

# DICHLORPHENAMIDE- dichlorphenamide tablet

## Torrent pharmaceuticals limited

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### HIGHLIGHTS OF PRESCRIBING INFORMATION

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

### DICHLORPHENAMIDE tablets, for oral use

**Initial U.S. Approval: 1958**

#### INDICATIONS AND USAGE

Dichlorphenamide tablets are an oral carbonic anhydrase inhibitor indicated for the treatment of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants ( 1)

#### DOSAGE AND ADMINISTRATION

- Initiate dosing at 50 mg by mouth once or twice daily ( 2.1)
- Titrate up or down dose based on individual response ( 2.1)
- The minimum recommended dosage is 50 mg daily, and the maximum recommended dosage is 200 mg daily ( 2.1)
- Evaluate response to dichlorphenamide tablets after 2 months of treatment ( 2.2)

#### DOSAGE FORMS AND STRENGTHS

Tablets: 50 mg ( 3)

#### CONTRAINDICATIONS

- Hepatic insufficiency ( 4)
- Severe pulmonary obstruction ( 4)
- Hypersensitivity to dichlorphenamide or other sulfonamides ( 4)
- Concomitant use with high dose aspirin ( 4)

#### WARNINGS AND PRECAUTIONS

- Hypersensitivity and Other Life-Threatening Reactions: discontinue dichlorphenamide at the first appearance of skin rash or any sign of immune- mediated or idiosyncratic adverse reaction ( 5.1)
- Hypokalemia: baseline and periodic measurements of serum potassium are recommended; if hypokalemia develops or persists, consider reducing the dose or discontinuing dichlorphenamide and correcting potassium levels ( 5.3)
- Metabolic acidosis: baseline and periodic measurements of serum bicarbonate are recommended; if metabolic acidosis develops or persists, consider reducing the dose or discontinuing dichlorphenamide ( 5.4)
- Falls: consider reducing the dose or discontinuing dichlorphenamide in patients who experience falls ( 5.5)

#### ADVERSE REACTIONS

Most common adverse reactions (incidence at least 10% and greater than placebo) include paresthesias, cognitive disorder, dysgeusia, and confusional state ( 6.1)

**To report SUSPECTED ADVERSE REACTIONS, contact Torrent Pharma, Inc. at 1-800-912-9561 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

#### DRUG INTERACTIONS

Aspirin: anorexia, tachypnea, lethargy, and coma have been reported with concomitant use of dichlorphenamide and high-dose aspirin. The concomitant use of dichlorphenamide tablets and high-dose aspirin is contraindicated. Dichlorphenamide tablets should be used with caution in patients receiving lower doses of aspirin ( 4, 5.2, 7.1)

#### USE IN SPECIFIC POPULATIONS

Pregnancy: Based on animal data, may cause fetal harm ( 8.1)

**See 17 for PATIENT COUNSELING INFORMATION.**

**Revised: 1/2023**

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## **FULL PRESCRIBING INFORMATION**

### **1 INDICATIONS AND USAGE**

Dichlorphenamide tablets are indicated for the treatment of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants.

## **2 DOSAGE AND ADMINISTRATION**

### **2.1 Dosage Information**

Initiate dosing at 50 mg by mouth or twice daily. The dosage may be increased or decreased based on individual response, at weekly intervals (or sooner in case of adverse reaction). The minimum recommended total daily dosage is 50 mg, and the maximum recommended total daily dosage is 200 mg.

### **2.2 Monitoring to Assess Effectiveness**

Primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants are a heterogeneous group of conditions, for which the response to dichlorphenamide may vary. Therefore, prescribers should evaluate the patient's response to dichlorphenamide after 2 months of treatment to decide whether dichlorphenamide tablets should be continued.

### **2.3 Monitoring to Assess Safety**

Baseline and periodic measurements of serum potassium and sodium bicarbonate during dichlorphenamide treatment is recommended [see *Warnings and Precautions ( 5.3, 5.4)*].

## **3 DOSAGE FORMS AND STRENGTHS**

White to off-white, round shaped, flat faced beveled edged tablet, scored on one side, engraved with 'ZD' above the score and '50' below the score, the other side is plain.

