1	1	1
Viral infection	<1	0	<1	1	1
<b>Injury, poisoning and procedural complications</b>					
Fall	<1	0	1	0	0
<b>Investigations</b>					
Alanine aminotransferase increased	1	1	2	1	1
Blood creatine phosphokinase increased	1	1	2	0	<1
Blood insulin increased	1	2	1	1	<1
Blood pressure increased	1	2	<1	<1	1
Blood triglycerides increased	<1	2	<1	0	0
Electrocardiogram QT corrected interval prolonged	3	3	4	3	5
Electrocardiogram T wave abnormal	1	2	1	2	1
Electrocardiogram T wave inversion	1	0	<1	1	1
Electrocardiogram abnormal	0	0	0	2	1
Heart rate increased	1	3	1	<1	1
Insulin C-peptide increased	1	2	1	1	0
Weight decreased	1	2	0	0	0
Weight increased	1	1	0	2	2

**Table 1.1:** Treatment-Emergent Adverse Events, Regardless of Causality, Reported by  $\geq 1\%$  of Patients with Schizophrenia in Any INVEGA Group and Which Occurred at Greater Incidence Than in the Placebo Group in the Three Placebo-Controlled, 6-Week, Double-Blind, Fixed-Dose Clinical Trials(continued) (Safety Analysis Set)

Body System or Organ Class Dictionary-derived Term	Placebo (N=355) %	3 mg (N=127) %	INVEGA		
			6 mg (N=235) %	9 mg (N=246) %	12 mg (N=242) %
<b>Metabolism and nutrition disorders</b>					
Decreased appetite	0	2	<1	<1	1
Increased appetite	<1	2	0	1	1
<b>Musculoskeletal and connective tissue disorders</b>					
Arthralgia	1	0	2	1	0
Back pain	1	1	1	1	2
Muscle rigidity	0	1	0	1	<1
Neck pain	<1	0	0	0	1
Pain in extremity	1	0	1	0	2
Shoulder pain	0	1	1	1	1
<b>Nervous system disorders</b>					
Akathisia	4	4	3	8	10
Dizziness	4	6	5	4	5
Dyskinesia	1	0	<1	<1	2
Dystonia	1	1	1	4	4
Extrapyramidal disorder	2	5	2	7	7
Headache	12	11	12	14	14
Hypertonia	1	2	1	4	3
Parkinsonism	0	0	<1	2	1
Sedation	4	1	5	3	6
Somnolence	3	5	3	7	5
Syncope	<1	1	1	1	<1
Tremor	3	3	3	4	3
<b>Psychiatric disorders</b>					
Aggression	1	2	<1	1	1
Anxiety	8	9	7	6	5

**Table 1.1:** Treatment-Emergent Adverse Events, Regardless of Causality, Reported by  $\geq 1\%$  of Patients with Schizophrenia in Any INVEGA Group and Which Occurred at Greater Incidence Than in the Placebo Group in the Three Placebo-Controlled, 6-Week, Double-Blind, Fixed-Dose Clinical Trials(continued) (Safety Analysis Set)

Body System or Organ Class Dictionary-derived Term	Placebo (N=355) %	3 mg (N=127) %	INVEGA		
			6 mg (N=235) %	9 mg (N=246) %	12 mg (N=242) %
<b>Psychiatric disorders (continued)</b>					
Depression	<1	0	1	<1	<1
Nightmare	0	0	<1	1	<1
Suicidal ideation	1	2	1	<1	<1
<b>Respiratory, thoracic and mediastinal disorders</b>					
Cough	1	3	2	3	2
Nasal congestion	1	1	1	1	1
<b>Skin and subcutaneous tissue disorders</b>					
Pruritus	1	0	1	1	0
<b>Vascular disorders</b>					
Hypotension	<1	2	<1	1	1
Orthostatic hypotension	1	2	1	2	4

### Dose-Related Adverse Reactions

Based on the pooled data from the three placebo-controlled, 6-week, fixed-dose studies, among the adverse reactions that occurred with a greater than 2% incidence in the subjects treated with INVEGA, the incidences of the following adverse reactions increased with dose: somnolence, orthostatic hypotension, akathisia, dystonia, extrapyramidal disorder, hypertonia, Parkinsonism, and salivary hypersecretion. For most of these, the increased incidence was seen primarily at the 12 mg dose, and, in some cases, the 9 mg dose.

### Elderly

The number of patients 65 years of age or older exposed to INVEGA during a placebo-controlled clinical trial in elderly subjects receiving flexible doses (3 – 12 mg/day) was limited (n=76). In general, the types and frequencies of adverse events reported in these subjects in this study were similar to those reported in the younger population of adult subjects studied in three placebo-controlled, 6-week, fixed-dose trials. Based on the limited data and consistent with general clinical practice, a greater sensitivity of older individuals to adverse events, including cardiac events, cannot be ruled out.

### Extrapyramidal Symptoms (EPS)

Pooled data from the three placebo-controlled, 6-week, fixed-dose studies provided information regarding treatment-emergent EPS. Several methods were used to measure EPS: (1) the Simpson-Angus global score, (2) the Barnes Akathisia Rating Scale global clinical rating score, (3) use of anticholinergic medications to treat emergent EPS, and (4) incidence of spontaneous reports of EPS. For the Simpson-Angus Scale, spontaneous EPS reports and use of anticholinergic

medications, there was a dose-related increase observed for the 9 mg and 12 mg doses. There was no difference observed between placebo and INVEGA 3 mg and 6 mg doses for any of these EPS measures.

EPS Group	Percentage of Patients				
	Placebo (N=355)	3 mg once daily (N=127)	6 mg once daily (N=235)	INVEGA 9 mg once daily (N=246)	12 mg once daily (N=242)
Parkinsonism <sup>a</sup>	9	11	3	15	14
Akathisia <sup>b</sup>	6	6	4	7	9
Use of anticholinergic medications <sup>c</sup>	10	10	9	22	22

a: For Parkinsonism, percent of patients with Simpson-Angus global score > 0.3 (Global score defined as total sum of items score divided by the number of items)

b: For Akathisia, percent of patients with Barnes Akathisia Rating Scale global score  $\geq$  2

c: Percent of patients who received anticholinergic medications to treat emergent EPS

EPS Group	Percentage of Patients				
	Placebo (N=355)	3 mg once daily (N=127)	6 mg once daily (N=235)	INVEGA 9 mg once daily (N=246)	12 mg once daily (N=242)
Overall percentage of patients with EPS- related AE	11.0	12.6	10.2	25.2	26.0
Dyskinesia	3.4	4.7	2.6	7.7	8.7
Dystonia	1.1	0.8	1.3	5.3	4.5
Hyperkinesia	3.9	3.9	3.0	8.1	9.9
Parkinsonism	2.3	3.1	2.6	7.3	6.2
Tremor	3.4	3.1	2.6	4.5	3.3

Dyskinesia group includes: Dyskinesia, Extrapyramidal disorder, Muscle twitching, Tardive dyskinesia

Dystonia group includes: Dystonia, Muscle spasms, Oculogyration, Trismus

Hyperkinesia group includes: Akathisia, Hyperkinesia

Parkinsonism group includes: Bradykinesia, Cogwheel rigidity, Drooling, Hypertonia, Hypokinesia, Muscle rigidity, Musculoskeletal stiffness, Parkinsonism

Tremor group includes: Tremor

### Weight Gain

In the pooled data from the three placebo-controlled, 6-week, fixed-dose studies, the proportions of patients meeting a weight gain criterion of  $\geq$  7% of body weight were compared, revealing a similar incidence of weight gain for INVEGA 3 mg and 6 mg (7% and 6%, respectively) compared with placebo (5%), and a higher incidence of weight gain for INVEGA 9 mg and 12 mg (9% and 9%, respectively).

