

DEPAKOTE® ER
(divalproex sodium)
extended-release tablets

BOX WARNING

HEPATOTOXICITY

HEPATIC FAILURE RESULTING IN FATALITIES HAS OCCURRED IN PATIENTS RECEIVING VALPROIC ACID AND ITS DERIVATIVES. EXPERIENCE HAS INDICATED THAT CHILDREN UNDER THE AGE OF TWO YEARS ARE AT A CONSIDERABLY INCREASED RISK OF DEVELOPING FATAL HEPATOTOXICITY, ESPECIALLY THOSE ON MULTIPLE ANTICONVULSANTS, THOSE WITH CONGENITAL METABOLIC DISORDERS, THOSE WITH SEVERE SEIZURE DISORDERS ACCOMPANIED BY MENTAL RETARDATION, AND THOSE WITH ORGANIC BRAIN DISEASE. WHEN DEPAKOTE IS USED IN THIS PATIENT GROUP, IT SHOULD BE USED WITH EXTREME CAUTION AND AS A SOLE AGENT. THE BENEFITS OF THERAPY SHOULD BE WEIGHED AGAINST THE RISKS. ABOVE THIS AGE GROUP, EXPERIENCE IN EPILEPSY HAS INDICATED THAT THE INCIDENCE OF FATAL HEPATOTOXICITY DECREASES CONSIDERABLY IN PROGRESSIVELY OLDER PATIENT GROUPS.

THESE INCIDENTS USUALLY HAVE OCCURRED DURING THE FIRST SIX MONTHS OF TREATMENT. SERIOUS OR FATAL HEPATOTOXICITY MAY BE PRECEDED BY NON-SPECIFIC SYMPTOMS SUCH AS MALAISE, WEAKNESS, LETHARGY, FACIAL EDEMA, ANOREXIA, AND VOMITING. IN PATIENTS WITH EPILEPSY, A LOSS OF SEIZURE CONTROL MAY ALSO OCCUR. PATIENTS SHOULD BE MONITORED CLOSELY FOR APPEARANCE OF THESE SYMPTOMS. LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS.

TERATOGENICITY

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS SUCH AS NEURAL TUBE DEFECTS (E.G., SPINA BIFIDA). ACCORDINGLY, THE USE OF DEPAKOTE TABLETS IN WOMEN OF CHILDBEARING POTENTIAL REQUIRES THAT THE BENEFITS OF ITS USE BE WEIGHED AGAINST THE RISK OF INJURY TO THE FETUS. THIS IS ESPECIALLY IMPORTANT WHEN THE TREATMENT OF A SPONTANEOUSLY REVERSIBLE CONDITION NOT ORDINARILY ASSOCIATED WITH PERMANENT INJURY OR RISK OF DEATH (E.G., MIGRAINE) IS CONTEMPLATED. SEE WARNINGS, INFORMATION FOR PATIENTS.

AN INFORMATION SHEET DESCRIBING THE TERATOGENIC POTENTIAL OF VALPROATE IS AVAILABLE FOR PATIENTS.

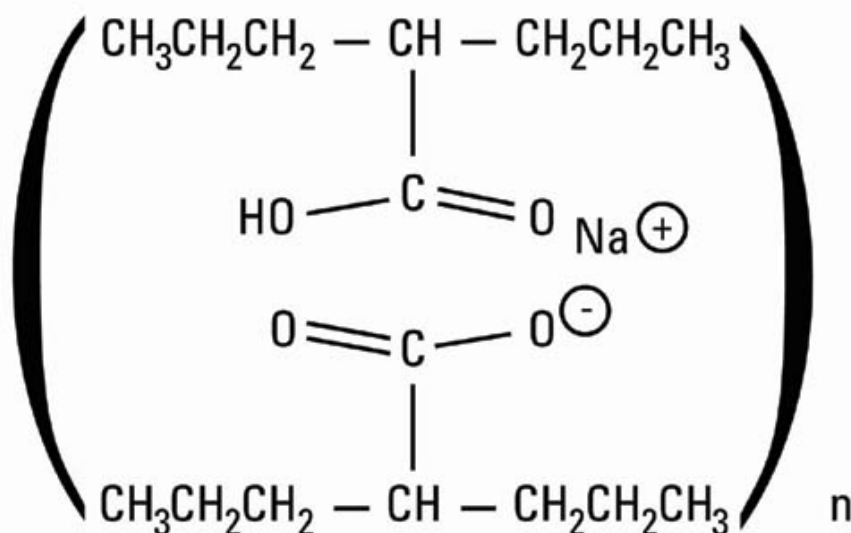
PANCREATITIS

CASES OF LIFE-THREATENING PANCREATITIS HAVE BEEN REPORTED IN BOTH CHILDREN AND ADULTS RECEIVING VALPROATE. SOME OF THE CASES HAVE BEEN DESCRIBED AS HEMORRHAGIC WITH A RAPID PROGRESSION FROM INITIAL SYMPTOMS TO DEATH. CASES HAVE BEEN REPORTED SHORTLY AFTER INITIAL USE AS WELL AS AFTER SEVERAL YEARS OF USE. PATIENTS AND GUARDIANS SHOULD BE WARNED THAT ABDOMINAL PAIN, NAUSEA, VOMITING,

AND/OR ANOREXIA CAN BE SYMPTOMS OF PANCREATITIS THAT REQUIRE PROMPT MEDICAL EVALUATION. IF PANCREATITIS IS DIAGNOSED, VALPROATE SHOULD ORDINARILY BE DISCONTINUED. ALTERNATIVE TREATMENT FOR THE UNDERLYING MEDICAL CONDITION SHOULD BE INITIATED AS CLINICALLY INDICATED. (See **WARNINGS** and **PRECAUTIONS**.)

DESCRIPTION

Divalproex sodium is a stable co-ordination compound comprised of sodium valproate and valproic acid in a 1:1 molar relationship and formed during the partial neutralization of valproic acid with 0.5 equivalent of sodium hydroxide. Chemically it is designated as sodium hydrogen bis(2-propylpentanoate). Divalproex sodium has the following structure:



Divalproex sodium occurs as a white powder with a characteristic odor.

DEPAKOTE ER 250 and 500 mg tablets are for oral administration. DEPAKOTE ER tablets contain divalproex sodium in a once-a-day extended-release formulation equivalent to 250 and 500 mg of valproic acid.

Inactive Ingredients

DEPAKOTE ER 250 and 500 mg tablets: FD&C Blue No. 1, hypromellose, lactose, microcrystalline cellulose, polyethylene glycol, potassium sorbate, propylene glycol, silicon dioxide, titanium dioxide, and triacetin.

In addition, 500 mg tablets contain iron oxide and polydextrose.

CLINICAL PHARMACOLOGY

Pharmacodynamics

Divalproex sodium dissociates to the valproate ion in the gastrointestinal tract. The mechanisms by which valproate exerts its therapeutic effects have not been established. It

has been suggested that its activity in epilepsy is related to increased brain concentrations of gamma-aminobutyric acid (GABA).

Pharmacokinetics

Absorption/Bioavailability

The absolute bioavailability of DEPAKOTE ER tablets administered as a single dose after a meal was approximately 90% relative to intravenous infusion.

When given in equal total daily doses, the bioavailability of DEPAKOTE ER is less than that of DEPAKOTE (divalproex sodium delayed-release tablets). In five multiple-dose studies in healthy subjects (N=82) and in subjects with epilepsy (N=86), when administered under fasting and nonfasting conditions, DEPAKOTE ER given once daily produced an average bioavailability of 89% relative to an equal total daily dose of DEPAKOTE given BID, TID, or QID. The median time to maximum plasma valproate concentrations (C_{max}) after DEPAKOTE ER administration ranged from 4 to 17 hours. After multiple once-daily dosing of DEPAKOTE ER, the peak-to-trough fluctuation in plasma valproate concentrations was 10-20% lower than that of regular DEPAKOTE given BID, TID, or QID.

Conversion from DEPAKOTE to DEPAKOTE ER

When DEPAKOTE ER is given in doses 8 to 20% higher than the total daily dose of DEPAKOTE, the two formulations are bioequivalent. In two randomized, crossover studies, multiple daily doses of DEPAKOTE were compared to 8 to 20% higher once-daily doses of DEPAKOTE ER. In these two studies, DEPAKOTE ER and DEPAKOTE regimens were equivalent with respect to area under the curve (AUC; a measure of the extent of bioavailability). Additionally, valproate C_{max} was lower, and C_{min} was either higher or not different, for DEPAKOTE ER relative to DEPAKOTE regimens (see following table).

Bioavailability of DEPAKOTE ER Tablets Relative to DEPAKOTE When DEPAKOTE ER Dose is 8 to 20% Higher

Study Population	Regimens	Relative Bioavailability		
		AUC ₂₄	C_{max}	C_{min}
Healthy Volunteers (N=35)	DEPAKOTE ER vs. DEPAKOTE 1000 & 1500 mg DEPAKOTE ER vs. 875 & 1250 mg DEPAKOTE	1.059	0.882	1.173
Patients with epilepsy on concomitant enzyme-inducing antiepilepsy drugs (N = 64)	DEPAKOTE ER vs. DEPAKOTE 1000 to 5000 mg DEPAKOTE ER vs. 875 to 4250 mg DEPAKOTE	1.008	0.899	1.022

Concomitant antiepilepsy drugs (topiramate, phenobarbital, carbamazepine, phenytoin, and lamotrigine were evaluated) that induce the cytochrome P450 isozyme system did not significantly alter valproate bioavailability when converting between DEPAKOTE and DEPAKOTE ER.

Distribution

Protein Binding

The plasma protein binding of valproate is concentration dependent and the free fraction increases from approximately 10% at 40 µg/mL to 18.5% at 130 µg/mL. Protein binding of valproate is reduced in the elderly, in patients with chronic hepatic diseases, in patients with renal impairment, and in the presence of other drugs (e.g., aspirin). Conversely, valproate may displace certain protein-bound drugs (e.g., phenytoin, carbamazepine, warfarin, and tolbutamide) (see **PRECAUTIONS - Drug Interactions** for more detailed information on the pharmacokinetic interactions of valproate with other drugs).

CNS Distribution

Valproate concentrations in cerebrospinal fluid (CSF) approximate unbound concentrations in plasma (about 10% of total concentration).

Metabolism

Valproate is metabolized almost entirely by the liver. In adult patients on monotherapy, 30-50% of an administered dose appears in urine as a glucuronide conjugate. Mitochondrial β-oxidation is the other major metabolic pathway, typically accounting for over 40% of the dose. Usually, less than 15-20% of the dose is eliminated by other oxidative mechanisms. Less than 3% of an administered dose is excreted unchanged in urine.

The relationship between dose and total valproate concentration is nonlinear; concentration does not increase proportionally with the dose, but rather, increases to a lesser extent due to saturable plasma protein binding. The kinetics of unbound drug are linear.

Elimination

Mean plasma clearance and volume of distribution for total valproate are 0.56 L/hr/1.73 m² and 11 L/1.73 m², respectively. Mean plasma clearance and volume of distribution for free valproate are 4.6 L/hr/1.73 m² and 92 L/1.73 m². Mean terminal half-life for valproate monotherapy ranged from 9 to 16 hours following oral dosing regimens of 250 to 1000 mg.

The estimates cited apply primarily to patients who are not taking drugs that affect hepatic metabolizing enzyme systems. For example, patients taking enzyme-inducing antiepileptic drugs (carbamazepine, phenytoin, and phenobarbital) will clear valproate more rapidly.

Special Populations

Effect of Age

Pediatric

The valproate pharmacokinetic profile following administration of DEPAKOTE ER was characterized in a multiple-dose, non-fasting, open-label, multi-center study in children and adolescents. DEPAKOTE ER once-daily doses ranged from 250 to 1750 mg. Once-daily administration of DEPAKOTE ER in pediatric patients (10-17 years) produced plasma VPA concentration-time profiles similar to those that have been observed in adults.

Elderly

The capacity of elderly patients (age range: 68 to 89 years) to eliminate valproate has been shown to be reduced compared to younger adults (age range: 22 to 26 years). Intrinsic clearance is reduced by 39%; the free fraction is increased by 44%. Accordingly, the initial dosage should be reduced in the elderly (see **DOSAGE AND ADMINISTRATION**).

Effect of Gender

There are no differences in the body surface area adjusted unbound clearance between males and females (4.8 ± 0.17 and 4.7 ± 0.07 L/hr per 1.73 m^2 , respectively).

Effect of Race

The effects of race on the kinetics of valproate have not been studied.

Effect of Disease

Liver Disease

(see **BOXED WARNING, CONTRAINDICATIONS, and WARNINGS**).

Liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 patients with acute hepatitis, compared with 6 healthy subjects. In that study, the half-life of valproate was increased from 12 to 18 hours. Liver disease is also associated with decreased albumin concentrations and larger unbound fractions (2 to 2.6 fold increase) of valproate. Accordingly, monitoring of total concentrations may be misleading since free concentrations may be substantially elevated in patients with hepatic disease whereas total concentrations may appear to be normal.

Renal Disease

A slight reduction (27%) in the unbound clearance of valproate has been reported in patients with renal failure (creatinine clearance < 10 mL/minute); however, hemodialysis typically reduces valproate concentrations by about 20%. Therefore, no dosage adjustment appears to be necessary in patients with renal failure. Protein binding in these patients is substantially reduced; thus, monitoring total concentrations may be misleading.

Plasma Levels and Clinical Effect

The relationship between plasma concentration and clinical response is not well documented. One contributing factor is the nonlinear, concentration dependent protein binding of valproate which affects the clearance of the drug. Thus, monitoring of total serum valproate cannot provide a reliable index of the bioactive valproate species.

For example, because the plasma protein binding of valproate is concentration dependent, the free fraction increases from approximately 10% at $40 \mu\text{g/mL}$ to 18.5% at $130 \mu\text{g/mL}$. Higher than expected free fractions occur in the elderly, in hyperlipidemic patients, and in patients with hepatic and renal diseases.

Mania

In a placebo-controlled clinical trial of acute mania, patients were dosed to clinical response with trough plasma concentrations between 85 and $125 \mu\text{g/mL}$ (See **DOSAGE AND ADMINISTRATION**).

Epilepsy

The therapeutic range in epilepsy is commonly considered to be 50 to 100 µg/mL of total valproate, although some patients may be controlled with lower or higher plasma concentrations.

Clinical Trials

Mania

The effectiveness of DEPAKOTE ER for the treatment of acute mania is based in part on studies establishing the effectiveness of DEPAKOTE (divalproex sodium delayed release tablets) for this indication. DEPAKOTE ER's effectiveness was confirmed in one randomized, double-blind, placebo-controlled, parallel group, 3-week, multicenter study. The study was designed to evaluate the safety and efficacy of DEPAKOTE ER in the treatment of bipolar I disorder, manic or mixed type, in adults. Adult male and female patients who had a current DSM-IV TR primary diagnosis of bipolar I disorder, manic or mixed type, and who were hospitalized for acute mania, were enrolled into this study. DEPAKOTE ER was initiated at a dose of 25 mg/kg/day given once daily, increased by 500 mg/day on Day 3, then adjusted to achieve plasma valproate concentrations in the range of 85-125 µg/mL. Mean daily DEPAKOTE ER doses for observed cases were 2362 mg (range: 500-4000), 2874 mg (range: 1500-4500), 2993 mg (range: 1500-4500), 3181 mg (range: 1500-5000), and 3353 mg (range: 1500-5500) at Days 1, 5, 10, 15, and 21, respectively. Mean valproate concentrations were 96.5 µg/mL, 102.1 µg/mL, 98.5 µg/mL, 89.5 µg/mL at Days 5, 10, 15 and 21, respectively. Patients were assessed on the Mania Rating Scale (MRS; score ranges from 0-52).

DEPAKOTE ER was significantly more effective than placebo in reduction of the MRS total score.