## **4 CONTRAINDICATIONS**

Dichlorphenamide is contraindicated in the following circumstances:

- Hypersensitivity to dichlorphenamide or other sulfonamides [see *Warnings and Precautions ( 5.1)*]
- Concomitant use of dichlorphenamide and high dose aspirin [see *Warnings and Precautions ( 5.2)* and *Drug Interactions ( 7.1)*]
- Severe pulmonary disease, limiting compensation to metabolic acidosis caused by dichlorphenamide [see *Warnings and Precautions ( 5.4)*]
- Hepatic insufficiency: dichlorphenamide may aggravate hepatic encephalopathy.

## **5 WARNINGS AND PRECAUTIONS**

### **5.1 Hypersensitivity and Other Life-Threatening Reactions**

Fatalities associated with the administration of sulfonamides have occurred because of adverse reactions including Stevens-Johnson syndrome, toxic epidermal necrolysis, fulminant hepatic necrosis, agranulocytosis, aplastic anemia, and other blood

dyscrasias. Pulmonary involvement can occur in isolation or as part of a systemic reaction.

Dichlorphenamide should be discontinued at the first appearance of skin rash or any sign of immune-mediated or other life-threatening adverse reaction.

## **5.2 Concomitant Use of Aspirin or Other Salicylates**

Carbonic anhydrase inhibitors, including dichlorphenamide, can cause metabolic acidosis [see *Warnings and Precautions* ( 5.4)] , which can increase the risk of salicylate toxicity. Anorexia, tachypnea, lethargy, and coma have been reported with concomitant use of dichlorphenamide and high-dose aspirin. Therefore, the concomitant use of dichlorphenamide and high-dose aspirin is contraindicated.

Patients with concomitant use of dichlorphenamide and low-dose aspirin should be carefully monitored.

## **5.3 Hypokalemia**

Dichlorphenamide increases potassium excretion and can cause hypokalemia. The risk of hypokalemia is greater when dichlorphenamide is used in patients with conditions associated with hypokalemia (e.g., adrenocortical excess, renal tubular acidosis type 1 and 2), and in patients receiving other drugs that may cause hypokalemia [see *Drug Interactions* ( 7.3)] .

Baseline and periodic measurements of serum potassium during dichlorphenamide treatment is recommended.

If hypokalemia develops or persists, consideration should be given to reducing the dose or discontinuing dichlorphenamide and correction of potassium levels.

## **5.4 Metabolic Acidosis**

Dichlorphenamide can cause hyperchloremic non-anion gap metabolic acidosis. Concomitant use of dichlorphenamide with other drugs that cause metabolic acidosis may increase the severity of acidosis. Concomitant use of dichlorphenamide in compensated patients with respiratory acidosis, such as in advanced lung diseases, may lead to respiratory decompensation.

Baseline and periodic measurements of serum bicarbonate during dichlorphenamide treatment are recommended.

If metabolic acidosis develops or persists, consideration should be given to reducing the dose or discontinuing dichlorphenamide [see *Drug Interactions* ( 7.4)].

## **5.5 Falls**

Dichlorphenamide increases the risk of falls. The risk of falls is greater in the elderly and with higher doses of dichlorphenamide. Consider dose reduction or discontinuation of dichlorphenamide in patients who experience falls while treated with dichlorphenamide.

## **6 ADVERSE REACTIONS**

The following serious adverse reactions are described elsewhere in labeling:

- Hypersensitivity and Other Life-Threatening Reactions [see Warnings and Precautions ( 5.1)]
- Hypokalemia [see Warnings and Precautions ( 5.3)]
- Metabolic Acidosis [see Warnings and Precautions ( 5.4)]
- Falls □[see Warnings and Precautions ( 5.5)]

## 6.1 Clinical Trial Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In a 9-week randomized controlled trial in adults with hyperkalemic or hypokalemic periodic paralysis (Study 1), the most common adverse reactions in patients treated with dichlorphenamide, with rates greater than placebo, were paresthesia, cognitive disorder, dysgeusia, and confusional state. The mean dose of dichlorphenamide was 94 mg/day in patients with hypokalemic periodic paralysis and 82 mg/day in patients with hyperkalemic periodic paralysis.