### ECG Changes

In the pooled data from the three placebo-controlled, 6-week, fixed-dose studies, between-group comparisons revealed no clinically important differences between INVEGA and placebo in the incidence of ECG parameters outside clinically important limits, with the exception of heart rate. Compared with placebo (23%), a higher percentage of subjects treated with INVEGA (36%, 3, 6, 9, 12 mg) had heart rate values  $\geq 100$  bpm.

### Abnormal Hematologic and Clinical Chemistry Findings

In the pooled data from the three placebo-controlled, 6-week, fixed-dose studies, a between-group comparison revealed no medically important differences between INVEGA and placebo in the proportions of subjects experiencing potentially clinically significant changes in routine serum chemistry, hematology, or urinalysis parameters. Similarly, there were no differences between INVEGA and placebo in the incidence of discontinuations due to changes in hematology, urinalysis, or serum chemistry, including mean changes from baseline in fasting glucose, insulin, c-peptide, triglyceride, HDL, LDL, and total cholesterol measurements. However, INVEGA was associated with increases in serum prolactin (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**). Maximum mean increases of serum prolactin concentrations were generally observed on Day 15 of treatment (first post-baseline measurement), and remained above baseline levels at study endpoint. The incidence of potentially prolactin-related adverse events was small and similar to that for placebo.

### Clinical Trial Adverse Drug Reactions in Short-Term, Placebo-Controlled, Fixed-Dose Studies

The following ADRs, where a causal relationship is suspected between the drug and the reported event, were reported in patients treated with INVEGA (n=850) in the three placebo-controlled, 6-week, double-blind, fixed-dose clinical trials in patients with schizophrenia. The following terms and frequencies were applied: *very common* ( $\geq 10\%$ ), *common (frequent)* ( $\geq 1\%$  to  $< 10\%$ ), *uncommon (infrequent)* ( $\geq 0.1\%$  to  $< 1\%$ ), *rare* ( $\geq 0.01\%$  to  $< 0.1\%$ ), and *very rare* ( $< 0.01\%$ ). The majority of ADRs were mild to moderate in severity.

**Cardiac disorders:** *common:* atrioventricular block first degree, bradycardia, sinus tachycardia, tachycardia, bundle branch block; *uncommon:* palpitations, sinus arrhythmia

**Eye disorders:** *uncommon:* oculogyration

**Gastrointestinal disorders:** *common:* abdominal pain upper, dry mouth, salivary hypersecretion, vomiting

**General disorders:** *common:* asthenia, fatigue; *uncommon:* edema

**Immune system disorders:** *uncommon:* anaphylactic reaction

**Investigations:** *common:* weight increased; *uncommon:* electrocardiogram abnormal

**Metabolism and nutrition disorders:** *uncommon:* increased appetite

**Musculoskeletal and connective tissue disorders:** *uncommon:* muscle rigidity

**Nervous system disorders:** *very common:* headache; *common:* akathisia, dizziness, dystonia, extrapyramidal disorder, hypertonia, Parkinsonism, sedation, somnolence, tremor; *uncommon:* dizziness postural, dyskinesia, grand mal convulsion, syncope

**Psychiatric disorders:** *uncommon:* nightmare

**Reproductive system and breast disorders:** *uncommon:* amenorrhea, breast discharge, erectile dysfunction, galactorrhea, gynecomastia, menstruation irregular

**Vascular disorders:** *common:* orthostatic hypotension; *uncommon:* hypotension, ischemia

### **Adverse Drug Reactions in a Long-Term, Placebo-Controlled Study**

The safety of INVEGA was also evaluated in a longer-term trial in adults with schizophrenia (see **Product Monograph Part II: CLINICAL TRIALS**). In general, the types, frequencies, and severities of ADRs reported during the initial 14-week open-label phase of this study were comparable to those reported in the 6-week, placebo-controlled, fixed-dose studies. The ADRs reported during the longer-term double-blind phase of this study were similar in type and severity to those observed in the initial 14-week open-label phase, but occurred at generally lower frequencies.

### **Post-Market Adverse Drug Reactions**

Adverse events first identified as ADRs during postmarketing experience with INVEGA are included in Table 1.2. The frequencies are provided according to the following convention:

Very common	≥1/10
Common	≥1/100 to <1/10
Uncommon	≥1/1,000 to <1/100
Rare	≥1/10,000 to <1/1,000
Very rare	<1/10,000, including isolated reports

**Table 1.2:** Adverse Drug Reactions Identified During Postmarketing Experience with INVEGA by Frequency Category Estimated from Spontaneous Reporting Rates

<b>Reproductive System and Breast Disorders</b>
<i>Very rare</i> Priapism

### **Safety Information Reported with Risperidone**

Paliperidone is the major active metabolite of risperidone. The release profile and pharmacokinetic characteristics of INVEGA are considerably different than those observed with oral immediate-release risperidone formulations (see **ACTION AND CLINICAL PHARMACOLOGY**); however, the receptor binding profile of paliperidone is very similar to that of the parent compound. Safety information reported with risperidone in clinical trials and postmarketing experience that may be relevant to INVEGA can be found in local labelling for risperidone.

## **DRUG INTERACTIONS**

### **Drug-Drug Interactions**

Caution is advised when prescribing INVEGA with drugs known to prolong the QT interval.

### Potential for INVEGA to Affect Other Drugs

Paliperidone is not expected to cause clinically important pharmacokinetic interactions with drugs that are metabolized by cytochrome P-450 isozymes. In vitro studies in human liver microsomes showed that paliperidone does not substantially inhibit the metabolism of drugs metabolized by cytochrome P450 isozymes, including CYP1A2, CYP2A6, CYP2C8/9/10, CYP2D6, CYP2E1, CYP3A4, and CYP3A5. Therefore, paliperidone is not expected to inhibit clearance of drugs that are metabolized by these metabolic pathways in a clinically relevant manner. Paliperidone is also not expected to have enzyme-inducing properties.

A population pharmacokinetic analysis to evaluate the influence of predicted CYP2D6 phenotype on exposure indicated that no adjustment in the paliperidone dose on the basis of predicted phenotype is warranted.

Paliperidone is a weak inhibitor of P-glycoprotein (P-gp) at high concentrations. No in vivo data are available and the clinical relevance of this with respect to P-gp mediated transport of other drugs is unknown.