Migraine

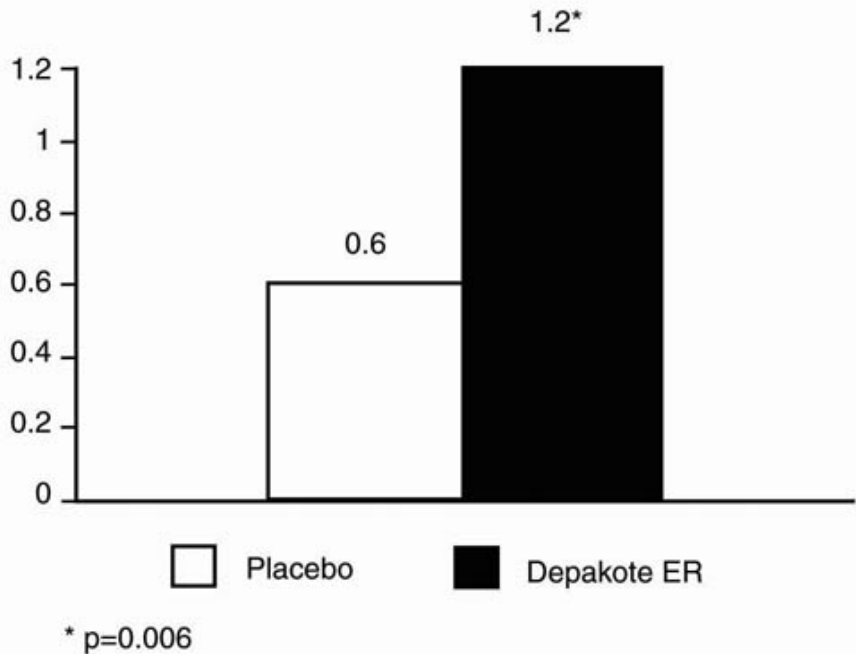
The results of a multicenter, randomized, double-blind, placebo-controlled, parallel-group clinical trial demonstrated the effectiveness of DEPAKOTE ER in the prophylactic treatment of migraine headache. This trial recruited patients with a history of migraine headaches with or without aura occurring on average twice or more a month for the preceding three months. Patients with cluster or chronic daily headaches were excluded. Women of childbearing potential were allowed in the trial if they were deemed to be practicing an effective method of contraception.

Patients who experienced ≥ 2 migraine headaches in the 4-week baseline period were randomized in a 1:1 ratio to DEPAKOTE ER or placebo and treated for 12 weeks. Patients initiated treatment on 500 mg once daily for one week, and were then increased to 1000 mg once daily with an option to permanently decrease the dose back to 500 mg once daily during the second week of treatment if intolerance occurred. Ninety-eight of 114 DEPAKOTE ER-treated patients (86%) and 100 of 110 placebo-treated patients (91%) treated at least two weeks maintained the 1000 mg once daily dose for the duration of their treatment periods. Treatment outcome was assessed on the basis of reduction in 4-week migraine headache rate in the treatment period compared to the baseline period.

Patients (50 male, 187 female) ranging in age from 16 to 69 were treated with DEPAKOTE ER (N=122) or placebo (N=115). Four patients were below the age of 18 and 3 were above the age of 65. Two hundred and two patients (101 in each treatment group)

completed the treatment period. The mean reduction in 4-week migraine headache rate was 1.2 from a baseline mean of 4.4 in the DEPAKOTE ER group, versus 0.6 from a baseline mean of 4.2 in the placebo group. The treatment difference was statistically significant (see Figure 1).

Figure 1. Mean Reduction In 4-Week Migraine Headache Rates



Epilepsy

The efficacy of DEPAKOTE in reducing the incidence of complex partial seizures (CPS) that occur in isolation or in association with other seizure types was established in two controlled trials using DEPAKOTE (divalproex sodium delayed-release tablets).

In one, multiclinic, placebo controlled study employing an add-on design, (adjunctive therapy) using DEPAKOTE, 144 patients who continued to suffer eight or more CPS per 8 weeks during an 8 week period of monotherapy with doses of either carbamazepine or phenytoin sufficient to assure plasma concentrations within the "therapeutic range" were randomized to receive, in addition to their original antiepilepsy drug (AED), either DEPAKOTE or placebo. Randomized patients were to be followed for a total of 16 weeks. The following table presents the findings.

Adjunctive Therapy Study Median Incidence of CPS per 8 Weeks

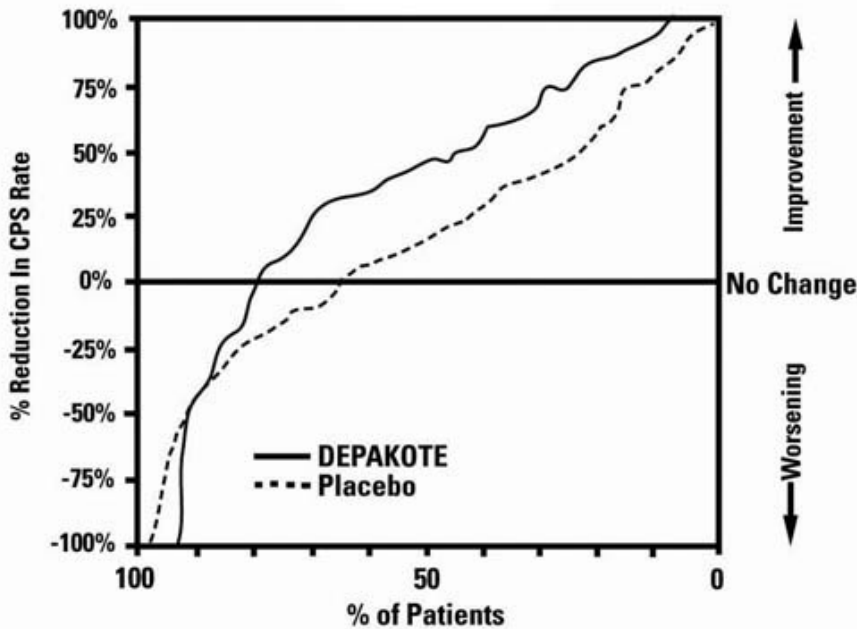
Add-on Treatment	Number of Patients	Baseline Incidence	Experimental Incidence
DEPAKOTE	75	16.0	8.9*
Placebo	69	14.5	11.5

* Reduction from baseline statistically significantly greater for DEPAKOTE than placebo at $p \leq 0.05$ level.

Figure 2 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the adjunctive therapy study. A positive percent reduction indicates an

improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for an effective treatment is shifted to the left of the curve for placebo. This figure shows that the proportion of patients achieving any particular level of improvement was consistently higher for DEPAKOTE than for placebo. For example, 45% of patients treated with DEPAKOTE had a $\geq 50\%$ reduction in complex partial seizure rate compared to 23% of patients treated with placebo.

Figure 2.



The second study assessed the capacity of DEPAKOTE to reduce the incidence of CPS when administered as the sole AED. The study compared the incidence of CPS among patients randomized to either a high or low dose treatment arm. Patients qualified for entry into the randomized comparison phase of this study only if 1) they continued to experience 2 or more CPS per 4 weeks during an 8 to 12 week long period of monotherapy with adequate doses of an AED (i.e., phenytoin, carbamazepine, phenobarbital, or primidone) and 2) they made a successful transition over a two week interval to DEPAKOTE. Patients entering the randomized phase were then brought to their assigned target dose, gradually tapered off their concomitant AED and followed for an interval as long as 22 weeks. Less than 50% of the patients randomized, however, completed the study. In patients converted to DEPAKOTE monotherapy, the mean total valproate concentrations during monotherapy were 71 and 123 $\mu\text{g}/\text{mL}$ in the low dose and high dose groups, respectively.

The following table presents the findings for all patients randomized who had at least one post-randomization assessment.

Monotherapy Study Median Incidence of CPS per 8 Weeks

Treatment	Number of Patients	Baseline Incidence	Randomized Phase Incidence
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High dose DEPAKOTE	131	13.2	10.7*
Low dose DEPAKOTE	134	14.2	13.8

* Reduction from baseline statistically significantly greater for high dose than low dose at $p \leq 0.05$ level.

Figure 3 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the monotherapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for a more effective treatment is shifted to the left of the curve for a less effective treatment. This figure shows that the proportion of patients achieving any particular level of reduction was consistently higher for high dose DEPAKOTE than for low dose DEPAKOTE. For example, when switching from carbamazepine, phenytoin, phenobarbital or primidone monotherapy to high dose DEPAKOTE monotherapy, 63% of patients experienced no change or a reduction in complex partial seizure rates compared to 54% of patients receiving low dose DEPAKOTE.

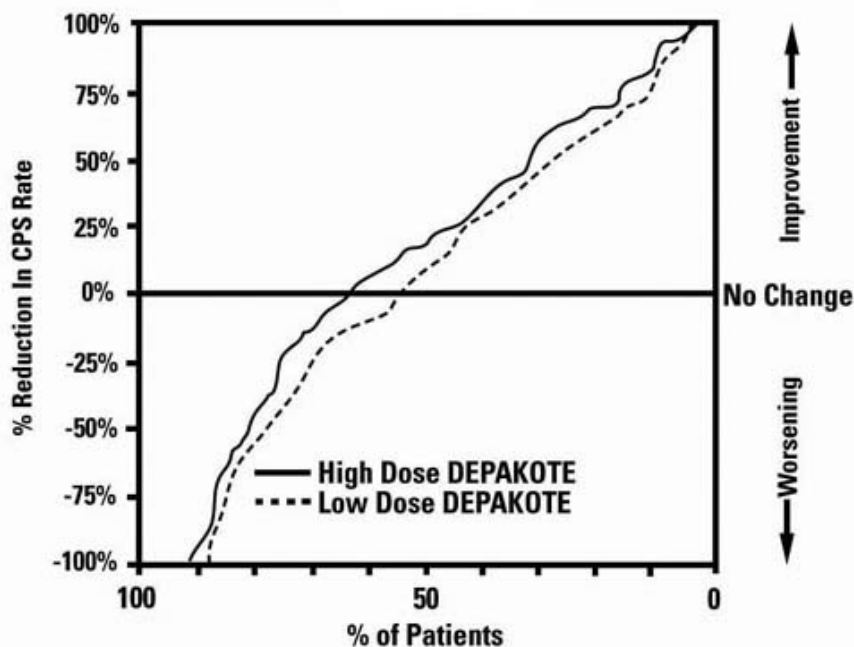


Figure 3.

INDICATIONS AND USAGE

Mania

DEPAKOTE ER (divalproex sodium extended-release) is indicated for the treatment of acute manic or mixed episodes associated with bipolar disorder, with or without psychotic features. A manic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood. Typical symptoms of mania include pressure of speech,

motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, poor judgement, aggressiveness, and possible hostility. A mixed episode is characterized by the criteria for a manic episode in conjunction with those for a major depressive episode (depressed mood, loss of interest or pleasure in nearly all activities).

The efficacy of DEPAKOTE ER is based in part on studies of DEPAKOTE (divalproex sodium delayed release tablets) in this indication, and was confirmed in a 3-week trial with patients meeting DSM-IV TR criteria for bipolar I disorder, manic or mixed type, who were hospitalized for acute mania (See **Clinical Trials** under **CLINICAL PHARMACOLOGY**).

The effectiveness of DEPAKOTE ER for long-term use in mania, i.e., more than 3 weeks, has not been systematically evaluated in controlled clinical trials. Therefore, physicians who elect to use DEPAKOTE ER for extended periods should continually reevaluate the long-term risk and benefits of the drug for the individual patient.

Migraine

DEPAKOTE ER is indicated for prophylaxis of migraine headaches in adults. There is no evidence that DEPAKOTE ER is useful in the acute treatment of migraine headaches. Because valproic acid may be a hazard to the fetus, DEPAKOTE ER should be considered for women of childbearing potential only after this risk has been thoroughly discussed with the patient and weighed against the potential benefits of treatment (see **WARNINGS - Usage In Pregnancy, PRECAUTIONS - Information for Patients**).

Epilepsy

DEPAKOTE ER is indicated as monotherapy and adjunctive therapy in the treatment of adults and children 10 years of age or older with complex partial seizures that occur either in isolation or in association with other types of seizures. DEPAKOTE ER is also indicated for use as sole and adjunctive therapy in the treatment of simple and complex absence seizures in adults and children 10 years of age or older, and adjunctively in adults and children 10 years of age or older with multiple seizure types that include absence seizures.

Simple absence is defined as very brief clouding of the sensorium or loss of consciousness accompanied by certain generalized epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

SEE **WARNINGS** FOR STATEMENT REGARDING FATAL HEPATIC DYSFUNCTION.

CONTRAINDICATIONS

DIVALPROEX SODIUM SHOULD NOT BE ADMINISTERED TO PATIENTS WITH HEPATIC DISEASE OR SIGNIFICANT HEPATIC DYSFUNCTION.

Divalproex sodium is contraindicated in patients with known hypersensitivity to the drug.

Divalproex sodium is contraindicated in patients with known urea cycle disorders (see **WARNINGS**).

WARNINGS

Hepatotoxicity

Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid. These incidents usually have occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as malaise, weakness, lethargy, facial edema, anorexia, and vomiting. Patients should be monitored closely for appearance of these symptoms. Liver function tests should be performed prior to therapy and at frequent intervals thereafter, especially during the first six months. However, physicians should not rely totally on serum biochemistry since these tests may not be abnormal in all instances, but should also consider the results of careful interim medical history and physical examination.

Caution should be observed when administering DEPAKOTE products to patients with a prior history of hepatic disease. Patients on multiple anticonvulsants, children, those with congenital metabolic disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease may be at particular risk. Experience has indicated that children under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions. Above this age group, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of drug.

Pancreatitis

Cases of life-threatening pancreatitis have been reported in both children and adults receiving valproate. Some of the cases have been described as hemorrhagic with rapid progression from initial symptoms to death. Some cases have occurred shortly after initial use as well as after several years of use. The rate based upon the reported cases exceeds that expected in the general population and there have been cases in which pancreatitis recurred after rechallenge with valproate. In clinical trials, there were 2 cases of pancreatitis without alternative etiology in 2416 patients, representing 1044 patient-years experience. Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical evaluation. If pancreatitis is diagnosed, valproate should ordinarily be discontinued. Alternative treatment for the underlying medical condition should be initiated as clinically indicated (see **BOXED WARNING**).

Urea Cycle Disorders (UCD)

Divalproex sodium is contraindicated in patients with known urea cycle disorders.

Hyperammonemic encephalopathy, sometimes fatal, has been reported following initiation of valproate therapy in patients with urea cycle disorders, a group of uncommon genetic abnormalities, particularly ornithine transcarbamylase deficiency. Prior to the initiation of valproate therapy, evaluation for UCD should be considered in the following patients: 1) those with a history of unexplained encephalopathy or coma, encephalopathy associated with a protein load, pregnancy-related or postpartum encephalopathy, unexplained mental retardation, or history of elevated plasma ammonia or glutamine; 2) those with cyclical

vomiting and lethargy, episodic extreme irritability, ataxia, low BUN, or protein avoidance; 3) those with a family history of UCD or a family history of unexplained infant deaths (particularly males); 4) those with other signs or symptoms of UCD. Patients who develop symptoms of unexplained hyperammonemic encephalopathy while receiving valproate therapy should receive prompt treatment (including discontinuation of valproate therapy) and be evaluated for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **PRECAUTIONS**).

Somnolence in the Elderly

In a double-blind, multicenter trial of valproate in elderly patients with dementia (mean age = 83 years), doses were increased by 125 mg/day to a target dose of 20 mg/kg/day. A significantly higher proportion of valproate patients had somnolence compared to placebo, and although not statistically significant, there was a higher proportion of patients with dehydration. Discontinuations for somnolence were also significantly higher than with placebo. In some patients with somnolence (approximately one-half), there was associated reduced nutritional intake and weight loss. There was a trend for the patients who experienced these events to have a lower baseline albumin concentration, lower valproate clearance, and a higher BUN. In elderly patients, dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

Thrombocytopenia

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia [see **PRECAUTIONS**]) may be dose-related. In a clinical trial of DEPAKOTE (divalproex sodium) as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). The therapeutic benefit which may accompany the higher doses should therefore be weighed against the possibility of a greater incidence of adverse effects.

Usage In Pregnancy

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS. DATA SUGGEST THAT THERE IS AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS ASSOCIATED WITH THE USE OF VALPROATE BY WOMEN WITH SEIZURE DISORDERS DURING PREGNANCY WHEN COMPARED TO THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO DO NOT USE ANTIEPILEPTIC DRUGS DURING PREGNANCY, THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO USE OTHER ANTIEPILEPTIC DRUGS, AND THE BACKGROUND INCIDENCE FOR THE GENERAL POPULATION. THEREFORE, VALPROATE SHOULD BE CONSIDERED FOR WOMEN OF CHILDBEARING POTENTIAL ONLY AFTER THE RISKS HAVE BEEN THOROUGHLY DISCUSSED WITH THE PATIENT AND WEIGHED AGAINST THE POTENTIAL BENEFITS OF TREATMENT.

THE DATA DESCRIBED BELOW WERE GAINED ALMOST EXCLUSIVELY FROM WOMEN WHO RECEIVED VALPROATE TO TREAT EPILEPSY. THERE ARE MULTIPLE REPORTS IN THE CLINICAL LITERATURE THAT INDICATE THE USE OF ANTIEPILEPTIC DRUGS DURING PREGNANCY RESULTS IN AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS IN OFFSPRING. ANTIEPILEPTIC DRUGS, INCLUDING VALPROATE, SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING POTENTIAL ONLY IF THEY ARE CLEARLY SHOWN TO BE ESSENTIAL IN THE MANAGEMENT OF THEIR MEDICAL CONDITION.