Table 1 lists the incidence of adverse reactions that occurred in  $\geq 5\%$  of patients treated with dichlorphenamide and more commonly than in patients treated with placebo in Study 1.

**Table 1: Adverse Reactions in Patients Treated with dichlorphenamide with Incidence  $\geq 5\%$  and more common than in Patients Treated with Placebo in Study 1**

	<b>Adverse Reaction</b>	<b>Dichlorphenamide</b> N = 36 (%)	<b>Placebo</b> N = 29 (%)
	Paresthesia	44	14
	Cognitive disorder <sub>1</sub>	14	7
Nervous system disorders	Dysgeusia	14	0
	Confusional state	11	0
	Headache	8	7
	Hypoesthesia	8	0
	Lethargy	8	0
Gastrointestinal disorders	Dizziness	6	0
	Diarrhea	6	3
	Nausea	6	0
General disorders and administration site conditions	Fatigue	8	0
	Malaise	6	0
Investigations	Weight decreased	6	0
	Muscle spasms	8	0
Musculoskeletal and connective tissue disorders	Arthralgia	6	3
	Muscle twitching	6	0
Respiratory	Dyspnea	6	0

	Pharyngolaryngeal pain	6	0
Skin	Rash	8	0
	Pruritus	6	0

<sup>1</sup>Cognitive disorder combined cases with the preferred terms of *cognitive disorder, disturbance in attention, and mental impairment*.

## 6.2 Postmarketing Experience

Adverse reactions have been identified during postapproval use of dichlorphenamide. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

The following are adverse reactions which have been reported during postapproval use of dichlorphenamide and were serious or are not reported in the previous section of labeling [see *Clinical Trials Experience ( 6.1)*]: amnesia, cardiac failure, condition aggravated, convulsion, hallucination, nephrolithiasis, pancytopenia, psychotic disorder, renal tubular necrosis, stupor, syncope, tremor.

## 7 DRUG INTERACTIONS

### 7.1 Aspirin and Other Salicylates

Carbonic anhydrase inhibitors, including dichlorphenamide, can cause metabolic acidosis [see *Warning and Precautions ( 5.2, 5.4)*], which can increase the risk of salicylate toxicity. Anorexia, tachypnea, lethargy, and coma have been reported with concomitant use of dichlorphenamide and high-dose aspirin. Therefore, concomitant use of dichlorphenamide and high-dose aspirin is contraindicated. Patients with concomitant use of dichlorphenamide and low-dose aspirin should be carefully monitored [see *Contraindications ( 4) and Warnings and Precautions ( 5.2)*].

### 7.2 Drugs that are Substrates of Organic Anion Transporter1 (OAT1)

*In vitro*, dichlorphenamide is an inhibitor of OAT1 transporters. The concomitant administration of dichlorphenamide may increase the plasma exposures of OAT1 substrates. Use of dichlorphenamide with drugs that are sensitive to OAT1 inhibition (e.g., methotrexate, famotidine, oseltamivir) is not recommended [see *Clinical Pharmacology ( 12.3)*].

### 7.3 Drugs that Cause Hypokalemia

The risk of hypokalemia is greater with coadministration of dichlorphenamide and other drugs that can cause hypokalemia (e.g., loop diuretics, thiazide diuretics, laxatives, antifungals, penicillins, and theophylline) [see *Warnings and Precautions ( 5.3)*].

### 7.4 Drugs that Cause Metabolic Acidosis

Coadministration of dichlorphenamide and other drugs that can cause metabolic acidosis may increase the severity of the acidosis [see *Warnings and Precautions ( 5.4)*].

## 7.5 Drugs that are Inhibitors of OAT1 or OAT3

An *in vitro* transporter study indicated that dichlorphenamide is a substrate of human transporters OAT1 and OAT3 [see *Clinical Pharmacology* ( 12.3)] . Therefore, signs of dichlorphenamide toxicity should be monitored when administered with OAT1 or OAT3 inhibitors.

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

#### Risk Summary

There are no adequate data on the developmental risk associated with the use of dichlorphenamide in pregnant women. A no-effect dose has not been established. Dichlorphenamide was teratogenic when administered orally to pregnant rats.