Given the primary CNS effects of paliperidone (see **ADVERSE REACTIONS**), INVEGA should be used with caution in combination with other centrally acting drugs and alcohol. Paliperidone may antagonize the effect of levodopa and other dopamine agonists.

Because of its potential for inducing orthostatic hypotension (see **WARNINGS AND PRECAUTIONS, Cardiovascular**), an additive effect may be observed when INVEGA is administered with other therapeutic agents that have this potential.

### Potential for Other Drugs to Affect INVEGA

Paliperidone is not a substrate of CYP1A2, CYP2A6, CYP2C9, CYP2C19, and CYP3A5. This suggests that an interaction with inhibitors or inducers of these isozymes is unlikely.

While in vitro studies indicate that CYP2D6 and CYP3A4 may be minimally involved in paliperidone metabolism, there are no indications in vitro nor in vivo that these isozymes play a significant role in the metabolism of paliperidone (see **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics**).

In an interaction study in healthy subjects in which INVEGA was administered concomitantly with paroxetine, a potent CYP2D6 inhibitor, no clinically relevant effects on the pharmacokinetics of paliperidone were observed.

Carbamazepine and other potent CYP3A4 inducers:

Co-administration of INVEGA once daily with carbamazepine 200 mg twice daily caused a decrease of approximately 37% in the mean steady-state  $C_{max}$  and AUC of paliperidone. As is typical of CYP3A4 inducers, carbamazepine is also a P-glycoprotein (P-gp) inducer. Although in vitro studies have shown that paliperidone is a substrate of both P-gp and CYP3A4, the relative contributions of P-gp and CYP3A4 to changes in the pharmacokinetic parameters are unclear.

On initiation of carbamazepine, the dose of INVEGA should be re-evaluated and increased if necessary. Conversely, on discontinuation of carbamazepine, the dose of INVEGA should be re-evaluated and decreased if necessary. Until more data are available, these recommendation should

be extended to other potent CYP3A4 inducers and/or P-glycoprotein upregulators.

Paliperidone, a cation under physiological pH, is primarily excreted unchanged by the kidneys, approximately half via filtration and half via active secretion. Concomitant administration of trimethoprim, a drug known to inhibit active renal cation drug transport, did not influence the pharmacokinetics of paliperidone.

#### Concomitant Use of INVEGA with Risperidone

Since paliperidone (9-hydroxy-risperidone) is the major active metabolite of risperidone, concomitant use of INVEGA with oral risperidone is not recommended since the combination of the two will lead to additive paliperidone exposure.

#### Drug-Food Interactions

Following administration of a single 12 mg paliperidone extended-release tablet to healthy ambulatory subjects with a standard high-fat/high-caloric meal, the mean  $C_{max}$  and AUC values of paliperidone increased by 60% and 54%, respectively, compared with administration under fasting conditions. Although the presence or absence of food at the time of administration of INVEGA may increase or decrease exposure to paliperidone, these changes are not considered clinically relevant. Clinical trials establishing the safety and efficacy of INVEGA were carried out in subjects without regard to the timing of meals.

#### Drug-Herb Interactions

Interactions with herbal products have not been established.

#### Drug-Laboratory Interactions

Interactions with laboratory tests have not been established.

#### Drug-Lifestyle Interactions

##### Smoking

No dosage adjustment is recommended based on smoking status. Based on in vitro studies utilizing human liver enzymes, paliperidone is not a substrate for CYP1A2; smoking should, therefore, not have an effect on the pharmacokinetics of paliperidone. Consistent with these in vitro results, population pharmacokinetic evaluation has not revealed any differences between smokers and non-smokers.

## **DOSAGE AND ADMINISTRATION**

### Dosing Considerations

- Since paliperidone (9-hydroxy-risperidone) is the major active metabolite of risperidone, concomitant use of INVEGA with oral risperidone is not recommended since the combination of the two will lead to additive paliperidone exposure.
- INVEGA should be administered orally once daily, preferably in the morning, without regard to meals. Clinical trials establishing the safety and efficacy of INVEGA were carried out in patients without regard to food intake. INVEGA must be swallowed whole with the aid of liquids, and must not be chewed, divided, or crushed. The medication is contained within a nonabsorbable shell designed to release the drug at a controlled rate. The tablet shell, along

with insoluble core components, is eliminated from the body; patients should not be concerned if they occasionally notice something that looks like a tablet in their stool.

### **Recommended Dose and Dosage Adjustment**

#### **Adult**

The recommended starting and target dose of INVEGA is 6 mg once daily. No initial dose titration is required. However, in some cases a lower dose of 3 mg/day may be sufficient.

In clinical trials a dose range of 3 to 12 mg/day was studied and while efficacy was observed across all doses, there was a dose-related increase in adverse effects (see **ADVERSE REACTIONS** and *Product Monograph Part II: CLINICAL TRIALS*).

Dose adjustments should be made after clinical reassessment and generally should occur at intervals of more than 5 days. When dose adjustments are indicated, small increments/decrements of 3 mg/day are recommended, up to a maximum of 12 mg/day.

#### **Patients with Hepatic Impairment**

No dose adjustment is required in patients with mild to moderate hepatic impairment. INVEGA has not been studied in patients with severe hepatic impairment.

#### **Patients with Renal Impairment**

For patients with mild renal impairment (creatinine clearance = 50 to < 80 mL/min), the maximum recommended initial dose is 3 mg once daily. The dose may be increased to a maximum of 6 mg once daily based on clinical response and tolerability.

For patients with moderate to severe renal impairment (creatinine clearance = 10 to < 50 mL/min), the recommended initial dose of INVEGA is 1.5 mg once daily which may then be increased to 3 mg once daily after clinical reassessment.

As INVEGA has not been studied in patients with creatinine clearance < 10 mL/min, use is not recommended in such patients.

#### **Elderly**

Dosing recommendations for elderly patients with normal renal function ( $\geq 80$  mL/min) are the same as for adults with normal renal function. However, because elderly patients may have diminished renal function, dose adjustments may be required according to their renal function status (see *Patients with Renal Impairment* above).

#### **Pediatrics**

Safety and effectiveness of INVEGA in patients < 18 years of age have not been studied.

#### **Other Special Populations**

No dose adjustment for INVEGA is recommended based on gender, race, or smoking status.

## OVERDOSAGE

### Symptoms

In general, expected signs and symptoms are those resulting from an exaggeration of paliperidone's known pharmacological effects, i.e., drowsiness and sedation, tachycardia and hypotension, QT prolongation, and extrapyramidal symptoms. In the case of acute overdosage, the possibility of multiple drug involvement should be considered.

### Treatment

Consideration should be given to the extended-release nature of the product when assessing treatment needs and recovery. There is no specific antidote to paliperidone. General supportive measures should be employed. Establish and maintain a clear airway and ensure adequate oxygenation and ventilation. Cardiovascular monitoring should commence immediately and should include continuous electrocardiographic monitoring for possible arrhythmias. Hypotension and circulatory collapse should be treated with appropriate measures such as intravenous fluid and/or sympathomimetic agents. Gastric lavage (after intubation if the patient is unconscious) and administration of activated charcoal together with a laxative should be considered. In case of severe extrapyramidal symptoms, anticholinergic agents should be administered. Close supervision and monitoring should continue until the patient recovers.