Antiepileptic drugs should not be discontinued abruptly in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

HUMAN DATA

Congenital Malformations

The North American Antiepileptic Drug Pregnancy Registry reported 16 cases of congenital malformations among the offspring of 149 women with epilepsy who were exposed to valproic acid monotherapy during the first trimester of pregnancy at doses of approximately 1,000 mg per day, for a prevalence rate of 10.7% (95% CI 6.3%-16.9%). Three of the 149 offspring (2%) had neural tube defects and 6 of the 149 (4%) had less severe malformations. Among epileptic women who were exposed to other antiepileptic drug monotherapies during pregnancy (1,048 patients) the malformation rate was 2.9% (95% CI 2.0% to 4.1%). There was a 4-fold increase in congenital malformations among infants with valproic acid-exposed mothers compared with those treated with other antiepileptic monotherapies as a group (Odds Ratio 4.0; 95% CI 2.1 to 7.4). This increased risk does not reflect a comparison versus any specific antiepileptic drug, but the risk versus the heterogeneous group of all other antiepileptic drug monotherapies combined. The increased teratogenic risk from valproic acid in women with epilepsy is expected to be reflected in an increased risk in other indications (e.g., migraine or bipolar disorder).

THE STRONGEST ASSOCIATION OF MATERNAL VALPROATE USAGE WITH CONGENITAL MALFORMATIONS IS WITH NEURAL TUBE DEFECTS (AS DISCUSSED UNDER THE NEXT SUBHEADING). HOWEVER, OTHER CONGENITAL ANOMALIES (E.G. CRANIOFACIAL DEFECTS, CARDIOVASCULAR MALFORMATIONS AND ANOMALIES INVOLVING VARIOUS BODY SYSTEMS), COMPATIBLE AND INCOMPATIBLE WITH LIFE, HAVE BEEN REPORTED. SUFFICIENT DATA TO DETERMINE THE INCIDENCE OF THESE CONGENITAL ANOMALIES IS NOT AVAILABLE.

Neural Tube Defects

THE INCIDENCE OF NEURAL TUBE DEFECTS IN THE FETUS IS INCREASED IN MOTHERS RECEIVING VALPROATE DURING THE FIRST TRIMESTER OF PREGNANCY. THE CENTERS FOR DISEASE CONTROL (CDC) HAS ESTIMATED THE RISK OF VALPROIC ACID EXPOSED WOMEN HAVING CHILDREN WITH SPINA

BIFIDA TO BE APPROXIMATELY 1 TO 2%. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG) ESTIMATES THE GENERAL POPULATION RISK FOR CONGENITAL NEURAL TUBE DEFECTS AS 0.14% TO 0.2%.

Tests to detect neural tube and other defects using current accepted procedures should be considered a part of routine prenatal care in pregnant women receiving valproate.

Evidence suggests that pregnant women who receive folic acid supplementation may be at decreased risk for congenital neural tube defects in their offspring compared to pregnant women not receiving folic acid. Whether the risk of neural tube defects in the offspring of women receiving valproate specifically is reduced by folic acid supplementation is unknown. DIETARY FOLIC ACID SUPPLEMENTATION BOTH PRIOR TO AND DURING PREGNANCY SHOULD BE ROUTINELY RECOMMENDED TO PATIENTS CONTEMPLATING PREGNANCY.

Other Adverse Pregnancy Effects

PATIENTS TAKING VALPROATE MAY DEVELOP CLOTTING ABNORMALITIES (SEE **PRECAUTIONS - GENERAL AND WARNINGS**). A PATIENT WHO HAD LOW FIBRINOGEN WHEN TAKING MULTIPLE ANTICONVULSANTS INCLUDING VALPROATE GAVE BIRTH TO AN INFANT WITH AFIBRINOGENEMIA WHO SUBSEQUENTLY DIED OF HEMORRHAGE. IF VALPROATE IS USED IN PREGNANCY, THE CLOTTING PARAMETERS SHOULD BE MONITORED CAREFULLY.

PATIENTS TAKING VALPROATE MAY DEVELOP HEPATIC FAILURE (SEE **WARNINGS - HEPATOTOXICITY AND BOX WARNING**). FATAL HEPATIC FAILURES, IN A NEWBORN AND IN AN INFANT, HAVE BEEN REPORTED FOLLOWING THE MATERNAL USE OF VALPROATE DURING PREGNANCY.

ANIMAL DATA

Animal studies have demonstrated valproate-induced teratogenicity. Increased frequencies of malformations, as well as intrauterine growth retardation and death, have been observed in mice, rats, rabbits, and monkeys following prenatal exposure to valproate. Malformations of the skeletal system are the most common structural abnormalities produced in experimental animals, but neural tube closure defects have been seen in mice exposed to maternal plasma valproate concentrations exceeding approximately 230 µg/mL (2.3 times the upper limit of the human therapeutic range for epilepsy) during susceptible periods of embryonic development. Administration of an oral dose of 200 mg/kg/day or greater (50% of the maximum human daily dose or greater on a mg/m² basis) to pregnant rats during organogenesis produced malformations (skeletal, cardiac, and urogenital) and growth retardation in the offspring. These doses resulted in peak maternal plasma valproate levels of approximately 340 µg/mL or greater (3.4 times the upper limit of the human therapeutic range for epilepsy or greater). Behavioral deficits have been reported in the offspring of rats given a dose of 200 mg/kg/day throughout most of pregnancy. An oral dose of 350 mg/kg/day (approximately 2 times the maximum human daily dose on a mg/m² basis) produced skeletal and visceral malformations in rabbits exposed during organogenesis. Skeletal malformations, growth retardation, and death

were observed in rhesus monkeys following administration of an oral dose of 200 mg/kg/day (equal to the maximum human daily dose on a mg/m² basis) during organogenesis. This dose resulted in peak maternal plasma valproate levels of approximately 280 µg/mL (2.8 times the upper limit of the human therapeutic range for epilepsy).

PRECAUTIONS

Hepatic Dysfunction

See **BOXED WARNING, CONTRAINDICATIONS** and **WARNINGS**.

Pancreatitis

See **BOXED WARNING** and **WARNINGS**.

Hyperammonemia

Hyperammonemia has been reported in association with valproate therapy and may be present despite normal liver function tests. In patients who develop unexplained lethargy and vomiting or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. If ammonia is increased, valproate therapy should be discontinued. Appropriate interventions for treatment of hyperammonemia should be initiated, and such patients should undergo investigation for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **WARNINGS – Urea Cycle Disorders (UCD)** and **PRECAUTIONS - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

Asymptomatic elevations of ammonia are more common and when present, require close monitoring of plasma ammonia levels. If the elevation persists, discontinuation of valproate therapy should be considered.

Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use

Concomitant administration of topiramate and valproic acid has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. Clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level of consciousness and/or cognitive function with lethargy or vomiting. In most cases, symptoms and signs abated with discontinuation of either drug. This adverse event is not due to a pharmacokinetic interaction. It is not known if topiramate monotherapy is associated with hyperammonemia. Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, an interaction of topiramate and valproic acid may exacerbate existing defects or unmask deficiencies in susceptible persons. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia**).

General

Because of reports of thrombocytopenia (see **WARNINGS**), inhibition of the secondary phase of platelet aggregation, and abnormal coagulation parameters, (e.g., low fibrinogen), platelet counts and coagulation tests are recommended before initiating therapy and at periodic intervals. It is recommended that patients receiving DEPAKOTE be monitored for platelet count and coagulation parameters prior to planned surgery. In a clinical trial of DEPAKOTE as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). Evidence of hemorrhage, bruising, or a disorder of hemostasis/coagulation is an indication for reduction of the dosage or withdrawal of therapy.

Since DEPAKOTE may interact with concurrently administered drugs which are capable of enzyme induction, periodic plasma concentration determinations of valproate and concomitant drugs are recommended during the early course of therapy where clinically appropriate (see **PRECAUTIONS – Drug Interactions**).

Valproate is partially eliminated in the urine as a keto-metabolite which may lead to a false interpretation of the urine ketone test.

There have been reports of altered thyroid function tests associated with valproate. The clinical significance of these is unknown.

There are *in vitro* studies that suggest valproate stimulates the replication of the HIV and CMV viruses under certain experimental conditions. The clinical consequence, if any, is not known. Additionally, the relevance of these *in vitro* findings is uncertain for patients receiving maximally suppressive antiretroviral therapy. Nevertheless, these data should be borne in mind when interpreting the results from regular monitoring of the viral load in HIV infected patients receiving valproate or when following CMV infected patients clinically.

Multi-organ Hypersensitivity Reaction

Multi-organ hypersensitivity reactions have been rarely reported in close temporal association to the initiation of valproate therapy in adult and pediatric patients (median time to detection 21 days; range 1 to 40 days). Although there have been a limited number of reports, many of these cases resulted in hospitalization and at least one death has been reported. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement. Other associated manifestations may include lymphadenopathy, hepatitis, liver function test abnormalities, hematological abnormalities (e.g., eosinophilia, thrombocytopenia, neutropenia), pruritis, nephritis, oliguria, hepatorenal syndrome, arthralgia, and asthenia. Because the disorder is variable in its expression, other organ system symptoms and signs, not noted here, may occur. If this reaction is suspected, valproate should be discontinued and an alternative treatment started. Although the existence of cross sensitivity with other drugs that produce this syndrome is unclear, the experience amongst drugs associated with multi-organ hypersensitivity would indicate this to be a possibility.

Information for Patients

Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis and, therefore, require further medical evaluation promptly.

Patients should be informed of the signs and symptoms associated with hyperammonemic encephalopathy (see **PRECAUTIONS – Hyperammonemia**) and be told to inform the prescriber if any of these symptoms occur.

Since DEPAKOTE products may produce CNS depression, especially when combined with another CNS depressant (eg, alcohol), patients should be advised not to engage in hazardous activities, such as driving an automobile or operating dangerous machinery, until it is known that they do not become drowsy from the drug.

Since DEPAKOTE has been associated with certain types of birth defects, female patients of child-bearing age considering the use of DEPAKOTE ER should be advised of the risk and of alternative therapeutic options and to read the **Patient Information Leaflet**, which appears as the last section of the labeling. This is especially important when the treatment of a spontaneously reversible condition not ordinarily associated with permanent injury or risk of death (e.g., migraine) is considered.

Patients should be instructed that a fever associated with other organ system involvement (rash, lymphadenopathy, etc.) may be drug-related and should be reported to the physician immediately (see PRECAUTIONS - Multi-organ Hypersensitivity Reaction).

Drug Interactions

Effects of Co-Administered Drugs on Valproate Clearance

Drugs that affect the level of expression of hepatic enzymes, particularly those that elevate levels of glucuronosyltransferases, may increase the clearance of valproate. For example, phenytoin, carbamazepine, and phenobarbital (or primidone) can double the clearance of valproate. Thus, patients on monotherapy will generally have longer half-lives and higher concentrations than patients receiving polytherapy with antiepilepsy drugs.

In contrast, drugs that are inhibitors of cytochrome P450 isozymes, e.g., antidepressants, may be expected to have little effect on valproate clearance because cytochrome P450 microsomal mediated oxidation is a relatively minor secondary metabolic pathway compared to glucuronidation and beta-oxidation.

Because of these changes in valproate clearance, monitoring of valproate and concomitant drug concentrations should be increased whenever enzyme inducing drugs are introduced or withdrawn.

The following list provides information about the potential for an influence of several commonly prescribed medications on valproate pharmacokinetics. The list is not exhaustive nor could it be, since new interactions are continuously being reported.

Drugs for Which a Potentially Important Interaction Has Been Observed

Aspirin

A study involving the co-administration of aspirin at antipyretic doses (11 to 16 mg/kg) with valproate to pediatric patients (N=6) revealed a decrease in protein binding and an inhibition of metabolism of valproate. Valproate free fraction was increased 4-fold in the presence of aspirin compared to valproate alone. The β -oxidation pathway consisting of 2-

E-valproic acid, 3-OH-valproic acid, and 3-keto valproic acid was decreased from 25% of total metabolites excreted on valproate alone to 8.3% in the presence of aspirin. Whether or not the interaction observed in this study applies to adults is unknown, but caution should be observed if valproate and aspirin are to be co-administered.

Felbamate

A study involving the co-administration of 1200 mg/day of felbamate with valproate to patients with epilepsy (N=10) revealed an increase in mean valproate peak concentration by 35% (from 86 to 115 µg/mL) compared to valproate alone. Increasing the felbamate dose to 2400 mg/day increased the mean valproate peak concentration to 133 µg/mL (another 16% increase). A decrease in valproate dosage may be necessary when felbamate therapy is initiated.

Meropenem

Subtherapeutic valproic acid levels have been reported when meropenem was co-administered.

Rifampin

A study involving the administration of a single dose of valproate (7 mg/kg) 36 hours after 5 nights of daily dosing with rifampin (600 mg) revealed a 40% increase in the oral clearance of valproate. Valproate dosage adjustment may be necessary when it is co-administered with rifampin.

Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

Antacids

A study involving the co-administration of valproate 500 mg with commonly administered antacids (Maalox, Trisogel, and Titalac - 160 mEq doses) did not reveal any effect on the extent of absorption of valproate.

Chlorpromazine

A study involving the administration of 100 to 300 mg/day of chlorpromazine to schizophrenic patients already receiving valproate (200 mg BID) revealed a 15% increase in trough plasma levels of valproate.

Haloperidol

A study involving the administration of 6 to 10 mg/day of haloperidol to schizophrenic patients already receiving valproate (200 mg BID) revealed no significant changes in valproate trough plasma levels.

Cimetidine and Ranitidine

Cimetidine and ranitidine do not affect the clearance of valproate.

Effects of Valproate on Other Drugs

Valproate has been found to be a weak inhibitor of some P450 isozymes, epoxide hydrase, and glucuronyltransferases.

The following list provides information about the potential for an influence of valproate co-administration on the pharmacokinetics or pharmacodynamics of several commonly prescribed medications. The list is not exhaustive, since new interactions are continuously being reported.

Drugs for Which a Potentially Important Valproate Interaction Has Been Observed

Amitriptyline/Nortriptyline

Administration of a single oral 50 mg dose of amitriptyline to 15 normal volunteers (10 males and 5 females) who received valproate (500 mg BID) resulted in a 21% decrease in plasma clearance of amitriptyline and a 34% decrease in the net clearance of nortriptyline. Rare postmarketing reports of concurrent use of valproate and amitriptyline resulting in an increased amitriptyline level have been received. Concurrent use of valproate and amitriptyline has rarely been associated with toxicity. Monitoring of amitriptyline levels should be considered for patients taking valproate concomitantly with amitriptyline. Consideration should be given to lowering the dose of amitriptyline/nortriptyline in the presence of valproate.

Carbamazepine/carbamazepine-10,11-Epoxyde

Serum levels of carbamazepine (CBZ) decreased 17% while that of carbamazepine-10,11-epoxyde (CBZ-E) increased by 45% upon co-administration of valproate and CBZ to epileptic patients.

Clonazepam

The concomitant use of valproic acid and clonazepam may induce absence status in patients with a history of absence type seizures.

Diazepam

Valproate displaces diazepam from its plasma albumin binding sites and inhibits its metabolism. Co-administration of valproate (1500 mg daily) increased the free fraction of diazepam (10 mg) by 90% in healthy volunteers (N=6). Plasma clearance and volume of distribution for free diazepam were reduced by 25% and 20%, respectively, in the presence of valproate. The elimination half-life of diazepam remained unchanged upon addition of valproate.

Ethosuximide

Valproate inhibits the metabolism of ethosuximide. Administration of a single ethosuximide dose of 500 mg with valproate (800 to 1600 mg/day) to healthy volunteers (N=6) was accompanied by a 25% increase in elimination half-life of ethosuximide and a 15% decrease in its total clearance as compared to ethosuximide alone. Patients receiving valproate and ethosuximide, especially along with other anticonvulsants, should be monitored for alterations in serum concentrations of both drugs.

Lamotrigine

In a steady-state study involving 10 healthy volunteers, the elimination half-life of lamotrigine increased from 26 to 70 hours with valproate co-administration (a 165% increase). The dose of lamotrigine should be reduced when co-administered with valproate. Serious skin reactions (such as Stevens-Johnson Syndrome and toxic epidermal necrolysis) have been reported with concomitant lamotrigine and valproate administration. See lamotrigine package insert for details on lamotrigine dosing with concomitant valproate administration.