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

#### Clinical Considerations

##### *Fetal/Neonatal adverse reactions*

Dichlorphenamide treatment can cause metabolic acidosis [see *Warnings and Precautions* ( 5.4)] . The effect of dichlorphenamide-induced metabolic acidosis has not been studied in pregnancy; however, metabolic acidosis in pregnancy (due to other causes) can cause decreased fetal growth, decreased fetal oxygenation, and fetal death, and may affect the fetus' ability to tolerate labor. Pregnant patients should be monitored for metabolic acidosis and treated as in the nonpregnant state. Newborns of mothers treated with dichlorphenamide should be monitored for metabolic acidosis because of possible occurrence of transient metabolic acidosis following birth.

##### *Labor or Delivery*

Although the effect of dichlorphenamide on labor and delivery in humans has not been established, the development of dichlorphenamide-induced metabolic acidosis in the mother and/or in the fetus might affect the fetus' ability to tolerate labor.

#### Data

##### *Animal Data*

Teratogenic effects (fetal limb reduction defects) were reported following oral administration of dichlorphenamide to pregnant rats during organogenesis at 350 mg/kg, or 17 times the maximum recommended human dose (200 mg/day) on a body surface area (mg/m<sup>2</sup>) basis. A no-effect dose for adverse effects on embryofetal development has not been established.

### 8.2 Lactation

#### Risk Summary

There are no data on the presence of dichlorphenamide in human milk, the effects on the breastfed infant, or the effects on milk production.

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for dichlorphenamide and any potential adverse effects on the breastfed infant from dichlorphenamide or from the underlying maternal condition.

#### 8.4 Pediatric Use

Safety and effectiveness of dichlorphenamide in pediatric patients have not been established.

#### 8.5 Geriatric Use

The risk of falls and of metabolic acidosis are greater in elderly patients [see *Warnings and Precautions* ( 5.4, 5.5)].

### 10 OVERDOSAGE

Symptoms of overdosage or toxicity may include drowsiness, anorexia, nausea, vomiting, dizziness, ataxia, tremor, and tinnitus.

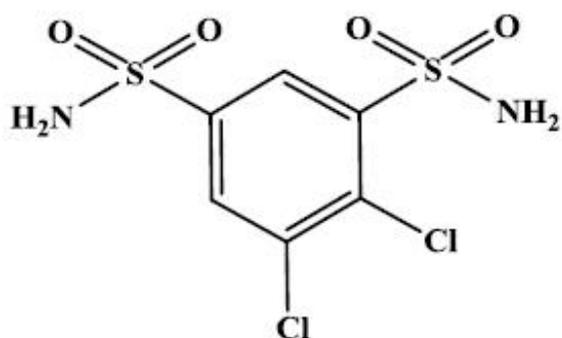
In the event of overdosage, induce emesis or perform gastric lavage. The electrolyte disturbances most likely to be encountered from overdosage are hypokalemia and hyperchloremic metabolic acidosis.

### 11 DESCRIPTION

Dichlorphenamide tablets USP contain dichlorphenamide, an oral carbonic anhydrase inhibitor.

Dichlorphenamide USP, a dichlorinated benzenedisulfonamide, is known chemically as 4,5-dichloro- 1,3-benzenedisulfonamide.

Its empirical formula is  $C_6H_6Cl_2N_2O_4S_2$  and its structural formula is:



Dichlorphenamide USP is a white or practically white, crystalline powder with a molecular weight of 305.16. It is very slightly soluble in water but soluble in dilute solutions of alkali carbonate and hydroxide.

Dichlorphenamide tablets USP are supplied as tablets, for oral administration, each containing 50 mg dichlorphenamide USP. Inactive ingredients are lactose monohydrate, partially pregelatinized starch and magnesium stearate.

FDA Approved dissolution test specifications differ from USP.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Dichlorphenamide is a carbonic anhydrase inhibitor. However, the precise mechanism by which dichlorphenamide exerts its therapeutic effects in patients with primary periodic paralysis is unknown.