## ACTION AND CLINICAL PHARMACOLOGY

### Mechanism of Action

Paliperidone is a centrally active dopamine D<sub>2</sub> antagonist with predominant serotonergic 5-HT<sub>2A</sub> antagonistic activity. Paliperidone is also active as an antagonist at  $\alpha_1$  and  $\alpha_2$  adrenergic receptors and H<sub>1</sub> histaminergic receptors. Paliperidone has no affinity for cholinergic muscarinic or  $\beta_1$ - and  $\beta_2$ -adrenergic receptors. The pharmacological activity of the (+)- and (-)-paliperidone enantiomers is qualitatively and quantitatively similar.

The mechanism of action of paliperidone, as with other drugs having efficacy in schizophrenia, is unknown. However, it has been proposed that the drug's therapeutic activity in schizophrenia is mediated through a combination of dopamine Type 2 (D<sub>2</sub>) and serotonin Type 2 (5HT<sub>2A</sub>) receptor antagonism. Antagonism at receptors other than D<sub>2</sub> and 5HT<sub>2A</sub> may explain some of the other effects of paliperidone.

### Pharmacodynamics

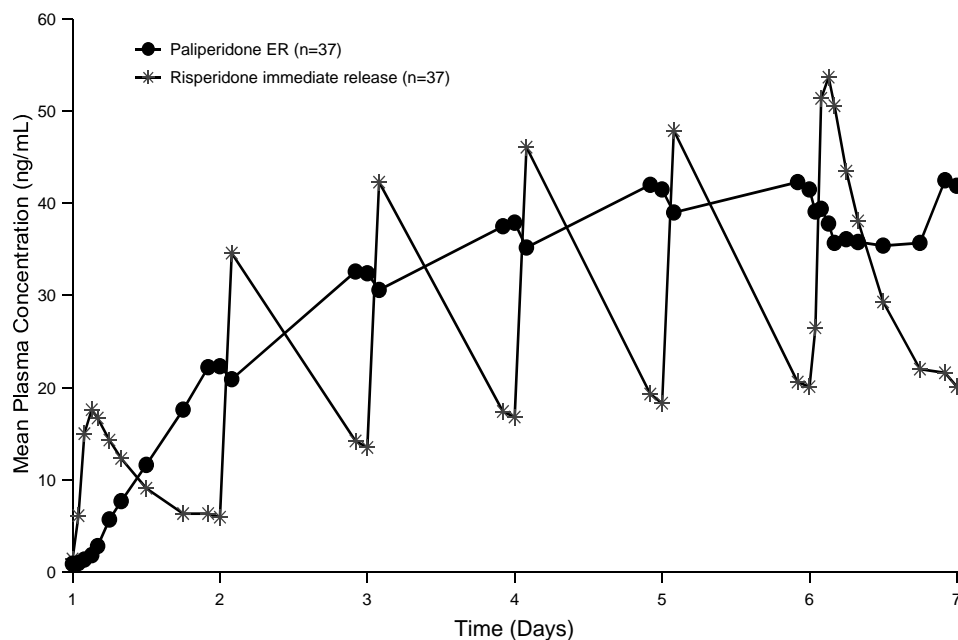
#### Formulation Characteristics

The controlled rate of release of paliperidone from the extended-release technology results in a pharmacokinetic profile with a slower rate of absorption than an immediate-release formulation, leading to an ascending plasma concentration profile over 24 hours on Day 1 of dosing. In studies with paliperidone and risperidone, an ascending profile paliperidone formulation concept demonstrated a differential effect on orthostatic hypotension compared to a flat or immediate-release profile. In one study (n=27), paliperidone administered to achieve an ascending profile with a total dose of 4 mg compared to a lower dose (2 mg) of immediate release risperidone resulted in lower incidences of orthostatic hypotension (32% vs. 46%). The extended-release profile showed a lower incidence of orthostatic hypotension and allows for initiation of treatment at an effective dose without titration, as is the typical practice with antipsychotic drugs to address initial orthostatic intolerance.

## Pharmacokinetics

Following a single dose, the plasma concentrations of paliperidone steadily rise to reach peak plasma concentration ( $C_{max}$ ) in approximately 24 hours after dosing. The pharmacokinetics of paliperidone following INVEGA administration are dose-proportional within the available dose range. The terminal elimination half-life of paliperidone, regardless of formulation, is approximately 23 hours.

Steady-state concentrations of paliperidone are attained within 4-5 days of dosing in most subjects. The release characteristics of INVEGA result in minimal peak-trough fluctuations as compared to those observed with immediate-release risperidone. In a study comparing the steady-state pharmacokinetics following once-daily administration of 12 mg paliperidone (administered as extended-release tablets) with 4 mg immediate-release risperidone in schizophrenic subjects, the fluctuation indexes were 38% for paliperidone extended-release compared to 125% for risperidone immediate-release (Figure 1.1).



**Figure 1.1** Steady-state concentration profile following administration of 12 mg paliperidone administered as six 2 mg extended-release tablets once daily for 6 days (paliperidone concentrations are represented) compared with risperidone immediate-release administered as 2 mg once daily on Day 1 and 4 mg once daily on Days 2 to 6 (paliperidone+risperidone concentrations are represented).

Following administration of INVEGA, the (+) and (-) enantiomers of paliperidone interconvert, reaching an AUC (+) to (-) ratio of approximately 1.6 at steady state.

**Absorption:** The absolute oral bioavailability of paliperidone from INVEGA (i.e., the extended release formulation) is 28%. It is thought that this is due to a higher fraction of paliperidone being released in the colon, where absorption is lower.

Following administration of a single 12 mg paliperidone extended-release tablet to healthy ambulatory subjects with a standard high-fat/high-caloric meal, the mean  $C_{max}$  and AUC values of paliperidone increased by 60% and 54%, respectively, compared with administration under fasting conditions. Although the presence or absence of food at the time of INVEGA administration may increase or decrease exposure to paliperidone, these changes are not considered clinically relevant. Clinical trials establishing the safety and efficacy of INVEGA were carried out in subjects without regard to the timing of meals (see **DOSAGE AND ADMINISTRATION**).

**Distribution:** Paliperidone is rapidly distributed. The apparent volume of distribution is 487 L. The plasma protein binding of paliperidone is 74%. It binds primarily to  $\alpha_1$ -acid glycoprotein and albumin. In vitro, high therapeutic concentrations of diazepam (3 mcg/mL), sulfamethazine (100 mcg/mL), warfarin (10 mcg/mL), and carbamazepine (10 mcg/mL) caused a slight increase in the free fraction of paliperidone at 50 ng/mL. These changes are not expected to be of clinical significance.

**Metabolism and Excretion:** The following data are based on a human mass balance study using oral solution of  $^{14}C$ -paliperidone, a dosage form which has approximately 100% bioavailability. One week following administration of a single 1 mg dose of oral solution  $^{14}C$ -paliperidone, 59% of the administered dose was excreted unchanged into urine, indicating that paliperidone is not extensively metabolized in the liver. Approximately 80% of the administered radioactivity was recovered in urine and 11% in the feces.