Phenobarbital

Valproate was found to inhibit the metabolism of phenobarbital. Co-administration of valproate (250 mg BID for 14 days) with phenobarbital to normal subjects (N=6) resulted in a 50% increase in half-life and a 30% decrease in plasma clearance of phenobarbital (60 mg single-dose). The fraction of phenobarbital dose excreted unchanged increased by 50% in presence of valproate.

There is evidence for severe CNS depression, with or without significant elevations of barbiturate or valproate serum concentrations. All patients receiving concomitant barbiturate therapy should be closely monitored for neurological toxicity. Serum barbiturate concentrations should be obtained, if possible, and the barbiturate dosage decreased, if appropriate.

Primidone, which is metabolized to a barbiturate, may be involved in a similar interaction with valproate.

Phenytoin

Valproate displaces phenytoin from its plasma albumin binding sites and inhibits its hepatic metabolism. Co-administration of valproate (400 mg TID) with phenytoin (250 mg) in normal volunteers (N=7) was associated with a 60% increase in the free fraction of phenytoin. Total plasma clearance and apparent volume of distribution of phenytoin increased 30% in the presence of valproate. Both the clearance and apparent volume of distribution of free phenytoin were reduced by 25%.

In patients with epilepsy, there have been reports of breakthrough seizures occurring with the combination of valproate and phenytoin. The dosage of phenytoin should be adjusted as required by the clinical situation.

Tolbutamide

From *in vitro* experiments, the unbound fraction of tolbutamide was increased from 20% to 50% when added to plasma samples taken from patients treated with valproate. The clinical relevance of this displacement is unknown.

Topiramate

Concomitant administration of valproic acid and topiramate has been associated with hyperammonemia with and without encephalopathy (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia and - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

Warfarin

In an *in vitro* study, valproate increased the unbound fraction of warfarin by up to 32.6%. The therapeutic relevance of this is unknown; however, coagulation tests should be monitored if DEPAKOTE therapy is instituted in patients taking anticoagulants.

Zidovudine

In six patients who were seropositive for HIV, the clearance of zidovudine (100 mg q8h) was decreased by 38% after administration of valproate (250 or 500 mg q8h); the half-life of zidovudine was unaffected.

Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

Acetaminophen

Valproate had no effect on any of the pharmacokinetic parameters of acetaminophen when it was concurrently administered to three epileptic patients.

Clozapine

In psychotic patients (N=11), no interaction was observed when valproate was co-administered with clozapine.

Lithium

Co-administration of valproate (500 mg BID) and lithium carbonate (300 mg TID) to normal male volunteers (N=16) had no effect on the steady-state kinetics of lithium.

Lorazepam

Concomitant administration of valproate (500 mg BID) and lorazepam (1 mg BID) in normal male volunteers (N=9) was accompanied by a 17% decrease in the plasma clearance of lorazepam.

Oral Contraceptive Steroids

Administration of a single-dose of ethinylloestradiol (50 µg)/levonorgestrel (250 µg) to 6 women on valproate (200 mg BID) therapy for 2 months did not reveal any pharmacokinetic interaction.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Valproic acid was administered orally to Sprague Dawley rats and ICR (HA/ICR) mice at doses of 80 and 170 mg/kg/day (approximately 10 to 50% of the maximum human daily dose on a mg/m² basis) for two years. A variety of neoplasms were observed in both species. The chief findings were a statistically significant increase in the incidence of subcutaneous fibrosarcomas in high dose male rats receiving valproic acid and a statistically significant dose-related trend for benign pulmonary adenomas in male mice receiving valproic acid. The significance of these findings for humans is unknown.

Mutagenesis

Valproate was not mutagenic in an *in vitro* bacterial assay (Ames test), did not produce dominant lethal effects in mice, and did not increase chromosome aberration frequency in an *in vivo* cytogenetic study in rats. Increased frequencies of sister chromatid exchange (SCE) have been reported in a study of epileptic children taking valproate, but this association was not observed in another study conducted in adults. There is some evidence that increased SCE frequencies may be associated with epilepsy. The biological significance of an increase in SCE frequency is not known.

Fertility

Chronic toxicity studies in juvenile and adult rats and dogs demonstrated reduced spermatogenesis and testicular atrophy at oral doses of 400 mg/kg/day or greater in rats (approximately equivalent to or greater than the maximum human daily dose on a mg/m² basis) and 150 mg/kg/day or greater in dogs (approximately 1.4 times the maximum human daily dose or greater on a mg/m² basis). Segment I fertility studies in rats have shown oral doses up to 350 mg/kg/day (approximately equal to the maximum human daily dose on a mg/m² basis) for 60 days to have no effect on fertility. THE EFFECT OF VALPROATE ON TESTICULAR DEVELOPMENT AND ON SPERM PRODUCTION AND FERTILITY IN HUMANS IS UNKNOWN.

Pregnancy

Pregnancy Category D: see **WARNINGS** .

Nursing Mothers

Valproate is excreted in breast milk. Concentrations in breast milk have been reported to be 1-10% of serum concentrations. It is not known what effect this would have on a nursing infant. Consideration should be given to discontinuing nursing when divalproex sodium is administered to a nursing woman.

Pediatric Use

The safety and effectiveness of DEPAKOTE ER for the prophylaxis of migraine headaches in pediatric patients has not been established. The safety and effectiveness of DEPAKOTE ER for the treatment of complex partial seizures, simple and complex absence seizures, and multiple seizure types that include absence seizures has not been established in pediatric patients under the age of 10 years. Experience has indicated that pediatric patients under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions (see **BOXED WARNING**). Above the age of 2 years, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

The basic toxicology and pathologic manifestations of valproate sodium in neonatal (4-day old) and juvenile (14-day old) rats are similar to those seen in young adult rats. However, additional findings, including renal alterations in juvenile rats and renal alterations and retinal dysplasia in neonatal rats, have been reported. These findings occurred at 240 mg/kg/day, a dosage approximately equivalent to the human maximum recommended daily dose on a mg/m² basis. They were not seen at 90 mg/kg, or 40% of the maximum human daily dose on a mg/m² basis.

Geriatric Use

Safety and effectiveness of DEPAKOTE ER in the prophylaxis of migraine patients over 65 have not been established.

No patients above the age of 65 years were enrolled in double-blind prospective clinical trials of mania associated with bipolar illness using DEPAKOTE (divalproex sodium delayed-release tablets). In a case review study of 583 patients using various valproate products, 72 patients (12%) were greater than 65 years of age. A higher percentage of patients above 65 years of age reported accidental injury, infection, pain, somnolence, and tremor. Discontinuation of valproate was occasionally associated with the latter two events. It is not clear whether these events indicate additional risk or whether they result from preexisting medical illness and concomitant medication use among these patients.

A study of elderly patients with dementia revealed drug related somnolence and discontinuation for somnolence (see **WARNINGS – Somnolence in the Elderly**). The starting dose should be reduced in these patients, and dosage reductions or discontinuation should be considered in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

ADVERSE REACTIONS

Mania

The incidence of treatment-emergent events has been ascertained based on combined data from two placebo-controlled clinical trials of DEPAKOTE ER in the treatment of manic episodes associated with bipolar disorder.

Table 1 summarizes those adverse events reported for patients in these trials where the incidence rate in the DEPAKOTE ER-treated group was greater than 5% and greater than the placebo incidence.

Table 1. Adverse Events Reported by > 5% of DEPAKOTE ER-Treated Patients During Placebo-Controlled Trials of Acute Mania¹

Adverse Event	DEPAKOTE ER (n=338)	Placebo (n=263)
Somnolence	26%	14%
Dyspepsia	23%	11%
Nausea	19%	13%
Vomiting	13%	5%
Diarrhea	12%	8%
Dizziness	12%	7%
Pain	11%	10%
Abdominal pain	10%	5%
Accidental injury	6%	5%
Asthenia	6%	5%
Pharyngitis	6%	5%

1. The following adverse event occurred at an equal or greater incidence for placebo than for DEPAKOTE ER: headache

The following additional adverse events were reported by greater than 1% but not more than 5% of the Depakote ER-treated patients in controlled clinical trials:

Body as a Whole

Back Pain, Flu Syndrome, Infection, Infection Fungal

Cardiovascular System

Hypertension

Digestive System

Constipation, Dry Mouth, Flatulence

Hemic and Lymphatic System

Ecchymosis

Metabolic and Nutritional Disorders

Peripheral Edema

Musculoskeletal System

Myalgia

Nervous System

Abnormal Gait, Hypertonia, Tremor

Respiratory System

Rhinitis

Skin and Appendages

Pruritis, Rash

Special Senses

Conjunctivitis

Urogenital System

Urinary Tract Infection, Vaginitis

Migraine

Based on the results of one multicenter, randomized, double-blind, placebo-controlled clinical trial, DEPAKOTE ER was well tolerated in the prophylactic treatment of migraine headache. Of the 122 patients exposed to DEPAKOTE ER in the placebo-controlled study, 8% discontinued for adverse events, compared to 9% for the 115 placebo patients.

Based on two placebo-controlled clinical trials and their long term extension, DEPAKOTE (divalproex sodium delayed-release tablets) was generally well tolerated with most adverse events rated as mild to moderate in severity. Of the 202 patients exposed to DEPAKOTE in the placebo-controlled trials, 17% discontinued for intolerance. This is compared to a rate of 5% for the 81 placebo patients. Including the long term extension study, the adverse events reported as the primary reason for discontinuation by $\geq 1\%$ of

248 DEPAKOTE-treated patients were alopecia (6%), nausea and/or vomiting (5%), weight gain (2%), tremor (2%), somnolence (1%), elevated SGOT and/or SGPT (1%), and depression (1%).

Table 2 includes those adverse events reported for patients in the placebo-controlled trial where the incidence rate in the DEPAKOTE ER-treated group was greater than 5% and was greater than that for placebo patients.

Table 2. Adverse Events Reported by > 5% of DEPAKOTE ER-Treated Patients During the Migraine Placebo-controlled Trial with a Greater Incidence than Patients Taking Placebo¹

Body System Event	Depakote ER (N=122)	Placebo (N=115)
Gastrointestinal System		
Nausea	15%	9%
Dyspepsia	7%	4%
Diarrhea	7%	3%
Vomiting	7%	2%
Abdominal Pain	7%	5%
Nervous System		
Somnolence	7%	2%
Other		
Infection	15%	14%

1. The following adverse events occurred in greater than 5% of DEPAKOTE ER-treated patients and at a greater incidence for placebo than for DEPAKOTE ER: asthenia and flu syndrome.

The following additional adverse events were reported by greater than 1% but not more than 5% of DEPAKOTE ER-treated patients and with a greater incidence than placebo in the placebo-controlled clinical trial for migraine prophylaxis:

Body as a Whole

Accidental injury, viral infection.

Digestive System

Increased appetite, tooth disorder.

Metabolic and Nutritional Disorders

Edema, weight gain.

Nervous System

Abnormal gait, dizziness, hypertonia, insomnia, nervousness, tremor, vertigo.

Respiratory System

Pharyngitis, rhinitis.

Skin and Appendages

Rash.

Special Senses

Tinnitus.

Table 3 includes those adverse events reported for patients in the placebo-controlled trials where the incidence rate in the DEPAKOTE-treated group was greater than 5% and was greater than that for placebo patients.

Table 3. Adverse Events Reported by > 5% of DEPAKOTE-Treated Patients During Migraine Placebo-controlled Trials with a Greater Incidence than Patients Taking Placebo¹

Body System Event	Depakote (N=202)	Placebo (N=81)
Gastrointestinal System		
Nausea	31%	10%
Dyspepsia	13%	9%
Diarrhea	12%	7%
Vomiting	11%	1%
Abdominal Pain	9%	4%
Increased Appetite	6%	4%
Nervous System		
Asthenia	20%	9%
Somnolence	17%	5%
Dizziness	12%	6%
Tremor	9%	0%
Other		
Weight Gain	8%	2%
Back Pain	8%	6%
Alopecia	7%	1%

1. The following adverse events occurred in greater than 5% of DEPAKOTE -treated patients and at a greater incidence for placebo than for DEPAKOTE: flu syndrome and pharyngitis.

The following additional adverse events not referred to above were reported by greater than 1% but not more than 5% of DEPAKOTE-treated patients and with a greater incidence than placebo in the placebo-controlled clinical trials:

Body as a Whole

Chest pain.

Cardiovascular System

Vasodilatation.

Digestive System

Constipation, dry mouth, flatulence, stomatitis.

Hemic and Lymphatic System

Ecchymosis.

Metabolic and Nutritional Disorders

Peripheral edema.

Musculoskeletal System

Leg cramps.

Nervous System

Abnormal dreams, confusion, paresthesia, speech disorder, thinking abnormalities.

Respiratory System

Dyspnea, sinusitis.

Skin and Appendages

Pruritus.

Urogenital System

Metrorrhagia.

Epilepsy

Based on a placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures, DEPAKOTE was generally well tolerated with most adverse events rated as mild to moderate in severity. Intolerance was the primary reason for discontinuation in the DEPAKOTE-treated patients (6%), compared to 1% of placebo-treated patients.

Table 4 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of DEPAKOTE-treated patients and for which the incidence was greater than in the placebo group, in the placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures. Since patients were also treated with other antiepilepsy drugs, it is not possible, in most cases, to determine whether the following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 4. Adverse Events Reported by $\geq 5\%$ of Patients Treated with DEPAKOTE During Placebo-Controlled Trial of Adjunctive Therapy for Complex Partial Seizures

Body System/Event	Depakote (%) (N=77)	Placebo (%) (N=70)
Body as a Whole		
Headache	31	21
Asthenia	27	7
Fever	6	4
Gastrointestinal System		
Nausea	48	14
Vomiting	27	7
Abdominal Pain	23	6
Diarrhea	13	6
Anorexia	12	0
Dyspepsia	8	4
Constipation	5	1
Nervous System		
Somnolence	27	11
Tremor	25	6
Dizziness	25	13
Diplopia	16	9
Amblyopia/Blurred Vision	12	9

Ataxia	8	1
Nystagmus	8	1
Emotional Lability	6	4
Thinking Abnormal	6	0
Amnesia	5	1
Respiratory System		
Flu Syndrome	12	9
Infection	12	6
Bronchitis	5	1
Rhinitis	5	4
Other		
Alopecia	6	1
Weight Loss	6	0

Table 5 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of patients in the high dose DEPAKOTE group, and for which the incidence was greater than in the low dose group, in a controlled trial of DEPAKOTE monotherapy treatment of complex partial seizures. Since patients were being titrated off another antiepilepsy drug during the first portion of the trial, it is not possible, in many cases, to determine whether the following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 5. Adverse Events Reported by $\geq 5\%$ of Patients in the High Dose Group in the Controlled Trial of DEPAKOTE Monotherapy for Complex Partial Seizures¹

Body System/Event	High Dose (%) (N=131)	Low Dose (%) (N=134)
Body as a Whole		
Asthenia	21	10
Digestive System		
Nausea	34	26
Diarrhea	23	19
Vomiting	23	15
Abdominal Pain	12	9
Anorexia	11	4
Dyspepsia	11	10
Hemic/Lymphatic System		
Thrombocytopenia	24	1
Ecchymosis	5	4
Metabolic/Nutritional		
Weight Gain	9	4
Peripheral Edema	8	3
Nervous System		
Tremor	57	19
Somnolence	30	18
Dizziness	18	13
Insomnia	15	9
Nervousness	11	7
Amnesia	7	4
Nystagmus	7	1
Depression	5	4
Respiratory System		
Infection	20	13
Pharyngitis	8	2

Dyspnea	5	1
Skin and Appendages		
Alopecia	24	13
Special Senses		
Amblyopia/Blurred Vision	8	4
Tinnitus	7	1

1. Headache was the only adverse event that occurred in $\geq 5\%$ of patients in the high dose group and at an equal or greater incidence in the low dose group.

The following additional adverse events were reported by greater than 1% but less than 5% of the 358 patients treated with DEPAKOTE in the controlled trials of complex partial seizures:

Body as a Whole

Back pain, chest pain, malaise.

Cardiovascular System

Tachycardia, hypertension, palpitation.

Digestive System

Increased appetite, flatulence, hematemesis, eructation, pancreatitis, periodontal abscess.

Hemic and Lymphatic System

Petechia.

Metabolic and Nutritional Disorders

SGOT increased, SGPT increased.

Musculoskeletal System

Myalgia, twitching, arthralgia, leg cramps, myasthenia.

Nervous System

Anxiety, confusion, abnormal gait, paresthesia, hypertonia, incoordination, abnormal dreams, personality disorder.

Respiratory System

Sinusitis, cough increased, pneumonia, epistaxis.

Skin and Appendages

Rash, pruritus, dry skin.

Special Senses

Taste perversion, abnormal vision, deafness, otitis media.

Urogenital System

Urinary incontinence, vaginitis, dysmenorrhea, amenorrhea, urinary frequency.