### 12.2 Pharmacodynamics

Dichlorphenamide can cause metabolic acidosis, which can increase the risk of salicylate toxicity with coadministration [see *Warnings and Precautions* ( 5.2)]. Dichlorphenamide-induced metabolic acidosis can also increase in severity with coadministration of other drugs that cause metabolic acidosis [see *Warnings and Precautions* ( 5.4)].

### 12.3 Pharmacokinetics

After single-dose administration in healthy subjects in fasted state, dichlorphenamide  $C_{max}$  and AUC increased in a dose-proportional manner within the range of 25 mg to 400 mg (2 times the maximum recommended dose). The steady-state is expected to be achieved within 10 days of twice-daily dosing.

#### Absorption

The median time to reach maximum concentration ( $T_{max}$ ) of dichlorphenamide was about 1.5 to 3 hours postdose after both single and multiple dose administrations.

#### Distribution

The plasma protein binding of dichlorphenamide is approximately 88%.

#### Elimination

Following a single-dose administration, mean terminal half-life was in the range of 32 to 66 hours.

#### Metabolism

Dichlorphenamide is not a substrate for CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6 and CYP3A4 isoforms when tested *in vitro*.

#### Drug Interaction Studies

##### *In vitro Assessment of Drug Interactions*

##### *Drug-Metabolizing Enzyme Inhibition*

Dichlorphenamide is not an inhibitor for CYP1A2, 2B6, 2C8, 2C9, 2C19, 2D6, or 3A4 enzymes when tested *in vitro*.

##### *Drug-Metabolizing Enzyme Induction*

Dichlorphenamide is not an inducer for CYP1A2, 2B6, or 3A4 enzymes when tested *in vitro*.

##### *In vitro Assessment of Transporter-Drug Interactions*

Dichlorphenamide is neither a substrate nor inhibitor for p-gp, BCRP, OATP1B1,

OATP1B3, OAT2, OAT4, OCT1, OCT2, MATE1, or MATE2-K when tested *in vitro*.

Dichlorphenamide is not an inhibitor of OAT3, but is an inhibitor of OAT1 based on *in vitro* studies [see *Drug Interactions* ( 7.4)].

Dichlorphenamide is a substrate for transporters OAT1 and OAT3 based on *in vitro* studies [see *Drug Interactions* ( 7.2)]

#### *In Vivo Drug Interactions*

The use of dichlorphenamide in combination with high-dose aspirin is contraindicated as it may lead to salicylate toxicity. The mechanism(s) of this interaction is not known.

#### Specific Populations

##### *Geriatrics*

The pharmacokinetics of dichlorphenamide in the elderly has not been determined.

## **13 NONCLINICAL TOXICOLOGY**

### **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**

#### Carcinogenesis

Studies to assess the carcinogenic potential of dichlorphenamide have not been conducted.

#### Mutagenesis

Studies to assess the genotoxicity of dichlorphenamide have not been conducted.

#### Impairment of Fertility

Studies to assess the effects of dichlorphenamide on fertility have not been conducted.

## **14 CLINICAL STUDIES**

The efficacy of dichlorphenamide tablets was evaluated in two clinical studies, Study 1 and Study 2.

### Study 1

Study 1 was a 9-week, double-blind, placebo-controlled multi-center study. Study 1 consisted of two substudies: a substudy in patients with hypokalemic periodic paralysis (n=44), and a substudy in patients with hyperkalemic periodic paralysis (n=21). The primary efficacy endpoint in both substudies was the average number of self-reported attacks of muscle weakness per week over the final 8 weeks of the trial. Withdrawal from the study for acute severe worsening (increase in attack frequency or severity) was also assessed as an endpoint.

In Study 1, the dose of dichlorphenamide tablets was 50 mg b.i.d. for treatment-naïve patients. Patients already on dichlorphenamide prior to the study continued on the same dose while on dichlorphenamide during the study. In patients taking acetazolamide prior to the study, the dose of dichlorphenamide was set at 20% of the acetazolamide dose. Dose reduction for tolerability was permitted.