Four metabolic pathways have been identified in vivo, of which each accounted for no more than 6.5% of the administered dose: dealkylation, hydroxylation, dehydrogenation, and benzisoxazole scission. In vitro studies suggested a role for CYP2D6 and CYP3A4 in the metabolism of paliperidone; however, in vivo results indicate that these isozymes play a very limited role in the metabolism of paliperidone. Despite the large variation in the general population with regard to the ability to metabolize CYP2D6 substrates, population pharmacokinetic analyses indicated no discernable difference on the exposure and apparent clearance of paliperidone after administration of INVEGA between extensive metabolizers and poor metabolizers of CYP2D6 substrates. In vitro studies using microsomal preparations of heterologous systems indicate that CYP1A2, CYP2A6, CYP2C9, CYP2C19, and CYP3A5 are not involved in the metabolism of paliperidone. Paliperidone is not expected to have enzyme-inducing properties.

### **Special Populations and Conditions**

**Pediatrics:** No data available.

**Geriatrics:** No dosage adjustment is recommended based on age alone. However, because elderly subjects may have diminished renal function, dose adjustments may be required according to their renal function status (see **Renal Insufficiency** below). Data from a pharmacokinetic study in elderly subjects ( $\geq 65$  years of age,  $n = 26$ ) indicated that the apparent steady-state clearance of paliperidone following INVEGA administration was 20% lower compared to that of adult subjects (18-45 years of age,  $n = 28$ ). However, there was no discernable effect of age in the population pharmacokinetic analysis involving schizophrenia subjects after correction for age-related decreases in CrCl.

**Gender:** No dosage adjustment is recommended based on gender. The apparent clearance of paliperidone following INVEGA administration is approximately 19% lower in women than men. This difference is largely explained by differences in lean body mass and creatinine clearance between men and women, as a population pharmacokinetics evaluation revealed no evidence of clinically significant gender-related differences in the pharmacokinetics of paliperidone following INVEGA administration after correction for lean body mass and creatinine clearance.

**Race:** No dosage adjustment is recommended based on race. Population pharmacokinetics analysis revealed no evidence of race-related differences in the pharmacokinetics of paliperidone following INVEGA administration.

**Hepatic Insufficiency:** Paliperidone is not extensively metabolized in the liver. In a study in subjects with moderate hepatic impairment (Child-Pugh class B), the plasma concentrations of unbound paliperidone were similar to those of healthy subjects. No dose adjustment is required in patients with mild to moderate hepatic impairment. INVEGA has not been studied in patients with severe hepatic impairment.

**Renal Insufficiency:** The dose should be reduced in patients with mild and moderate to severe renal impairment (see **DOSAGE AND ADMINISTRATION**). The disposition of paliperidone was studied in subjects with varying degrees of renal function. Elimination of paliperidone decreased with decreasing estimated creatinine clearance. Total clearance of paliperidone was reduced in subjects with impaired renal function by 32% in mild ( $\text{CrCl} = 50$  to  $< 80$  mL/min), 64% in moderate ( $\text{CrCl} = 30$  to  $< 50$  mL/min), and 71% in severe ( $\text{CrCl} = 10$  to  $< 30$  mL/min) renal impairment. The mean terminal elimination half-life of paliperidone was 24, 40, and 51 hours in subjects with mild, moderate, and severe renal impairment, respectively, compared with 23 hours in subjects with normal renal function ( $\text{CrCl} \geq 80$  mL/min). INVEGA has not been studied in subjects with creatinine clearance  $< 10$  mL/min.

**Smoking Status:** No dosage adjustment is recommended based on smoking status. Based on in vitro studies utilizing human liver enzymes, paliperidone is not a substrate for CYP1A2; smoking should, therefore, not have an effect on the pharmacokinetics of paliperidone. Consistent with these in vitro results, population pharmacokinetic evaluation has not revealed any differences between smokers and non-smokers.

## **STORAGE AND STABILITY**

INVEGA should be stored at 15 - 30°C. Protect from moisture.

Keep out of the reach of children.

## **DOSAGE FORMS, COMPOSITION AND PACKAGING**

### **Dosage Forms and Packaging**

INVEGA Extended-release Tablets contain paliperidone as the medicinal ingredient and are available in 3 mg, 6 mg and 9 mg dosage strengths as follows:

3 mg: A white capsule-shaped tablet printed with “PAL 3”. Orifices may or may not be visible. Bottles of 30 tablets.

6 mg: A beige capsule-shaped tablet printed with “PAL 6”. Orifices may or may not be visible. Bottles of 30 tablets.

9 mg: A pink capsule-shaped tablet printed with “PAL 9”. Orifices may or may not be visible. Bottles of 30 tablets.

### **Composition**

The following inactive ingredients are common to all tablet strengths: butylated hydroxytoluene, carnauba wax, cellulose acetate, ferric oxide red, ferric oxide yellow, hydroxyethyl cellulose, hypromellose, iron oxide black, polyethylene oxides, polyethylene glycol, propylene glycol, povidone, sodium chloride, stearic acid, and titanium dioxide.

The 3 mg tablets also contain lactose monohydrate and triacetin.

### **System Components and Performance**

INVEGA tablets utilize osmotic pressure to deliver paliperidone from the dosage form at a controlled rate. The system, which resembles a capsule-shaped tablet in appearance, comprises an osmotically active trilayer core surrounded by a subcoat and semipermeable membrane. The trilayer core is composed of two drug layers containing the drug and excipients, and a push layer containing osmotically active components. There are two precision laser-drilled orifices on the drug-layer dome of the tablet. Each strength is identified by a unique colour overcoat and print markings. In an aqueous environment, such as the gastrointestinal tract, the water-dispersible colour overcoat erodes quickly. Water is then imbibed through the semi-permeable, rate-controlling membrane. The membrane controls the rate at which water enters the tablet core, which, in turn, controls drug delivery. The hydrophilic polymers of the core hydrate and swell, creating a gel containing paliperidone that is then pushed out through the tablet orifices. The drug release rate from the system is designed to increase with time over a period of approximately 16 to 22 hours due to the drug-concentration gradient incorporated into the two drug layers of INVEGA. The ascending release rate of INVEGA allows patients to receive a therapeutically effective dose of paliperidone without the need for dose titration. The biologically inert components of the tablet remain intact during gastrointestinal transit and are eliminated in the stool, along with insoluble core components.