Other Patient Populations

The following adverse events not listed previously were reported by greater than 1% of DEPAKOTE-treated patients and with a greater incidence than placebo in placebo-controlled trials of manic episodes associated with bipolar disorder:

Body as a Whole

Chills, chills and fever, drug level increased, neck rigidity.

Cardiovascular System

Arrhythmia, hypotension, postural hypotension.

Digestive System

Dysphagia, fecal incontinence, gastroenteritis, glossitis, gum hemorrhage, mouth ulceration.

Hemic and Lymphatic System

Anemia, bleeding time increased, leukopenia.

Metabolic and Nutritional Disorders

Hypoproteinemia.

Musculoskeletal System

Arthrosis.

Nervous System

Agitation, catatonic reaction, dysarthria, hallucinations, hypokinesia, psychosis, reflexes increased, sleep disorder, tardive dyskinesia.

Respiratory System

Hiccup.

Skin and Appendages

Discoid lupus erythematosus, erythema nodosum, furunculosis, maculopapular rash, seborrhea, sweating, vesiculobullous rash.

Special Senses

Conjunctivitis, dry eyes, eye disorder, eye pain, photophobia, taste perversion.

Urogenital System

Cystitis, menstrual disorder.

Adverse events that have been reported with all dosage forms of valproate from epilepsy trials, spontaneous reports, and other sources are listed below by body system.

Gastrointestinal

The most commonly reported side effects at the initiation of therapy are nausea, vomiting, and indigestion. These effects are usually transient and rarely require discontinuation of therapy. Diarrhea, abdominal cramps, and constipation have been reported. Both anorexia with some weight loss and increased appetite with weight gain have also been reported. In some patients, many of whom have functional or anatomic (including ileostomy or colostomy) gastrointestinal disorders with shortened GI transit times, there have been postmarketing reports of DEPAKOTE ER tablets in the stool.

CNS Effects

Sedative effects have occurred in patients receiving valproate alone but occur most often in patients receiving combination therapy. Sedation usually abates upon reduction of other antiepileptic medication. Tremor (may be dose-related), hallucinations, ataxia, headache, nystagmus, diplopia, asterixis, "spots before eyes," dysarthria, dizziness, confusion, hypesthesia, vertigo, incoordination, and parkinsonism have been reported with the use of valproate. Rare cases of coma have occurred in patients receiving valproate alone or in conjunction with phenobarbital. In rare instances encephalopathy with or without fever has developed shortly after the introduction of valproate monotherapy without evidence of hepatic dysfunction or inappropriately high plasma valproate levels. Although recovery has been described following drug withdrawal, there have been fatalities in patients with hyperammonemic encephalopathy, particularly in patients with underlying urea cycle disorders (see **WARNINGS – Urea Cycle Disorders** and **PRECAUTIONS**).

Several reports have noted reversible cerebral atrophy and dementia in association with valproate therapy.

Dermatologic

Transient hair loss, skin rash, photosensitivity, generalized pruritus, erythema multiforme, and Stevens-Johnson syndrome. Rare cases of toxic epidermal necrolysis have been reported including a fatal case in a 6 month old infant taking valproate and several other concomitant medications. An additional case of toxic epidermal necrosis resulting in death was reported in a 35 year old patient with AIDS taking several concomitant medications and with a history of multiple cutaneous drug reactions. Serious skin reactions have been reported with concomitant administration of lamotrigine and valproate (see **PRECAUTIONS – Drug Interactions**).

Psychiatric

Emotional upset, depression, psychosis, aggression, hyperactivity, hostility, and behavioral deterioration.

Musculoskeletal

Weakness.

Hematologic

Thrombocytopenia and inhibition of the secondary phase of platelet aggregation may be reflected in altered bleeding time, petechiae, bruising, hematoma formation, epistaxis, and frank hemorrhage (see **PRECAUTIONS – General and Drug Interactions**). Relative lymphocytosis, macrocytosis, hypofibrinogenemia, leukopenia, eosinophilia, anemia including macrocytic with or without folate deficiency, bone marrow suppression, pancytopenia, aplastic anemia, agranulocytosis and acute intermittent porphyria.

Hepatic

Minor elevations of transaminases (eg, SGOT and SGPT) and LDH are frequent and appear to be dose-related. Occasionally, laboratory test results include increases in serum bilirubin and abnormal changes in other liver function tests. These results may reflect potentially serious hepatotoxicity (see **WARNINGS**).

Endocrine

Irregular menses, secondary amenorrhea, breast enlargement, galactorrhea, and parotid gland swelling. Abnormal thyroid function tests (see **PRECAUTIONS**).

There have been rare spontaneous reports of polycystic ovary disease. A cause and effect relationship has not been established.

Pancreatic

Acute pancreatitis including fatalities (see **WARNINGS**).

Metabolic

Hyperammonemia (see **PRECAUTIONS**), hyponatremia, and inappropriate ADH secretion.

There have been rare reports of Fanconi's syndrome occurring chiefly in children.

Decreased carnitine concentrations have been reported although the clinical relevance is undetermined.

Hyperglycinemia has occurred and was associated with a fatal outcome in a patient with preexistent nonketotic hyperglycinemia.

Genitourinary

Enuresis and urinary tract infection.

Special Senses

Hearing loss, either reversible or irreversible, has been reported; however, a cause and effect relationship has not been established. Ear pain has also been reported.

Other

Allergic reaction, anaphylaxis, edema of the extremities, lupus erythematosus, bone pain, cough increased, pneumonia, otitis media, bradycardia, cutaneous vasculitis, fever and hypothermia.

OVERDOSAGE

Overdosage with valproate may result in somnolence, heart block, and deep coma. Fatalities have been reported; however patients have recovered from valproate levels as high as 2120 µg/mL.

In overdose situations, the fraction of drug not bound to protein is high and hemodialysis or tandem hemodialysis plus hemoperfusion may result in significant removal of drug. The benefit of gastric lavage or emesis will vary with the time since ingestion. General supportive measures should be applied with particular attention to the maintenance of adequate urinary output.

Naloxone has been reported to reverse the CNS depressant effects of valproate overdosage. Because naloxone could theoretically also reverse the antiepileptic effects of valproate, it should be used with caution in patients with epilepsy.

DOSAGE AND ADMINISTRATION

DEPAKOTE ER is an extended-release product intended for once-a-day oral administration. DEPAKOTE ER tablets should be swallowed whole and should not be crushed or chewed.

Mania

DEPAKOTE ER tablets are administered orally. The recommended initial dose is 25 mg/kg/day given once daily. The dose should be increased as rapidly as possible to achieve the lowest therapeutic dose which produces the desired clinical effect or the desired range of plasma concentrations. In a placebo-controlled clinical trial of acute mania or mixed type, patients were dosed to a clinical response with a trough plasma concentration between 85 and 125 µg/mL. The maximum recommended dosage is 60 mg/kg/day.

There is no body of evidence available from controlled trials to guide a clinician in the longer term management of a patient who improves during DEPAKOTE ER treatment of an acute manic episode. While it is generally agreed that pharmacological treatment beyond an acute response in mania is desirable, both for maintenance of the initial response and for prevention of new manic episodes, there are no systematically obtained data to support the benefits of DEPAKOTE ER in such longer-term treatment (i.e., beyond 3 weeks).

Migraine

DEPAKOTE ER is indicated for prophylaxis of migraine headaches in adults.

The recommended starting dose is 500 mg once daily for 1 week, thereafter increasing to 1000 mg once daily. Although doses other than 1000 mg once daily of DEPAKOTE ER have not been evaluated in patients with migraine, the effective dose range of DEPAKOTE (divalproex sodium delayed-release tablets) in these patients is 500-1000 mg/day. As with other valproate products, doses of DEPAKOTE ER should be individualized and dose adjustment may be necessary. If a patient requires smaller dose adjustments than that available with DEPAKOTE ER, DEPAKOTE should be used instead.

Epilepsy

DEPAKOTE ER is indicated as monotherapy and adjunctive therapy for complex partial seizures, and for simple and complex absence seizures in adult patients and pediatric patients 10 years of age or older. As the DEPAKOTE ER dosage is titrated upward, concentrations of phenobarbital, carbamazepine, and/or phenytoin may be affected (see **PRECAUTIONS - Drug Interactions**).

Complex Partial Seizures for Adult Patients and Children 10 Years of Age or Older

Monotherapy (Initial Therapy)

DEPAKOTE ER has not been systematically studied as initial therapy. Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made.

The probability of thrombocytopenia increases significantly at total trough valproate plasma concentrations above 110 µg/mL in females and 135 µg/mL in males. The benefit of improved seizure control with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

Conversion to Monotherapy

Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50-100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. Concomitant antiepilepsy drug (AED) dosage can ordinarily be reduced by approximately 25% every 2 weeks. This reduction may be started at initiation of DEPAKOTE ER therapy, or delayed by 1 to 2 weeks if there is a concern that seizures are likely to occur with a reduction. The speed and duration of withdrawal of the concomitant AED can be highly variable, and patients should be monitored closely during this period for increased seizure frequency.

Adjunctive Therapy

DEPAKOTE ER may be added to the patient's regimen at a dosage of 10 to 15 mg/kg/day. The dosage may be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made.

In a study of adjunctive therapy for complex partial seizures in which patients were receiving either carbamazepine or phenytoin in addition to DEPAKOTE, no adjustment of carbamazepine or phenytoin dosage was needed (see **CLINICAL STUDIES**). However, since valproate may interact with these or other concurrently administered AEDs as well as other drugs (see **Drug Interactions**), periodic plasma concentration determinations of

concomitant AEDs are recommended during the early course of therapy (see **PRECAUTIONS - Drug Interactions**).

Simple and Complex Absence Seizures for Adult Patients and Children 10 Years of Age or Older

The recommended initial dose is 15 mg/kg/day, increasing at one week intervals by 5 to 10 mg/kg/day until seizures are controlled or side effects preclude further increases. The maximum recommended dosage is 60 mg/kg/day.

A good correlation has not been established between daily dose, serum concentrations, and therapeutic effect. However, therapeutic valproate serum concentrations for most patients with absence seizures is considered to range from 50 to 100 µg/mL. Some patients may be controlled with lower or higher serum concentrations (see **CLINICAL PHARMACOLOGY**).

As the DEPAKOTE ER dosage is titrated upward, blood concentrations of phenobarbital and/or phenytoin may be affected (see **PRECAUTIONS**).

Antiepilepsy drugs should not be abruptly discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life.

Conversion from DEPAKOTE to DEPAKOTE ER

In adult patients and pediatric patients 10 years of age or older with epilepsy previously receiving DEPAKOTE, DEPAKOTE ER should be administered once-daily using a dose 8 to 20% higher than the total daily dose of DEPAKOTE (Table 6). For patients whose DEPAKOTE total daily dose can not be directly converted to DEPAKOTE ER, consideration may be given at the clinician's discretion to increase the patient's DEPAKOTE total daily dose to the next higher dosage before converting to the appropriate total daily dose of DEPAKOTE ER.

Table 6. Dose Conversion

DEPAKOTE Total Daily Dose (mg)	DEPAKOTE ER (mg)
500* - 625	750
750* - 875	1000
1000*-1125	1250
1250-1375	1500
1500-1625	1750
1750	2000
1875-2000	2250
2125-2250	2500
2375	2750
2500-2750	3000
2875	3250
3000-3125	3500

* These total daily doses of DEPAKOTE cannot be directly converted to an 8 to 20% higher total daily dose of DEPAKOTE ER because the required dosing strengths of DEPAKOTE ER are not available. Consideration may be given at the clinician's discretion to increase the patient's DEPAKOTE total daily dose to the next higher dosage before converting to the appropriate total daily dose of DEPAKOTE ER.

There is insufficient data to allow a conversion factor recommendation for patients with DEPAKOTE doses above 3125 mg/day.

Plasma valproate C_{min} concentrations for DEPAKOTE ER on average are equivalent to DEPAKOTE, but may vary across patients after conversion. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 $\mu\text{g/mL}$) (see **Pharmacokinetics** - Absorption/Bioavailability).

General Dosing Advice

Dosing in Elderly Patients

Due to a decrease in unbound clearance of valproate and possibly a greater sensitivity to somnolence in the elderly, the starting dose should be reduced in these patients. Starting doses in the elderly lower than 250 mg can only be achieved by the use of DEPAKOTE. Dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence. The ultimate therapeutic dose should be achieved on the basis of both tolerability and clinical response (see **WARNINGS**).

Dose-Related Adverse Events

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia) may be dose-related. The probability of thrombocytopenia appears to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males) (see **PRECAUTIONS**). The benefit of improved therapeutic effect with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

G.I. Irritation

Patients who experience G.I. irritation may benefit from administration of the drug with food or by initiating therapy with a lower dose of DEPAKOTE.

Compliance

Patients should be informed to take DEPAKOTE ER every day as prescribed. If a dose is missed it should be taken as soon as possible, unless it is almost time for the next dose. If a dose is skipped, the patient should not double the next dose.

HOW SUPPLIED

DEPAKOTE ER 250 mg is available as white ovaloid tablets with the corporate **Abbott "A" logo**, and the Abbo-Code (HF). Each DEPAKOTE ER tablet contains divalproex sodium equivalent to 250 mg of valproic acid in the following package sizes:

Bottles of 60.....(**NDC** 0074-3826-60).

Bottles of 100.....(**NDC** 0074-3826-13).

Bottles of 500.....(**NDC** 0074-3826-53).

ABBO-PAC unit dose packages of 100.....(NDC 0074-3826-11).

DEPAKOTE ER 500 mg is available as gray ovaloid tablets with the corporate logo **Abbott “A” logo**, and the Abbo-Code HC. Each DEPAKOTE ER tablet contains divalproex sodium equivalent to 500 mg of valproic acid in the following packaging sizes:

Bottles of 100.....(NDC 0074-7126-13).

Bottles of 500.....(NDC 0074-7126-53).

ABBO-PAC unit dose packages of 100.....(NDC 0074-7126-11).

Recommended Storage

Store tablets at 25°C (77°F); excursions permitted to 15-30°C (59-86°F) [see USP Controlled Room Temperature].

Depakote ER 250 mg

Mfd. by Abbott Pharmaceuticals PR Ltd., Barceloneta, PR 00617

Depakote ER 500 mg

Mfd. by

Abbott Laboratories, North Chicago, IL 60064 U.S.A.

or

Abbott Pharmaceuticals PR Ltd., Barceloneta, PR 00617

Manufactured for

Abbott Laboratories

North Chicago, IL 60064, U.S.A.

Patient Information Leaflet

Important Information for Women Who Could Become Pregnant About the Use of DEPAKOTE®, DEPAKOTE® ER, DEPAKOTE® Sprinkle Capsules, and DEPAKENE®.

Please read this leaflet carefully before you take any of these medications. This leaflet provides a summary of important information about taking these medications to women who could become pregnant. If you have any questions or concerns, or want more information about these medications, contact your doctor or pharmacist.

Information for Women Who Could Become Pregnant

These medications can be obtained only by prescription from your doctor. The decision to use any of these medications is one that you and your doctor should make together, taking into account your individual needs and medical condition

Before using any of these medications, women who can become pregnant should consider the fact that these medications have been associated with birth defects, in particular, with spina bifida and other defects related to failure of the spinal canal to close normally. Approximately 1 to 2% of children born to women with epilepsy taking DEPAKOTE in the first 12 weeks of pregnancy had these defects (based on

data from the Centers for Disease Control, a U.S. agency based in Atlanta). The incidence in the general population is 0.1 to 0.2%.

These medications have also been associated with other birth defects such as defects of the heart, the bones, and other parts of the body. Information suggests that birth defects may be more likely to occur with these medications than some other drugs that treat your medical condition

Information for Women Who Are Planning to Get Pregnant

- Women taking any of these medications who are planning to get pregnant should discuss the treatment options with their doctor.

Information for Women Who Become Pregnant

- If you become pregnant while taking any of these medications you should contact your doctor immediately.

Other Important Information

- Your medication should be taken exactly as prescribed by your doctor to get the most benefit from your medication and reduce the risk of side effects.
- If you have taken more than the prescribed dose of your medication, contact your hospital emergency room or local poison center immediately.
- Your medication was prescribed for your particular condition. Do not use it for another condition or give the drug to others.

Facts About Birth Defects

It is important to know that birth defects may occur even in children of individuals not taking any medications or without any additional risk factors.

This summary provides important information about the use of DEPAKOTE®, DEPAKOTE® ER, DEPAKOTE® Sprinkle Capsules, and DEPAKENE® to women who could become pregnant. If you would like more information about the other potential risks and benefits of these medications, ask your doctor or pharmacist to let you read the professional labeling and then discuss it with them. If you have any questions or concerns about taking these medications, you should discuss them with your doctor.