#### *Hypokalemic Periodic Paralysis Substudy of Study 1*

In the hypokalemic periodic paralysis substudy, median age of patients was 45 years and 73% of patients were male. Patients treated with dichlorphenamide (n=24) had 2.2 fewer attacks per week than patients (n=20) treated with placebo (p=0.02). None of the patients randomized to dichlorphenamide reached the endpoint of withdrawal from the study for acute worsening, vs. five patients randomized to placebo. The mean dose of dichlorphenamide at Week 9 was 94 mg/day.

#### *Hyperkalemic Periodic Paralysis Substudy of Study 1*

In the Hyperkalemic Periodic Paralysis substudy, median age of patients was 43 years and 43% of patients were male. During the double-blind treatment period, patients treated with dichlorphenamide (n=12) had 3.9 fewer attacks per week than patients (n=9) treated with placebo (p=0.08). None of the patients randomized to dichlorphenamide reached the endpoint of withdrawal from the study for acute worsening, vs. two patients randomized to placebo. The mean dose of dichlorphenamide at Week 9 was 82 mg/day.

#### Study 2

Study 2 was a 35-week, double-blind, placebo-controlled, multi-center, two-period crossover study. Study 2 also consisted of two substudies: a substudy in patients with hypokalemic periodic paralysis (n=42), and a substudy in patients with hyperkalemic periodic paralysis (n=31), including patients with Paramyotonia Congenita. The primary endpoint in the hypokalemic periodic paralysis substudy was the incidence of acute intolerable worsening (based on attack frequency or severity) necessitating withdrawal. The primary endpoint in the hyperkalemic periodic paralysis substudy was the average number of self-reported attacks of muscle weakness per week. Dosing was determined similarly to Study 1.

#### *Hypokalemic Periodic Paralysis Substudy of Study 2*

The hypokalemic periodic paralysis substudy included patients with a mean age of 38 years; 79% of patients were male. Acute intolerable worsening was observed in 2 patients on dichlorphenamide vs. 11 patients on placebo (p=0.02). The mean dose of dichlorphenamide at the end of the study was 96 mg/day.

#### *Hyperkalemic Periodic Paralysis Substudy of Study 2*

The hyperkalemic periodic paralysis substudy included patients with a mean age of 37 years; and 79% of patients were male. Patients treated had 2.3 fewer attacks per week on dichlorphenamide than on placebo (p=0.006). The mean dose of dichlorphenamide at the end of the study was 73 mg/day.

## **16 HOW SUPPLIED/STORAGE AND HANDLING**

Each dichlorphenamide tablet USP, 50 mg is white to off-white, round shaped, flat faced beveled edged tablet, scored on one side, engraved with 'ZD' above the score and '50' below the score, the other side is plain.

Dichlorphenamide tablets are supplied as follows:

Bottles of 30	NDC 13668-676-30
Bottles of 100	NDC 13668-676-01

Store at 20° to 25°C (68° to 77°F); excursions permitted to 15° to 30°C (59° to 86°F)

[See USP Controlled Room Temperature].

## **17 PATIENT COUNSELING INFORMATION**

### Worsening of Symptoms

Advise patients to notify their physician if they experience acute worsening of symptoms of periodic paralysis.

### Hypersensitivity and Other Life-threatening Reactions

Inform patients that hypersensitivity and immune mediated reactions can occur with dichlorphenamide, and could be fatal. Advise patients to discontinue dichlorphenamide and notify their healthcare provider immediately if they develop a rash or signs and symptoms of anaphylaxis or other life-threatening reactions [see *Warnings and Precautions ( 5.1)*].

### Drug Interactions

Instruct patients to notify their healthcare provider of all of the drugs and over-the-counter medications that they take and to not take aspirin or other salicylates without first discussing with their healthcare provider [see *Drug Interactions ( 7.1, 7.2, 7.3, 7.4)*].

### Metabolic Acidosis

Instruct patients to contact their healthcare provider immediately if they develop possible manifestations of metabolic acidosis (e.g., fast breathing, fatigue/tiredness, loss of appetite, or irregular heart beat or palpitations) [see *Warnings and Precautions ( 5.4)*].

### Falls

Inform patients that dichlorphenamide can increase their risk of falls [see *Warnings and Precautions ( 5.5)*].