## PART II: SCIENTIFIC INFORMATION

### PHARMACEUTICAL INFORMATION

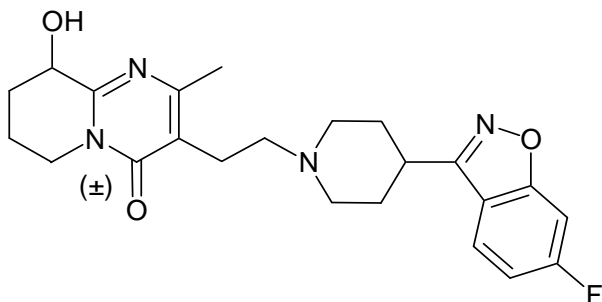
#### Drug Substance

Proper name: paliperidone

Chemical name: (±)-3-[2-[4-(6-fluoro-1,2-benzisoxazol-3-yl)-1-piperidinyl]ethyl]-6,7,8,9-tetrahydro-9-hydroxy-2-methyl-4H-pyrido[1,2-a]pyrimidin-4-one

Molecular formula and molecular mass: C<sub>23</sub>H<sub>27</sub>FN<sub>4</sub>O<sub>3</sub>, 426.49

Structural formula:



Physicochemical properties: Paliperidone is a white to yellow powder.

Ionization Constant: pK<sub>a1</sub> = 8.2

pK<sub>a2</sub> = 2.6

Partition Coefficient: log P = 2.39

Melting Point: 172.0 – 190.0°C

Paliperidone is sparingly soluble in 0.1N HCl and methylene chloride; practically insoluble in water, 0.1N NaOH, and hexane; and slightly soluble in N,N-dimethylformamide

### CLINICAL TRIALS

The efficacy of INVEGA was established in three placebo-controlled, double-blind, 6-week studies in non-elderly (mean age 37 years) patients.

The doses of INVEGA, which varied across the three studies, ranged from 3 to 15 mg once daily; an active control (olanzapine) was included in the 6-week studies in adults for assay sensitivity purposes.

Efficacy was evaluated using the Positive and Negative Syndrome Scale (PANSS), a validated multi-item inventory composed of five factors to evaluate positive symptoms, negative symptoms, disorganized thoughts, uncontrolled hostility/excitement, and anxiety/depression. The primary endpoint was decrease in total PANSS scores from baseline to endpoint.

The Clinical Global Impression - Severity (CGI-S) scale was one of the secondary outcomes. The CGI-S is an independent investigator-rated assessment of overall severity of illness.

In the first placebo-controlled 6-week trial (n=605) comparing fixed doses of INVEGA (3, 9, and 15 mg/day) with placebo, all doses were superior to placebo on the PANSS and all PANSS factors and the CGI scale.

In the second placebo-controlled 6-week trial (n=628) comparing fixed doses of INVEGA (6, 9, and 12 mg/day) with placebo, all doses were superior to placebo on the PANSS and all PANSS factors and the CGI scale.

In the third placebo-controlled 6-week trial (n=432) comparing fixed doses of INVEGA (6 and 12 mg/day) with placebo, both doses were superior to placebo on the PANSS and the CGI scale.

**Table 2.1:** Positive and Negative Syndrome Scale for Schizophrenia (PANSS) Total Score – Change From Baseline to End Point – LOCF for Each Study and Intent-to-Treat Analysis Set

	Placebo	INVEGA			
		3 mg	6 mg	9 mg	12 mg
<b>R076477-SCH-303</b>	(N=126)		(N=123)	(N=122)	(N=129)
N	126		123	122	129
Mean baseline	94.1		94.3	93.2	94.6
Mean change	-4.1		-17.9	-17.2	-23.3
P-value (vs. Placebo) <sup>a, b</sup>			<0.001	<0.001	<0.001
<b>R076477-SCH-304</b>	(N=105)		(N=111)		(N=111)
N	105		110		111
Mean baseline	93.6		92.3		94.1
Mean change	-8.0		-15.7		-17.5
P-value (vs. Placebo) <sup>a, b</sup>			0.006		<0.001
<b>R076477-SCH-305</b>	(N=120)	(N=123)		(N=123)	
N	120	123		123	
Mean baseline	93.9	91.6		93.9	
Mean change	-2.8	-15.0		-16.3	
P-value (vs. Placebo) <sup>a, b</sup>		<0.001		<0.001	

<sup>a</sup> Based on ANCOVA model with treatment (placebo and ER OROS paliperidone arms in each protocol) and analysis center as factors, and baseline value as a covariate.

<sup>b</sup> Pairwise comparison: p-values associated with Dunnett's procedure.

The number of patients 65 years of age or older exposed to INVEGA during a placebo-controlled clinical trial in elderly subjects receiving flexible doses (3 – 12 mg/day) was limited (n=76). In general, the types and frequencies of adverse events reported in these subjects in this study were similar to those reported in the younger population of adult subjects studied in three placebo-controlled, 6-week, fixed-dose trials. Based on the limited data and consistent with general clinical practice, a greater sensitivity of older individuals to adverse events, including cardiac events, cannot be ruled out.

In a longer-term, placebo-controlled trial, clinically stable patients with schizophrenia who were being maintained on INVEGA for 8 weeks (doses ranging from 3 to 15 mg once daily) were then randomized in a double-blind manner to either continue on INVEGA at their achieved stable dose or to placebo until they experienced a recurrence of schizophrenia symptoms. Patients treated with INVEGA experienced a significantly longer time to relapse following randomization compared to

placebo. An interim analysis performed when 43 recurrence events were reported, allowing for early termination of the study by predefined criteria, showed a significantly longer time to first recurrence in patients treated with INVEGA compared to placebo ( $p=0.0053$ ). At the final analysis, twice as many patients in the placebo group (51.5%) experienced a recurrence event as in the INVEGA group (22.1%).

## **DETAILED PHARMACOLOGY**

### **Preclinical Pharmacodynamics**

Paliperidone is the major active metabolite of risperidone and is pharmacologically very similar to the parent compound. In a series of standard in vivo pharmacology tests, paliperidone, its enantiomers and risperidone showed similar effects at closely related doses. In vitro, paliperidone and risperidone (1) shared nearly the same binding affinity for 5-HT<sub>2A</sub>, D<sub>2</sub>,  $\alpha_1$ , and  $\alpha_2$  receptors, (2) reversed dopamine-induced suppression of PRL release from anterior pituitary cells, and (3) reduced 5-HT-induced human platelet aggregation.

Paliperidone displays approximately 15 times higher affinity towards 5-HT<sub>2A</sub> receptors when compared with clozapine and approximately 120 times higher affinity compared with haloperidol. The affinity to D<sub>2</sub> receptors was about 20 times higher compared to clozapine and only 2 to 3 times lower compared with haloperidol. Paliperidone differed from clozapine and haloperidol by the remarkably shallow slope of its D<sub>2</sub> receptor dose occupancy curve.

Similar to risperidone, paliperidone does not interact with cholinergic muscarinic receptors.

### **Cardiovascular Pharmacology**

Paliperidone was devoid of major effects on several electrophysiological parameters in isolated cells and cardiac tissues in vitro, at concentrations matching and slightly exceeding therapeutically achieved plasma levels in man. Paliperidone and risperidone produced similar effects on cardio-hemodynamic parameters. Following administration of paliperidone in awake rats (i.v., s.c.) and dogs (p.o.), and in anesthetized dogs, guinea pigs and rabbits (i.v.) at higher tested dose levels, paliperidone produced cardiovascular effects consisting mainly of increased heart rate, decreased blood pressure, and changes in QT- and PQ-intervals. However, the results from these in vivo studies indicated an absence of cardiac electrophysiological effects, including QTc changes, with paliperidone at doses yielding plasma concentrations slightly in excess of the therapeutic ones in humans.