Depakote ER 250 mg

Mfd. by Abbott Pharmaceuticals PR Ltd., Barceloneta, PR 00617

Depakote ER 500 mg

Mfd. by

Abbott Laboratories, North Chicago, IL 60064 U.S.A.

or

Abbott Pharmaceuticals PR Ltd., Barceloneta, PR 00617

Manufactured for

Abbott Laboratories

North Chicago, IL 60064 U.S.A.

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DEPACON® **(valproate sodium injection)**

BOX WARNING

HEPATOTOXICITY

HEPATIC FAILURE RESULTING IN FATALITIES HAS OCCURRED IN PATIENTS RECEIVING VALPROIC ACID AND ITS DERIVATIVES. EXPERIENCE HAS INDICATED THAT CHILDREN UNDER THE AGE OF TWO YEARS ARE AT A CONSIDERABLY INCREASED RISK OF DEVELOPING FATAL HEPATOTOXICITY, ESPECIALLY THOSE ON MULTIPLE ANTICONVULSANTS, THOSE WITH CONGENITAL METABOLIC DISORDERS, THOSE WITH SEVERE SEIZURE DISORDERS ACCOMPANIED BY MENTAL RETARDATION, AND THOSE WITH ORGANIC BRAIN DISEASE. WHEN DEPACON IS USED IN THIS PATIENT GROUP, IT SHOULD BE USED WITH EXTREME CAUTION AND AS A SOLE AGENT. THE BENEFITS OF THERAPY SHOULD BE WEIGHED AGAINST THE RISKS. ABOVE THIS AGE GROUP, EXPERIENCE IN EPILEPSY HAS INDICATED THAT THE INCIDENCE OF FATAL HEPATOTOXICITY DECREASES CONSIDERABLY IN PROGRESSIVELY OLDER PATIENT GROUPS.

THESE INCIDENTS USUALLY HAVE OCCURRED DURING THE FIRST SIX MONTHS OF TREATMENT. SERIOUS OR FATAL HEPATOTOXICITY MAY BE PRECEDED BY NON-SPECIFIC SYMPTOMS SUCH AS MALAISE, WEAKNESS, LETHARGY, FACIAL EDEMA, ANOREXIA, AND VOMITING. IN PATIENTS WITH EPILEPSY, A LOSS OF SEIZURE CONTROL MAY ALSO OCCUR. PATIENTS SHOULD BE MONITORED CLOSELY FOR APPEARANCE OF THESE SYMPTOMS. LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS.

TERATOGENICITY

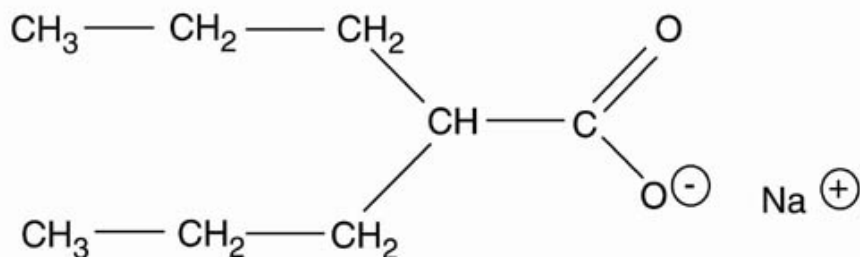
VALPROATE CAN PRODUCE TERATOGENIC EFFECTS SUCH AS NEURAL TUBE DEFECTS (E.G., SPINA BIFIDA). ACCORDINGLY, THE USE OF VALPROATE PRODUCTS IN WOMEN OF CHILDBEARING POTENTIAL REQUIRES THAT THE BENEFITS OF ITS USE BE WEIGHED AGAINST THE RISK OF INJURY TO THE FETUS. THIS IS ESPECIALLY IMPORTANT WHEN THE TREATMENT OF A SPONTANEOUSLY REVERSIBLE CONDITION NOT ORDINARILY ASSOCIATED WITH PERMANENT INJURY OR RISK OF DEATH (E.G., MIGRAINE) IS CONTEMPLATED. SEE **WARNINGS, INFORMATION FOR PATIENTS**.

PANCREATITIS

CASES OF LIFE-THREATENING PANCREATITIS HAVE BEEN REPORTED IN BOTH CHILDREN AND ADULTS RECEIVING VALPROATE. SOME OF THE CASES HAVE BEEN DESCRIBED AS HEMORRHAGIC WITH A RAPID PROGRESSION FROM INITIAL SYMPTOMS TO DEATH. CASES HAVE BEEN REPORTED SHORTLY AFTER INITIAL USE AS WELL AS AFTER SEVERAL YEARS OF USE. PATIENTS AND GUARDIANS SHOULD BE WARNED THAT ABDOMINAL PAIN, NAUSEA, VOMITING, AND/OR ANOREXIA CAN BE SYMPTOMS OF PANCREATITIS THAT REQUIRE PROMPT MEDICAL EVALUATION. IF PANCREATITIS IS DIAGNOSED, VALPROATE SHOULD ORDINARILY BE DISCONTINUED. ALTERNATIVE TREATMENT FOR THE UNDERLYING MEDICAL CONDITION SHOULD BE INITIATED AS CLINICALLY INDICATED. (See **WARNINGS** and **PRECAUTIONS** .)

DESCRIPTION

Valproate sodium is the sodium salt of valproic acid designated as sodium 2-propylpentanoate. Valproate sodium has the following structure:



Valproate sodium has a molecular weight of 166.2. It occurs as an essentially white and odorless, crystalline, deliquescent powder.

DEPACON solution is available in 5 mL single-dose vials for intravenous injection. Each mL contains valproate sodium equivalent to 100 mg valproic acid, edetate disodium 0.40 mg, and water for injection to volume. The pH is adjusted to 7.6 with sodium hydroxide and/or hydrochloric acid. The solution is clear and colorless.

CLINICAL PHARMACOLOGY

DEPACON exists as the valproate ion in the blood. The mechanisms by which valproate exerts its therapeutic effects have not been established. It has been suggested that its activity in epilepsy is related to increased brain concentrations of gamma-aminobutyric acid (GABA).

Pharmacokinetics

Bioavailability

Equivalent doses of intravenous (IV) valproate and oral valproate products are expected to result in equivalent C_{max} , C_{min} , and total systemic exposure to the valproate ion when the IV valproate is administered as a 60 minute infusion. However, the rate of valproate ion absorption may vary with the formulation used. These differences should be of minor clinical importance under the steady state conditions achieved in chronic use in the treatment of epilepsy.

Administration of DEPAKOTE (divalproex sodium) tablets and IV valproate (given as a one hour infusion), 250 mg every 6 hours for 4 days to 18 healthy male volunteers resulted in equivalent AUC, C_{max} , C_{min} at steady state, as well as after the first dose. The T_{max} after IV DEPACON occurs at the end of the one hour infusion, while the T_{max} after oral dosing with DEPAKOTE occurs at approximately 4 hours. Because the kinetics of unbound valproate are linear, bioequivalence between DEPACON and DEPAKOTE up to the maximum recommended dose of 60 mg/kg/day can be assumed. The AUC and C_{max} resulting from administration of IV valproate 500 mg as a single one hour infusion and a single 500 mg dose of DEPAKENE syrup to 17 healthy male volunteers were also equivalent.

Patients maintained on valproic acid doses of 750 mg to 4250 mg daily (given in divided doses every 6 hours) as oral DEPAKOTE (divalproex sodium) alone (n = 24) or with another stabilized antiepileptic drug [carbamazepine (n = 15), phenytoin (n = 11), or

phenobarbital (n = 1)], showed comparable plasma levels for valproic acid when switching from oral DEPAKOTE to IV valproate (1-hour infusion).

Eleven healthy volunteers were given single infusions of 1000 mg IV valproate over 5, 10, 30, and 60 minutes in a 4-period crossover study. Total valproate concentrations were measured; unbound concentrations were not measured. After the 5 minute infusions (mean rate of 2.8 mg/kg/min), mean C_{max} was 145 ± 32 $\mu\text{g/mL}$, while after the 60 minute infusions, mean C_{max} was 115 ± 8 $\mu\text{g/mL}$. Ninety to 120 minutes after infusion initiation, total valproate concentrations were similar for all 4 rates of infusion. Because protein binding is nonlinear at higher total valproate concentrations, the corresponding increase in unbound C_{max} at faster infusion rates will be greater.

Distribution

Protein Binding

The plasma protein binding of valproate is concentration dependent and the free fraction increases from approximately 10% at 40 $\mu\text{g/mL}$ to 18.5% at 130 $\mu\text{g/mL}$. Protein binding of valproate is reduced in the elderly, in patients with chronic hepatic diseases, in patients with renal impairment, and in the presence of other drugs (e.g., aspirin). Conversely, valproate may displace certain protein-bound drugs (e.g., phenytoin, carbamazepine, warfarin, and tolbutamide). (See **PRECAUTIONS - Drug Interactions** for more detailed information on the pharmacokinetic interactions of valproate with other drugs.)

CNS Distribution

Valproate concentrations in cerebrospinal fluid (CSF) approximate unbound concentrations in plasma (about 10% of total concentration).

Metabolism

Valproate is metabolized almost entirely by the liver. In adult patients on monotherapy, 30-50% of an administered dose appears in urine as a glucuronide conjugate. Mitochondrial β -oxidation is the other major metabolic pathway, typically accounting for over 40% of the dose. Usually, less than 15-20% of the dose is eliminated by other oxidative mechanisms. Less than 3% of an administered dose is excreted unchanged in urine.

The relationship between dose and total valproate concentration is nonlinear; concentration does not increase proportionally with the dose, but rather, increases to a lesser extent due to saturable plasma protein binding. The kinetics of unbound drug are linear.

Elimination

Mean plasma clearance and volume of distribution for total valproate are 0.56 L/hr/1.73 m^2 and 11 L/1.73 m^2 , respectively. Mean terminal half-life for valproate monotherapy after an intravenous infusion of 1000 mg was 16 ± 3.0 hours.

The estimates cited apply primarily to patients who are not taking drugs that affect hepatic metabolizing enzyme systems. For example, patients taking enzyme-inducing antiepileptic drugs (carbamazepine, phenytoin, and phenobarbital) will clear valproate more rapidly. Because of these changes in valproate clearance, monitoring of antiepileptic concentrations should be intensified whenever concomitant antiepileptics are introduced or withdrawn.

Special Populations

Effect of Age

Neonates

Children within the first two months of life have a markedly decreased ability to eliminate valproate compared to older children and adults. This is a result of reduced clearance (perhaps due to delay in development of glucuronosyltransferase and other enzyme systems involved in valproate elimination) as well as increased volume of distribution (in part due to decreased plasma protein binding). For example, in one study, the half-life in children under 10 days ranged from 10 to 67 hours compared to a range of 7 to 13 hours in children greater than 2 months.

Children

Pediatric patients (i.e., between 3 months and 10 years) have 50% higher clearances expressed on weight (i.e., mL/min/kg) than do adults. Over the age of 10 years, children have pharmacokinetic parameters that approximate those of adults.

Elderly

The capacity of elderly patients (age range: 68 to 89 years) to eliminate valproate has been shown to be reduced compared to younger adults (age range: 22 to 26). Intrinsic clearance is reduced by 39%; the free fraction is increased by 44%. Accordingly, the initial dosage should be reduced in the elderly. (See **DOSAGE AND ADMINISTRATION**).

Effect of Gender

There are no differences in the body surface area adjusted unbound clearance between males and females (4.8 ± 0.17 and 4.7 ± 0.07 L/hr per 1.73 m^2 , respectively).

Effect of Race

The effects of race on the kinetics of valproate have not been studied.

Effect of Disease

Liver Disease

(See **BOXED WARNING, CONTRAINDICATIONS, and WARNINGS**). Liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 patients with acute hepatitis, compared with 6 healthy subjects. In that study, the half-life of valproate was increased from 12 to 18 hours. Liver disease is also associated with decreased albumin concentrations and larger unbound fractions (2 to 2.6 fold increase) of valproate. Accordingly, monitoring of total concentrations may be misleading since free concentrations may be substantially elevated in patients with hepatic disease whereas total concentrations may appear to be normal.

Renal Disease

A slight reduction (27%) in the unbound clearance of valproate has been reported in patients with renal failure (creatinine clearance < 10 mL/minute); however, hemodialysis typically reduces valproate concentrations by about 20%. Therefore, no dosage adjustment appears to be necessary in patients with renal failure. Protein binding in these patients is substantially reduced; thus, monitoring total concentrations may be misleading.

Plasma Levels and Clinical Effect

The relationship between plasma concentration and clinical response is not well documented. One contributing factor is the nonlinear, concentration dependent protein binding of valproate which affects the clearance of the drug. Thus, monitoring of total serum valproate cannot provide a reliable index of the bioactive valproate species.

For example, because the plasma protein binding of valproate is concentration dependent, the free fraction increases from approximately 10% at 40 µg/mL to 18.5% at 130 µg/mL. Higher than expected free fractions occur in the elderly, in hyperlipidemic patients, and in patients with hepatic and renal diseases.

Epilepsy

The therapeutic range in epilepsy is commonly considered to be 50 to 100 µg/mL of total valproate, although some patients may be controlled with lower or higher plasma concentrations.

Equivalent doses of DEPACON and DEPAKOTE (divalproex sodium) yield equivalent plasma levels of the valproate ion (see **CLINICAL PHARMACOLOGY - Pharmacokinetics**).

CLINICAL STUDIES

The studies described in the following section were conducted with oral divalproex sodium products.

Epilepsy

The efficacy of DEPAKOTE (divalproex sodium) in reducing the incidence of complex partial seizures (CPS) that occur in isolation or in association with other seizure types was established in two controlled trials.

In one, multiclinic, placebo controlled study employing an add-on design (adjunctive therapy), 144 patients who continued to suffer eight or more CPS per 8 weeks during an 8 week period of monotherapy with doses of either carbamazepine or phenytoin sufficient to assure plasma concentrations within the "therapeutic range" were randomized to receive, in addition to their original antiepilepsy drug (AED), either DEPAKOTE or placebo. Randomized patients were to be followed for a total of 16 weeks. The following table presents the findings.

Adjunctive Therapy Study Median Incidence of CPS per 8 Weeks

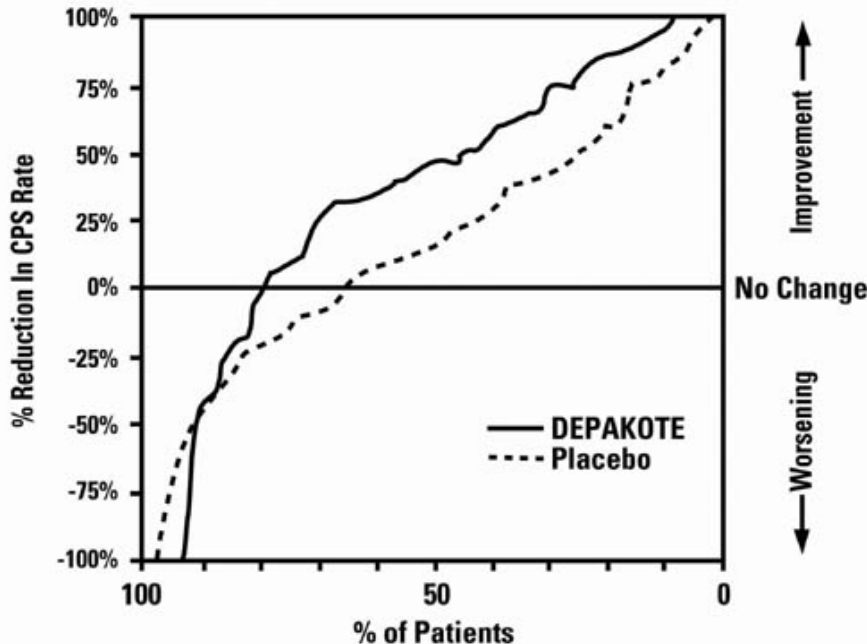
Add-on Treatment	Number of Patients	Baseline Incidence	Experimental Incidence
DEPAKOTE	75	16.0	8.9*
Placebo	69	14.5	11.5

* Reduction from baseline statistically significantly greater for DEPAKOTE than placebo at $p \leq 0.05$ level.

Figure 1 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the adjunctive therapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for an effective treatment is shifted to the left of the curve for placebo. This figure shows that the proportion of patients

achieving any particular level of improvement was consistently higher for DEPAKOTE than for placebo. For example, 45% of patients treated with DEPAKOTE had a $\geq 50\%$ reduction in complex partial seizure rate compared to 23% of patients treated with placebo.

Figure 1.