### Cognitive Impairment

Advise patients to notify their healthcare provider if they experience symptoms of cognitive impairment including confusion and memory lapse [see *Adverse Reactions ( 6.1)*].

### Driving and Operating Machinery

Dichlorphenamide may cause drowsiness/fatigue in some patients [see *Adverse Reactions ( 6.1)*]. Caution patients on the potential for impaired ability to drive and operate machinery.



### **Manufactured by:**

ZENARA PHARMA PVT. LTD., Hyderabad-500051, INDIA.

### **Manufactured for:**

TORRENT PHARMA INC., Basking Ridge, NJ 07920

8088950

Revised: August 2022

Dichlorphenamide 50 mg tablets 30 Counts

Each tablet contains 50 mg of dichlorphenamide, USP  
**Usual Dosage:** See Prescribing Information for dosage information.  
 Store at 20° to 25°C (68° to 77°F); excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].  
 Keep this and all medications out of the reach of children.  
 Dispense in a tight container with a child-resistant closure.

**Manufactured by:** ZENARA PHARMA PVT. LTD. Hyderabad-500051, INDIA.  
**Manufactured for:** TORRENT PHARMA INC. Basking Ridge, NJ 07920.

30 Tablets NDC 13668-676-30

**Dichlorphenamide Tablets, USP**

**50 mg**

8081342

 **Rx only**

LAB-PS0157/00 Mfg. Lic. No.: 01/RR/AP/2006/F/R

Over Printing Zone

## Dichlorphenamide 50 mg tablets 100 Counts

Each tablet contains 50 mg of dichlorphenamide, USP  
**Usual Dosage:** See Prescribing Information for dosage information.  
 Store at 20° to 25°C (68° to 77°F); excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].  
 Keep this and all medications out of the reach of children.  
 Dispense in a tight container with a child-resistant closure.

**Manufactured by:** ZENARA PHARMA PVT. LTD. Hyderabad-500051, INDIA.  
**Manufactured for:** TORRENT PHARMA INC. Basking Ridge, NJ 07920.

100 Tablets NDC 13668-676-01

**Dichlorphenamide Tablets, USP**

**50 mg**

8081343

 **Rx only**

LAB-PS0158/00 Mfg. Lic. No.: 01/RR/AP/2006/F/R

Over Printing Zone

## DICHLORPHENAMIDE

dichlorphenamide tablet

### Product Information

<b>Product Type</b>	HUMAN PRESCRIPTION DRUG	<b>Item Code (Source)</b>	NDC:13668-676
<b>Route of Administration</b>	ORAL		

### Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
<b>DICHLORPHENAMIDE</b> (UNII: VVJ6673MHY) (DICHLORPHENAMIDE - UNII:VVJ6673MHY)	DICHLORPHENAMIDE	50 mg

### Inactive Ingredients

Ingredient Name	Strength
<b>LACTOSE MONOHYDRATE</b> (UNII: EWQ57Q8I5X)	
<b>STARCH, CORN</b> (UNII: O8232NY3SJ)	
<b>MAGNESIUM STEARATE</b> (UNII: 70097M6130)	

### Product Characteristics

<b>Color</b>	white (to off-white)	<b>Score</b>	2 pieces
<b>Shape</b>	ROUND (flat faced beveled edged)	<b>Size</b>	6mm

<b>Flavor</b>		<b>Imprint Code</b>	ZD;50	
<b>Contains</b>				
<b>Packaging</b>				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:13668-676-30	30 in 1 BOTTLE; Type 0: Not a Combination Product	12/29/2022	
2	NDC:13668-676-01	100 in 1 BOTTLE; Type 0: Not a Combination Product	12/29/2022	
<b>Marketing Information</b>				
Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date	
ANDA	ANDA215924	12/29/2022		

**Labeler** - Torrent pharmaceuticals limited (650175722)

**Registrant** - Torrent Pharma, Inc. (790033935)

### Establishment

Name	Address	ID/FEI	Business Operations
Zenara Pharma Pvt. Ltd.		924839850	manufacture(13668-676) , pack(13668-676) , analysis(13668-676) , label(13668-676)

Revised: 11/2024

Torrent pharmaceuticals limited