### **Preclinical Pharmacokinetics**

Paliperidone exhibited species-dependent stereoselectivity in disposition and plasma protein binding. (-)-Paliperidone was more abundant than (+)-paliperidone in plasma of laboratory animals but not in humans. In mice and rats, (+)-paliperidone showed a higher free fraction, while in dogs and humans, the free fraction of (-)-paliperidone was higher than that of (+)-paliperidone.

Paliperidone was shown to distribute to specific brain regions with high density of 5-HT<sub>2A</sub>- and D<sub>2</sub>-receptors and to achieve exposure that was in excess of that in plasma. There was no undue tissue retention of paliperidone except in melanin-containing tissues of pigmented rats. The melanin binding of paliperidone was shown to be reversible.

The major biotransformation routes of paliperidone were similar in laboratory animals and in humans. All metabolites identified in the human mass balance study were also observed in at least one laboratory animal species. All the metabolites that were identified following paliperidone administration in humans were also observed following risperidone administration in humans.

### **Drug Interactions**

Paliperidone at relevant clinical concentrations had no or only marginal inhibitory effect on the major CYP450s including CYP1A2, CYP2A6, CYP2C8/9/10, CYP2D6, CYP2E1, CYP3A4, and CYP3A5. Paliperidone was shown to be a P-glycoprotein substrate but the influence of any drug-drug interaction with P-glycoprotein at the level of the blood-brain barrier is likely to be modest.

## **TOXICOLOGY**

Paliperidone was tested in an extensive series of toxicity studies. At equal dose levels, the toxicity profile of paliperidone was similar to risperidone in comparative repeat-dose toxicity studies in mice, rats and dogs. The toxicity profile mainly consisted of findings related to exaggerated pharmacodynamic effects of CNS- and PRL-mediated actions.

In the repeat-dose toxicity studies, NOELs could not be established because signs of exaggerated pharmacology were evident at the lowest dose tested; however, NOAELS were established. Exposure-based safety margins generally were low compared to the systemic exposure at the maximum recommended human dose. However, the main toxicity findings are either species-specific or can be easily assessed in the clinic.

Paliperidone ER tablets containing 15 mg of paliperidone were shown to be well tolerated in the GI tract of dogs in a 3-month repeat-dose toxicity study.

Genotoxicity studies were negative.

Slight pre-implantation loss was noted at the highest dose level (2.5 mg/kg/day for 21 days) in the female fertility study. The estimated exposure at the embryo-fetal NOEL in this study is similar to that attained in humans and the maximum recommended human dose. Since the increase in pre-implantation loss only occurred in the presence of maternal toxicity, this effect is of little relevance in terms of human risk.

The embryo-fetal developmental toxicity study with paliperidone in rabbits showed slight post-implantation loss at the highest dose level (5 mg/kg/day). The embryo-fetal NOAEL in this study yielded systemic exposure 22- to 34-fold higher than in humans at the maximum recommended human dose. These findings are considered to be of little relevance in terms of human risk.

The carcinogenic potential of paliperidone, an active metabolite of risperidone, was assessed based on studies with risperidone conducted in mice and rats. There were statistically significant increases in pituitary gland adenomas, endocrine pancreas adenomas, and mammary gland adenocarcinomas. These findings are considered to be of little predictive value to humans.

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**PART III: CONSUMER INFORMATION**

**PrINVEGA\***  
paliperidone Extended-release Tablets

This leaflet is Part III of a three-part "Product Monograph" published when INVEGA was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about INVEGA. Contact your doctor or pharmacist if you have any questions about the drug.

**ABOUT THIS MEDICATION**

**What the medication is used for:**

The doctor has prescribed INVEGA, also known as paliperidone, to help relieve the symptoms that are bothering you / the patient you are caring for. Although INVEGA cannot cure the illness, it can keep the symptoms under control and reduce the risk of relapse as you / the patient you are caring for continues treatment.

INVEGA belongs to a group of medicines called antipsychotic drugs. INVEGA is used to treat the symptoms of schizophrenia, which may include hallucinations (hearing, seeing or sensing things that are not there), mistaken beliefs, unusual suspiciousness, becoming withdrawn, incoherent speech, and behavioural and emotional flatness. People suffering from schizophrenia may also feel depressed, anxious, guilty or tense.

**What it does:**

Antipsychotic medications affect the chemicals that allow communication between nerve cells (neurotransmitters). These chemicals are called dopamine and serotonin. Exactly how INVEGA works is unknown. However, it seems to readjust the balance of dopamine and serotonin.

**When it should not be used:**

Do not take / give INVEGA if you/the patient you are caring for has had an allergic reaction to the medicine, or a related drug (risperidone), or any of the nonmedicinal ingredients.

Symptoms of an allergic reaction may include: itching, skin rash, swelling of the face, lips or tongue, shortness of breath.

**If you experience any of these symptoms / if these symptoms are experienced by the patient you are caring for, your doctor / the treating physician should be contacted immediately.**

**What the medicinal ingredient is:**

Paliperidone

**What the nonmedicinal ingredients are:**

The following inactive ingredients are common to all tablet strengths: butylated hydroxytoluene, carnauba wax, cellulose acetate, ferric oxide red, ferric oxide yellow, hydroxyethyl cellulose, hypromellose, iron oxide black, polyethylene oxides, polyethylene glycol, propylene glycol, povidone,

sodium chloride, stearic acid, and titanium dioxide.

The 3 mg tablets also contain lactose and triacetin.

**What dosage forms it comes in:**

INVEGA tablets are available in the following dosage strengths:  
3 mg, 6 mg and 9 mg

**WARNINGS AND PRECAUTIONS**

**Serious Warnings and Precautions**

Studies with various medicines of the group to which INVEGA belongs, when used in elderly patients with dementia, have been associated with an increased rate of death. Some of these studies included treatment with a related drug, RISPERDAL (risperidone). INVEGA is not indicated in elderly patients with dementia.

BEFORE you use INVEGA, talk to your doctor or pharmacist if you:

- have a history of stroke, mini-stroke, high cholesterol or high blood pressure
- were previously diagnosed with a condition known as Neuroleptic Malignant Syndrome (high temperature and muscle stiffness) or Tardive Dyskinesia (abnormal movements of the tongue or face). Both of these are conditions caused by antipsychotic drugs.
- have diabetes or a family history of diabetes
- are pregnant or planning to become pregnant
- are breast-feeding
- have/had a heart disease or heart disease treatment that makes you prone to low blood pressure
- have/have ever had blackouts or seizures
- have a narrowing or blockage of your gastrointestinal tract (your esophagus, stomach, or large or small intestine)
- have Parkinson's disease or Dementia with Lewy Bodies (DLB)
- are taking any other medicines (prescription or over-the-counter)
- drink alcoholic beverages or use drugs
- suffer from lactose intolerance because INVEGA tablets contain lactose
- are taking RISPERDAL (risperidone)
- have a history of kidney problems
- suffer from Alzheimer's disease
- are dehydrated
- exercise strenuously

In elderly patients with dementia, medicines in the same group as INVEGA have been associated with side effects including sudden change in mental state or sudden weakness or numbness of the face, arms or legs, especially on one side, slurred speech or vision problems. If any of these should occur, even for a short period of time, seek medical attention right away.

Shaking, muscle stiffness and difficulty in feeding, all of which are reversible, have been observed in newborns if a mother used RISPERDAL (risperidone) in the last trimester of her pregnancy. The same effects may occur when taking INVEGA.

It is important for the doctor to have all the above information before prescribing treatment and dosage. This list should be carefully reviewed by you and discussed with the doctor.

The safety and efficacy of INVEGA in children under the age of 18 have not been established.

## INTERACTIONS WITH THIS MEDICATION

Inform all doctors, dentists and pharmacists who are treating you that you are taking INVEGA. Inform them if you are taking or are planning on taking any other medicine. They will tell you which medicines you can take with INVEGA.

Since INVEGA works primarily in the brain, interference with other drugs that work in the brain (including alcohol) could occur. It is recommended that you DO NOT drink alcohol and only take drugs prescribed by your doctor.

Dopamine agonists, e.g. levodopa (antiparkinsonian agent), may decrease the effect of INVEGA.

Carbamazepine (an anticonvulsant) has been shown to decrease the levels of INVEGA in your blood. Since INVEGA can lower blood pressure, care should be taken when INVEGA is taken with other drugs that lower blood pressure.

## PROPER USE OF THIS MEDICATION

### Usual dose:

**Do not chew, crush or divide the tablets.** Swallow INVEGA tablets whole with water or other liquids.

Take INVEGA once each day preferably in the morning with or without food.

The INVEGA tablet does not dissolve completely after all the drug has been released, and you may sometimes notice it in your stool. This is normal.

It is very important that you take / give INVEGA the way the doctor has prescribed it.

The doctor has decided on the best dosage for you / the patient you are caring for based on individual needs. Dosage may be increased or decreased depending on the response.

It is important that you keep taking / giving INVEGA even after your / the symptoms have improved or disappeared. Do not change or stop taking / giving INVEGA without consulting the doctor.

DO NOT give INVEGA to anyone else. The doctor has prescribed it for you/the patient you are caring for.

### Overdose:

Immediately contact your doctor or go to the nearest hospital emergency department.

One or more of the following signs may occur in an overdose: sleepiness, drowsiness, tiredness, abnormal body movements, problems with standing and walking, dizziness from low blood pressure, abnormal heart beats, rapid heartbeat, reduced consciousness, and excessive trembling or excessive muscle stiffness.

### Missed dose:

If you miss a dose, do not take a double dose to make up for a forgotten dose.

If you miss one dose, take your next dose on the day following the missed dose.

If you miss two or more doses, contact your doctor.

## SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Like other medications, INVEGA can cause some side effects. These side effects are most likely to be minor and temporary. However, some may be serious and need medical attention. Many of the side effects are dose related, so it is important not to exceed your prescribed dose.

Very commonly headache may be experienced.

Common side effects may include: anxiety, sleepiness, faster heart rate, slowed heart rate, heart beat irregularities, lack of energy, restlessness, feeling dizzy, drop in blood pressure upon standing, stomach ache, dry mouth, increased saliva, being sick (vomiting), constipation, trembling, slowness of movement, muscle stiffness or spasm, and increased weight.

Uncommon side effects may include: increased appetite, runny nose, nightmares, swelling of legs or other body area, feeling dizzy upon standing, uncontrollable movements of face or body, seizures, sensation the room is spinning, painful eye movement, sensation your heart is racing, variation in heart rate, heart rhythm changes, decreased blood pressure, decreased blood flow, rigid muscles. Women may experience leakage of fluid or milk from the breast or missed or irregular periods. Men may experience breast swelling or difficulty getting or maintaining an erection.

Because some people experience drowsiness or blurred vision, you should not drive or operate machinery until you are reasonably certain that INVEGA does not affect your ability to carry out these activities.

In rare cases, high blood sugar has been reported. See your doctor if you experience symptoms such as excessive thirst or urination.

If you notice any side effects not listed in this leaflet, please tell your doctor or pharmacist.

Do not be alarmed by this list of possible side effects. You may not experience any of them. If any of these side effects are experienced, they are usually mild and temporary. However, do not hesitate to report undesired side effects to your doctor.

<b>SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM</b>				
Symptom / effect		Call your doctor right away		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
<b>Uncommon</b>	Symptoms of allergic reaction, such as itching, skin rash, swelling of the mouth, face, lips, or tongue, or shortness of breath.			✓
<b>Very Rare</b>	A state of confusion, reduced consciousness, high fever, or pronounced muscle stiffness.		✓	
	Marked changes in body temperature (generally as a result of several factors together including extreme heat or cold).		✓	

**Seek medical attention right away if the following occur while you or the patient you are caring for are/is taking INVEGA:**

- muscle twitching or abnormal movements of the face or tongue
- sudden change in mental state or sudden weakness or numbness of the face, arms or legs, especially on one side, slurred speech or vision problems, even for a short period of time
- continuous erection of the penis
- if you have taken INVEGA in the last three months of your pregnancy and you notice that your newborn baby develops shaking, muscle stiffness or difficulty in feeding. These symptoms can be reversible. Contact your doctor immediately.

*This is not a complete list of side effects. For any unexpected effects while taking INVEGA, contact your doctor or pharmacist.*

## HOW TO STORE IT

Store INVEGA in its original package.

INVEGA tablets should be stored between 15 - 30°C. Protect from moisture.

Keep INVEGA out of the reach of children.

The expiry date for INVEGA is printed on the package. Do not use the medicine in the package after this date.

## REPORTING SUSPECTED SIDE EFFECTS

To monitor drug safety, Health Canada, through the Canada Vigilance Program, collects information on serious and unexpected effects of drugs. If you suspect you have had a serious or unexpected reaction to this drug you may notify Canada Vigilance:

By toll-free telephone: 866-234-2345  
 By toll-free fax: 866-678-6789  
 online: [www.healthcanada.gc.ca/medeffect](http://www.healthcanada.gc.ca/medeffect)  
 By email: [CanadaVigilance@hc-sc.gc.ca](mailto:CanadaVigilance@hc-sc.gc.ca)

By regular mail:  
 Canada Vigilance National Office  
 Marketed Health Products Safety & Effectiveness  
 Information Bureau  
 Marketed Health Products Directorate  
 Health Products & Food Branch  
 Health Canada  
 Tunney's Pasture, AL 0701C  
 Ottawa, ON K1A 0K9

**NOTE: Should you require information related to the management of the side effect, please contact your health care provider before notifying Canada Vigilance. The Canada Vigilance Program does not provide medical advice.**

## MORE INFORMATION

This document plus the full Product Monograph, prepared for health professionals can be found at:

<http://www.janssen-ortho.com>

or by contacting the sponsor, Janssen-Ortho Inc., at: 1-800-567-3331.

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