The second study assessed the capacity of DEPAKOTE to reduce the incidence of CPS when administered as the sole AED. The study compared the incidence of CPS among patients randomized to either a high or low dose treatment arm. Patients qualified for entry into the randomized comparison phase of this study only if 1) they continued to experience 2 or more CPS per 4 weeks during an 8 to 12 week long period of monotherapy with adequate doses of an AED (i.e., phenytoin, carbamazepine, phenobarbital, or primidone) and 2) they made a successful transition over a two week interval to DEPAKOTE. Patients entering the randomized phase were then brought to their assigned target dose, gradually tapered off their concomitant AED and followed for an interval as long as 22 weeks. Less than 50% of the patients randomized, however, completed the study. In patients converted to DEPAKOTE monotherapy, the mean total valproate concentrations during monotherapy were 71 and 123 $\mu\text{g}/\text{mL}$ in the low dose and high dose groups, respectively.

The following table presents the findings for all patients randomized who had at least one post-randomization assessment.

Monotherapy Study Median Incidence of CPS per 8 Weeks

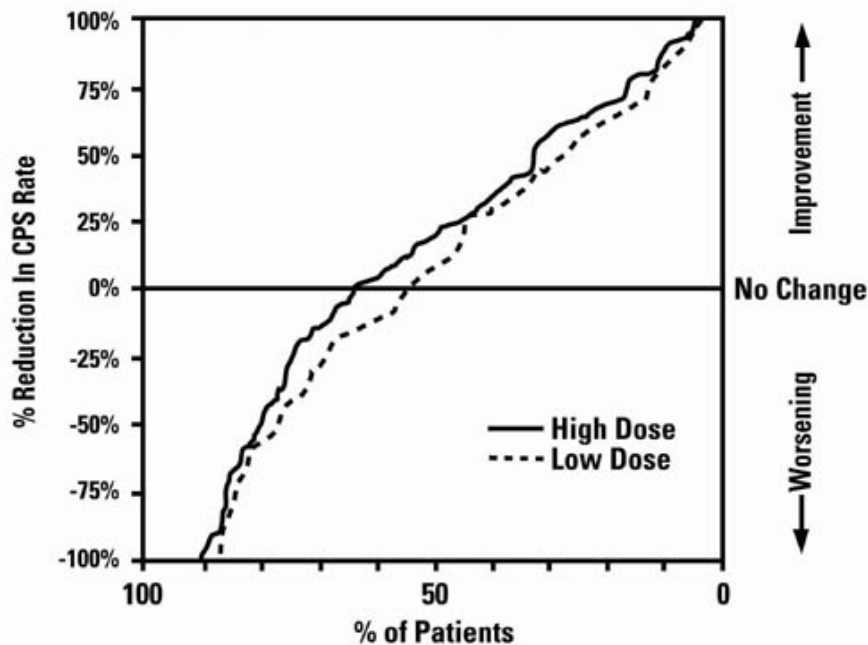
Treatment	Number of Patients	Baseline Incidence	Randomized Phase Incidence
High dose DEPAKOTE	131	13.2	10.7*
Low dose DEPAKOTE	134	14.2	13.8

* Reduction from baseline statistically significantly greater for high dose than low dose at $p \leq 0.05$ level.

Figure 2 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the monotherapy study. A positive percent reduction indicates an improvement

(i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for a more effective treatment is shifted to the left of the curve for a less effective treatment. This figure shows that the proportion of patients achieving any particular level of reduction was consistently higher for high dose DEPAKOTE than for low dose DEPAKOTE. For example, when switching from carbamazepine, phenytoin, phenobarbital or primidone monotherapy to high dose DEPAKOTE monotherapy, 63% of patients experienced no change or a reduction in complex partial seizure rates compared to 54% of patients receiving low dose DEPAKOTE.

Figure 2.



INDICATIONS AND USAGE

DEPACON is indicated as an intravenous alternative in patients for whom oral administration of valproate products is temporarily not feasible in the following conditions:

DEPACON is indicated as monotherapy and adjunctive therapy in the treatment of patients with complex partial seizures that occur either in isolation or in association with other types of seizures. DEPACON is also indicated for use as sole and adjunctive therapy in the treatment of patients with simple and complex absence seizures, and adjunctively in patients with multiple seizure types that include absence seizures.

Simple absence is defined as very brief clouding of the sensorium or loss of consciousness accompanied by certain generalized epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

SEE **WARNINGS** FOR STATEMENT REGARDING FATAL HEPATIC DYSFUNCTION.

CONTRAINDICATIONS

VALPROATE SODIUM INJECTION SHOULD NOT BE ADMINISTERED TO PATIENTS WITH HEPATIC DISEASE OR SIGNIFICANT HEPATIC DYSFUNCTION.

Valproate sodium injection is contraindicated in patients with known hypersensitivity to the drug.

Valproate sodium injection is contraindicated in patients with known urea cycle disorders (see **WARNINGS**).

WARNINGS

Hepatotoxicity

Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid. These incidents usually have occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as malaise, weakness, lethargy, facial edema, anorexia, and vomiting. In patients with epilepsy, a loss of seizure control may also occur. Patients should be monitored closely for appearance of these symptoms. Liver function tests should be performed prior to therapy and at frequent intervals thereafter, especially during the first six months of valproate therapy. However, physicians should not rely totally on serum biochemistry since these tests may not be abnormal in all instances, but should also consider the results of careful interim medical history and physical examination.

Caution should be observed when administering valproate products to patients with a prior history of hepatic disease. Patients on multiple anticonvulsants, children, those with congenital metabolic disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease may be at particular risk. Experience has indicated that children under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions. When DEPACON is used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Use of DEPACON has not been studied in children below the age of 2 years. Above this age group, experience with valproate products in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of drug.

Pancreatitis

Cases of life-threatening pancreatitis have been reported in both children and adults receiving valproate. Some of the cases have been described as hemorrhagic with rapid progression from initial symptoms to death. Some cases have occurred shortly after initial use as well as after several years of use. The rate based upon the reported cases exceeds that expected in the general population and there have been cases in which pancreatitis recurred after rechallenge with valproate. In clinical trials, there were 2 cases of pancreatitis without alternative etiology in 2416 patients, representing 1044 patient-years experience. Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical evaluation. If pancreatitis is diagnosed, valproate should ordinarily be

discontinued. Alternative treatment for the underlying medical condition should be initiated as clinically indicated (see **BOXED WARNING**).

Urea Cycle Disorders (UCD)

Valproate sodium is contraindicated in patients with known urea cycle disorders.

Hyperammonemic encephalopathy, sometimes fatal, has been reported following initiation of valproate therapy in patients with urea cycle disorders, a group of uncommon genetic abnormalities, particularly ornithine transcarbamylase deficiency. Prior to the initiation of valproate therapy, evaluation for UCD should be considered in the following patients: 1) those with a history of unexplained encephalopathy or coma, encephalopathy associated with a protein load, pregnancy-related or postpartum encephalopathy, unexplained mental retardation, or history of elevated plasma ammonia or glutamine; 2) those with cyclical vomiting and lethargy, episodic extreme irritability, ataxia, low BUN, or protein avoidance; 3) those with a family history of UCD or a family history of unexplained infant deaths (particularly males); 4) those with other signs or symptoms of UCD. Patients who develop symptoms of unexplained hyperammonemic encephalopathy while receiving valproate therapy should receive prompt treatment (including discontinuation of valproate therapy) and be evaluated for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **PRECAUTIONS**).

Somnolence in the Elderly

In a double-blind, multicenter trial of valproate in elderly patients with dementia (mean age = 83 years), doses were increased by 125 mg/day to a target dose of 20 mg/kg/day. A significantly higher proportion of valproate patients had somnolence compared to placebo, and although not statistically significant, there was a higher proportion of patients with dehydration. Discontinuations for somnolence were also significantly higher than with placebo. In some patients with somnolence (approximately one-half), there was associated reduced nutritional intake and weight loss. There was a trend for the patients who experienced these events to have a lower baseline albumin concentration, lower valproate clearance, and a higher BUN. In elderly patients, dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

Thrombocytopenia

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia [see **PRECAUTIONS**]) may be dose-related. In a clinical trial of DEPAKOTE as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). The therapeutic benefit which may accompany the higher doses should therefore be weighed against the possibility of a greater incidence of adverse effects.

Post-traumatic Seizures

A study was conducted to evaluate the effect of IV valproate in the prevention of post-traumatic seizures in patients with acute head injuries. Patients were randomly assigned to receive either IV valproate given for one week (followed by oral valproate products for either one or six months per random treatment assignment) or IV phenytoin given for one week (followed by placebo). In this study, the incidence of death was found to be higher in the two groups assigned to valproate treatment compared to the rate in those assigned to the IV phenytoin treatment group (13% vs 8.5%, respectively). Many of these patients were critically ill with multiple and/or severe injuries, and evaluation of the causes of death did not suggest any specific drug-related causation. Further, in the absence of a concurrent placebo control during the initial week of intravenous therapy, it is impossible to determine if the mortality rate in the patients treated with valproate was greater or less than that expected in a similar group not treated with valproate, or whether the rate seen in the IV phenytoin treated patients was lower than would be expected. Nonetheless, until further information is available, it seems prudent not to use DEPACon in patients with acute head trauma for the prophylaxis of post-traumatic seizures.

Usage In Pregnancy

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS. DATA SUGGEST THAT THERE IS AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS ASSOCIATED WITH THE USE OF VALPROATE BY WOMEN WITH SEIZURE DISORDERS DURING PREGNANCY WHEN COMPARED TO THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO DO NOT USE ANTIEPILEPTIC DRUGS DURING PREGNANCY, THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO USE OTHER ANTIEPILEPTIC DRUGS, AND THE BACKGROUND INCIDENCE FOR THE GENERAL POPULATION. THEREFORE, VALPROATE SHOULD BE CONSIDERED FOR WOMEN OF CHILDBEARING POTENTIAL ONLY AFTER THE RISKS HAVE BEEN THOROUGHLY DISCUSSED WITH THE PATIENT AND WEIGHED AGAINST THE POTENTIAL BENEFITS OF TREATMENT.

THERE ARE MULTIPLE REPORTS IN THE CLINICAL LITERATURE THAT INDICATE THE USE OF ANTIEPILEPTIC DRUGS DURING PREGNANCY RESULTS IN AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS IN OFFSPRING. ANTIEPILEPTIC DRUGS, INCLUDING VALPROATE, SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING POTENTIAL ONLY IF THEY ARE CLEARLY SHOWN TO BE ESSENTIAL IN THE MANAGEMENT OF THEIR MEDICAL CONDITION.

Antiepileptic drugs should not be discontinued abruptly in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

HUMAN DATA

Congenital Malformations

The North American Antiepileptic Drug Pregnancy Registry reported 16 cases of congenital malformations among the offspring of 149 women with epilepsy who were exposed to valproic acid monotherapy during the first trimester of pregnancy at doses of approximately 1,000 mg per day, for a prevalence rate of 10.7% (95% CI 6.3%-16.9%). Three of the 149 offspring (2%) had neural tube defects and 6 of the 149 (4%) had less

severe malformations. Among epileptic women who were exposed to other antiepileptic drug monotherapies during pregnancy (1,048 patients) the malformation rate was 2.9% (95% CI 2.0% to 4.1%). There was a 4-fold increase in congenital malformations among infants with valproic acid-exposed mothers compared with those treated with other antiepileptic monotherapies as a group (Odds Ratio 4.0; 95% CI 2.1 to 7.4). This increased risk does not reflect a comparison versus any specific antiepileptic drug, but the risk versus the heterogeneous group of all other antiepileptic drug monotherapies combined. The increased teratogenic risk from valproic acid in women with epilepsy is expected to be reflected in an increased risk in other indications (e.g., migraine or bipolar disorder).

THE STRONGEST ASSOCIATION OF MATERNAL VALPROATE USAGE WITH CONGENITAL MALFORMATIONS IS WITH NEURAL TUBE DEFECTS (AS DISCUSSED UNDER THE NEXT SUBHEADING). HOWEVER, OTHER CONGENITAL ANOMALIES (E.G. CRANIOFACIAL DEFECTS, CARDIOVASCULAR MALFORMATIONS AND ANOMALIES INVOLVING VARIOUS BODY SYSTEMS), COMPATIBLE AND INCOMPATIBLE WITH LIFE, HAVE BEEN REPORTED. SUFFICIENT DATA TO DETERMINE THE INCIDENCE OF THESE CONGENITAL ANOMALIES IS NOT AVAILABLE.

Neural Tube Defects

THE INCIDENCE OF NEURAL TUBE DEFECTS IN THE FETUS IS INCREASED IN MOTHERS RECEIVING VALPROATE DURING THE FIRST TRIMESTER OF PREGNANCY. THE CENTERS FOR DISEASE CONTROL (CDC) HAS ESTIMATED THE RISK OF VALPROIC ACID EXPOSED WOMEN HAVING CHILDREN WITH SPINA BIFIDA TO BE APPROXIMATELY 1 TO 2%. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG) ESTIMATES THE GENERAL POPULATION RISK FOR CONGENITAL NEURAL TUBE DEFECTS AS 0.14% TO 0.2%.

Tests to detect neural tube and other defects using current accepted procedures should be considered a part of routine prenatal care in pregnant women receiving valproate.

Evidence suggests that pregnant women who receive folic acid supplementation may be at decreased risk for congenital neural tube defects in their offspring compared to pregnant women not receiving folic acid. Whether the risk of neural tube defects in the offspring of women receiving valproate specifically is reduced by folic acid supplementation is unknown. DIETARY FOLIC ACID SUPPLEMENTATION BOTH PRIOR TO AND DURING PREGNANCY SHOULD BE ROUTINELY RECOMMENDED TO PATIENTS CONTEMPLATING PREGNANCY.

Other Adverse Pregnancy Effects

PATIENTS TAKING VALPROATE MAY DEVELOP CLOTTING ABNORMALITIES (SEE **PRECAUTIONS - GENERAL AND WARNINGS**). A PATIENT WHO HAD LOW FIBRINOGEN WHEN TAKING MULTIPLE ANTICONVULSANTS INCLUDING VALPROATE GAVE BIRTH TO AN INFANT WITH AFIBRINOGENEMIA WHO SUBSEQUENTLY DIED OF HEMORRHAGE. IF VALPROATE IS USED IN PREGNANCY, THE CLOTTING PARAMETERS SHOULD BE MONITORED CAREFULLY.

PATIENTS TAKING VALPROATE MAY DEVELOP HEPATIC FAILURE (SEE **WARNINGS - HEPATOTOXICITY AND BOX WARNING**). FATAL HEPATIC FAILURES, IN A NEWBORN AND IN AN INFANT, HAVE BEEN REPORTED FOLLOWING THE MATERNAL USE OF VALPROATE DURING PREGNANCY.

ANIMAL DATA

Animal studies have demonstrated valproate-induced teratogenicity. Increased frequencies of malformations, as well as intrauterine growth retardation and death, have been observed in mice, rats, rabbits, and monkeys following prenatal exposure to valproate. Malformations of the skeletal system are the most common structural abnormalities produced in experimental animals, but neural tube closure defects have been seen in mice exposed to maternal plasma valproate concentrations exceeding 230 µg/mL (2.3 times the upper limit of the human therapeutic range) during susceptible periods of embryonic development. Administration of an oral dose of 200 mg/kg/day or greater (50% of the maximum human daily dose or greater on a mg/m² basis) to pregnant rats during organogenesis produced malformations (skeletal, cardiac, and urogenital) and growth retardation in the offspring. These doses resulted in peak maternal plasma valproate levels of approximately 340 µg/mL or greater (3.4 times the upper limit of the human therapeutic range or greater). Behavioral deficits have been reported in the offspring of rats given a dose of 200 mg/kg/day throughout most of pregnancy. An oral dose of 350 mg/kg/day (approximately 2 times the maximum human daily dose on a mg/m² basis) produced skeletal and visceral malformations in rabbits exposed during organogenesis. Skeletal malformations, growth retardation, and death were observed in rhesus monkeys following administration of an oral dose of 200 mg/kg/day (equal to the maximum human daily dose on a mg/m² basis) during organogenesis. This dose resulted in peak maternal plasma valproate levels of approximately 280 µg/mL (2.8 times the upper limit of the human therapeutic range).

PRECAUTIONS

Hepatic Dysfunction

See **BOXED WARNING, CONTRAINDICATIONS** and **WARNINGS**.

Pancreatitis

See **BOXED WARNING** and **WARNINGS**.

Hyperammonemia

Hyperammonemia has been reported in association with valproate therapy and may be present despite normal liver function tests. In patients who develop unexplained lethargy and vomiting or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. If ammonia is increased, valproate therapy should be discontinued. Appropriate interventions for treatment of hyperammonemia should be initiated, and such patients should undergo investigation for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders and PRECAUTIONS - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

Asymptomatic elevations of ammonia are more common and when present, require close monitoring of plasma ammonia levels. If the elevation persists, discontinuation of valproate therapy should be considered.

Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use

Concomitant administration of topiramate and valproic acid has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. Clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level of consciousness and/or cognitive function with lethargy or vomiting. In most cases, symptoms and signs abated with discontinuation of either drug. This adverse event is not due to a pharmacokinetic interaction. It is not known if topiramate monotherapy is associated with hyperammonemia. Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, an interaction of topiramate and valproic acid may exacerbate existing defects or unmask deficiencies in susceptible persons. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. (See **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia**).

General

Because of reports of thrombocytopenia (see **WARNINGS**), inhibition of the secondary phase of platelet aggregation, and abnormal coagulation parameters, (e.g., low fibrinogen), platelet counts and coagulation tests are recommended before initiating therapy and at periodic intervals. It is recommended that patients receiving DEPACON be monitored for platelet count and coagulation parameters prior to planned surgery. In a clinical trial of DEPAKOTE (divalproex sodium) as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). Evidence of hemorrhage, bruising, or a disorder of hemostasis/coagulation is an indication for reduction of the dosage or withdrawal of therapy.

Since DEPACON may interact with concurrently administered drugs which are capable of enzyme induction, periodic plasma concentration determinations of valproate and concomitant drugs are recommended during the early course of therapy. (See **PRECAUTIONS - Drug Interactions**).

Valproate is partially eliminated in the urine as a keto-metabolite which may lead to a false interpretation of the urine ketone test.

There have been reports of altered thyroid function tests associated with valproate. The clinical significance of these is unknown.

There are *in vitro* studies that suggest valproate stimulates the replication of the HIV and CMV viruses under certain experimental conditions. The clinical consequence, if any, is not known. Additionally, the relevance of these *in vitro* findings is uncertain for patients receiving maximally suppressive antiretroviral therapy. Nevertheless, these data should be borne in mind when interpreting the results from regular monitoring of the viral load in HIV infected patients receiving valproate or when following CMV infected patients clinically.

Multi-organ Hypersensitivity Reaction

Multi-organ hypersensitivity reactions have been rarely reported in close temporal association to the initiation of valproate therapy in adult and pediatric patients (median time to detection 21 days; range 1 to 40 days). Although there have been a limited number of reports, many of these cases resulted in hospitalization and at least one death has been reported. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement. Other associated manifestations may include lymphadenopathy, hepatitis, liver function test abnormalities, hematological abnormalities (e.g., eosinophilia, thrombocytopenia, neutropenia), pruritis, nephritis, oliguria, hepatorenal syndrome, arthralgia, and asthenia. Because the disorder is variable in its expression, other organ system symptoms and signs, not noted here, may occur. If this reaction is suspected, valproate should be discontinued and an alternative treatment started. Although the existence of cross sensitivity with other drugs that produce this syndrome is unclear, the experience amongst drugs associated with multi-organ hypersensitivity would indicate this to be a possibility.

Information for Patients

Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis and, therefore, require further medical evaluation promptly.

Patients should be informed of the signs and symptoms associated with hyperammonemic encephalopathy (see **PRECAUTIONS – Hyperammonemia**) and be told to inform the prescriber if any of these symptoms occur.

Since DEPACON may produce CNS depression, especially when combined with another CNS depressant (e.g., alcohol), patients should be advised not to engage in hazardous activities, such as driving an automobile or operating dangerous machinery, until it is known that they do not become drowsy from the drug.

Since DEPAKOTE has been associated with certain types of birth defects, female patients of child-bearing age considering the use of DEPACON should be advised of the risk and of alternative therapeutic options and to read the Patient Information Leaflet, which appears as the last section of the labeling. **This is especially important when the treatment of a spontaneously reversible condition not ordinarily associated with permanent injury or risk of death (e.g., migraine) is considered.**

Patients should be instructed that a fever associated with other organ system involvement (rash, lymphadenopathy, etc.) may be drug-related and should be reported to the physician immediately (see **PRECAUTIONS - Multi-organ Hypersensitivity Reaction**).

Drug Interactions

Effects of Co-Administered Drugs on Valproate Clearance

Drugs that affect the level of expression of hepatic enzymes, particularly those that elevate levels of glucuronosyltransferases, may increase the clearance of valproate. For example, phenytoin, carbamazepine, and phenobarbital (or primidone) can double the clearance of valproate. Thus, patients on monotherapy will generally have longer half-lives and higher concentrations than patients receiving polytherapy with antiepilepsy drugs.

In contrast, drugs that are inhibitors of cytochrome P450 isozymes, e.g., antidepressants, may be expected to have little effect on valproate clearance because cytochrome P450

microsomal mediated oxidation is a relatively minor secondary metabolic pathway compared to glucuronidation and beta-oxidation.

Because of these changes in valproate clearance, monitoring of valproate and concomitant drug concentrations should be increased whenever enzyme inducing drugs are introduced or withdrawn.

The following list provides information about the potential for an influence of several commonly prescribed medications on valproate pharmacokinetics. The list is not exhaustive nor could it be, since new interactions are continuously being reported.

Drugs for Which a Potentially Important Interaction Has Been Observed

Aspirin

A study involving the co-administration of aspirin at antipyretic doses (11 to 16 mg/kg) with valproate to pediatric patients (n = 6) revealed a decrease in protein binding and an inhibition of metabolism of valproate. Valproate free fraction was increased 4-fold in the presence of aspirin compared to valproate alone. The β -oxidation pathway consisting of 2-E-valproic acid, 3-OH-valproic acid, and 3-keto valproic acid was decreased from 25% of total metabolites excreted on valproate alone to 8.3% in the presence of aspirin. Caution should be observed if valproate and aspirin are to be co-administered.

Felbamate

A study involving the co-administration of 1200 mg/day of felbamate with valproate to patients with epilepsy (n = 10) revealed an increase in mean valproate peak concentration by 35% (from 86 to 115 μ g/mL) compared to valproate alone. Increasing the felbamate dose to 2400 mg/day increased the mean valproate peak concentration to 133 μ g/mL (another 16% increase). A decrease in valproate dosage may be necessary when felbamate therapy is initiated.

Meropenem

Subtherapeutic valproic acid levels have been reported when meropenem was co-administered.

Rifampin

A study involving the administration of a single dose of valproate (7 mg/kg) 36 hours after 5 nights of daily dosing with rifampin (600 mg) revealed a 40% increase in the oral clearance of valproate. Valproate dosage adjustment may be necessary when it is co-administered with rifampin.

Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

Antacids

A study involving the co-administration of valproate 500 mg with commonly administered antacids (Maalox, Trisogel, and Titalac - 160 mEq doses) did not reveal any effect on the extent of absorption of valproate.

Chlorpromazine

A study involving the administration of 100 to 300 mg/day of chlorpromazine to schizophrenic patients already receiving valproate (200 mg BID) revealed a 15% increase in trough plasma levels of valproate.

Haloperidol

A study involving the administration of 6 to 10 mg/day of haloperidol to schizophrenic patients already receiving valproate (200 mg BID) revealed no significant changes in valproate trough plasma levels.

Cimetidine and Ranitidine

Cimetidine and ranitidine do not affect the clearance of valproate.

Effects of Valproate on Other Drugs

Valproate has been found to be a weak inhibitor of some P450 isozymes, epoxide hydrase, and glucuronyl transferases.

The following list provides information about the potential for an influence of valproate co-administration on the pharmacokinetics or pharmacodynamics of several commonly prescribed medications. The list is not exhaustive, since new interactions are continuously being reported.

Drugs for Which a Potentially Important Valproate Interaction Has Been Observed

Amitriptyline/Nortriptyline

Administration of a single oral 50 mg dose of amitriptyline to 15 normal volunteers (10 males and 5 females) who received valproate (500 mg BID) resulted in a 21% decrease in plasma clearance of amitriptyline and a 34% decrease in the net clearance of nortriptyline. Rare postmarketing reports of concurrent use of valproate and amitriptyline resulting in an increased amitriptyline level have been received. Concurrent use of valproate and amitriptyline has rarely been associated with toxicity. Monitoring of amitriptyline levels should be considered for patients taking valproate concomitantly with amitriptyline. Consideration should be given to lowering the dose of amitriptyline/nortriptyline in the presence of valproate.

Carbamazepine/carbamazepine-10,11-Epoxyde

Serum levels of carbamazepine (CBZ) decreased 17% while that of carbamazepine-10,11-epoxyde (CBZ-E) increased by 45% upon co-administration of valproate and CBZ to epileptic patients.

Clonazepam

The concomitant use of valproic acid and clonazepam may induce absence status in patients with a history of absence type seizures.

Diazepam

Valproate displaces diazepam from its plasma albumin binding sites and inhibits its metabolism. Co-administration of valproate (1500 mg daily) increased the free fraction of diazepam (10 mg) by 90% in healthy volunteers (n = 6). Plasma clearance and volume of distribution for free diazepam were reduced by 25% and 20%, respectively, in the

presence of valproate. The elimination half-life of diazepam remained unchanged upon addition of valproate.

Ethosuximide

Valproate inhibits the metabolism of ethosuximide. Administration of a single ethosuximide dose of 500 mg with valproate (800 to 1600 mg/day) to healthy volunteers (n = 6) was accompanied by a 25% increase in elimination half-life of ethosuximide and a 15% decrease in its total clearance as compared to ethosuximide alone. Patients receiving valproate and ethosuximide, especially along with other anticonvulsants, should be monitored for alterations in serum concentrations of both drugs.

Lamotrigine

In a steady-state study involving 10 healthy volunteers, the elimination half-life of lamotrigine increased from 26 to 70 hours with valproate co-administration (a 165% increase). The dose of lamotrigine should be reduced when co-administered with valproate. Serious skin reactions (such as Stevens-Johnson Syndrome and toxic epidermal necrolysis) have been reported with concomitant lamotrigine and valproate administration. See lamotrigine package insert for details on lamotrigine dosing with concomitant valproate administration.

Phenobarbital

Valproate was found to inhibit the metabolism of phenobarbital. Co-administration of valproate (250 mg BID for 14 days) with phenobarbital to normal subjects (n = 6) resulted in a 50% increase in half-life and a 30% decrease in plasma clearance of phenobarbital (60 mg single-dose). The fraction of phenobarbital dose excreted unchanged increased by 50% in presence of valproate.

There is evidence for severe CNS depression, with or without significant elevations of barbiturate or valproate serum concentrations. All patients receiving concomitant barbiturate therapy should be closely monitored for neurological toxicity. Serum barbiturate concentrations should be obtained, if possible, and the barbiturate dosage decreased, if appropriate.

Primidone, which is metabolized to a barbiturate, may be involved in a similar interaction with valproate.

Phenytoin

Valproate displaces phenytoin from its plasma albumin binding sites and inhibits its hepatic metabolism. Co-administration of valproate (400 mg TID) with phenytoin (250 mg) in normal volunteers (n = 7) was associated with a 60% increase in the free fraction of phenytoin. Total plasma clearance and apparent volume of distribution of phenytoin increased 30% in the presence of valproate. Both the clearance and apparent volume of distribution of free phenytoin were reduced by 25%.

In patients with epilepsy, there have been reports of breakthrough seizures occurring with the combination of valproate and phenytoin. The dosage of phenytoin should be adjusted as required by the clinical situation.

Tolbutamide

From *in vitro* experiments, the unbound fraction of tolbutamide was increased from 20% to 50% when added to plasma samples taken from patients treated with valproate. The clinical relevance of this displacement is unknown.

Topiramate

Concomitant administration of valproic acid and topiramate has been associated with hyperammonemia with and without encephalopathy (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia and - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

Warfarin

In an *in vitro* study, valproate increased the unbound fraction of warfarin by up to 32.6%. The therapeutic relevance of this is unknown; however, coagulation tests should be monitored if valproate therapy is instituted in patients taking anticoagulants.

Zidovudine

In six patients who were seropositive for HIV, the clearance of zidovudine (100 mg q8h) was decreased by 38% after administration of valproate (250 or 500 mg q8h); the half-life of zidovudine was unaffected.

Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

Acetaminophen

Valproate had no effect on any of the pharmacokinetic parameters of acetaminophen when it was concurrently administered to three epileptic patients.

Clozapine

In psychotic patients (n = 11), no interaction was observed when valproate was co-administered with clozapine.

Lithium

Co-administration of valproate (500 mg BID) and lithium carbonate (300 mg TID) to normal male volunteers (n = 16) had no effect on the steady-state kinetics of lithium.

Lorazepam

Concomitant administration of valproate (500 mg BID) and lorazepam (1 mg BID) in normal male volunteers (n = 9) was accompanied by a 17% decrease in the plasma clearance of lorazepam.

Oral Contraceptive Steroids

Administration of a single-dose of ethinylloestradiol (50 µg)/levonorgestrel (250 µg) to 6 women on valproate (200 mg BID) therapy for 2 months did not reveal any pharmacokinetic interaction.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Valproic acid was administered orally to Sprague Dawley rats and ICR (HA/ICR) mice at doses of 80 and 170 mg/kg/day (approximately 10 to 50% of the maximum human daily dose on a mg/m² basis) for two years. A variety of neoplasms were observed in both species. The chief findings were a statistically significant increase in the incidence of subcutaneous fibrosarcomas in high dose male rats receiving valproic acid and a statistically significant dose-related trend for benign pulmonary adenomas in male mice receiving valproic acid. The significance of these findings for humans is unknown.

Mutagenesis

Valproate was not mutagenic in an *in vitro* bacterial assay (Ames test), did not produce dominant lethal effects in mice, and did not increase chromosome aberration frequency in an *in vivo* cytogenetic study in rats. Increased frequencies of sister chromatid exchange (SCE) have been reported in a study of epileptic children taking valproate, but this association was not observed in another study conducted in adults. There is some evidence that increased SCE frequencies may be associated with epilepsy. The biological significance of an increase in SCE frequency is not known.

Fertility

Chronic toxicity studies in juvenile and adult rats and dogs demonstrated reduced spermatogenesis and testicular atrophy at oral doses of 400 mg/kg/day or greater in rats (approximately equivalent to or greater than the maximum human daily dose on a mg/m² basis) and 150 mg/kg/day or greater in dogs (approximately 1.4 times the maximum human daily dose or greater on a mg/m² basis). Segment I fertility studies in rats have shown oral doses up to 350 mg/kg/day (approximately equal to the maximum human daily dose on a mg/m² basis) for 60 days to have no effect on fertility. THE EFFECT OF VALPROATE ON TESTICULAR DEVELOPMENT AND ON SPERM PRODUCTION AND FERTILITY IN HUMANS IS UNKNOWN.

Pregnancy

Pregnancy Category D: See **WARNINGS** .

Nursing Mothers

Valproate is excreted in breast milk. Concentrations in breast milk have been reported to be 1-10% of serum concentrations. It is not known what effect this would have on a nursing infant. Consideration should be given to discontinuing nursing when valproate is administered to a nursing woman.

Pediatric Use

Experience with oral valproate has indicated that pediatric patients under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions (see **BOXED WARNING**). The safety of DEPACON has not been studied in individuals below the age of 2 years. If a decision is made to use DEPACON in this age group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above the age of 2 years, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

Younger children, especially those receiving enzyme-inducing drugs, will require larger maintenance doses to attain targeted total and unbound valproic acid concentrations.

The variability in free fraction limits the clinical usefulness of monitoring total serum valproic acid concentrations. Interpretation of valproic acid concentrations in children should include consideration of factors that affect hepatic metabolism and protein binding.

No unique safety concerns were identified in the 35 patients age 2 to 17 years who received DEPACON in clinical trials.

The basic toxicology and pathologic manifestations of valproate sodium in neonatal (4-day old) and juvenile (14-day old) rats are similar to those seen in young adult rats. However, additional findings, including renal alterations in juvenile rats and renal alterations and retinal dysplasia in neonatal rats, have been reported. These findings occurred at 240 mg/kg/day, a dosage approximately equivalent to the human maximum recommended daily dose on a mg/m² basis. They were not seen at 90 mg/kg, or 40% of the maximum human daily dose on a mg/m² basis.

Geriatric Use

No patients above the age of 65 years were enrolled in double-blind prospective clinical trials of mania associated with bipolar illness. In a case review study of 583 patients, 72 patients (12%) were greater than 65 years of age. A higher percentage of patients above 65 years of age reported accidental injury, infection, pain, somnolence, and tremor. Discontinuation of valproate was occasionally associated with the latter two events. It is not clear whether these events indicate additional risk or whether they result from preexisting medical illness and concomitant medication use among these patients.

A study of elderly patients with dementia revealed drug related somnolence and discontinuation for somnolence (see **WARNINGS - Somnolence in the Elderly**). The starting dose should be reduced in these patients, and dosage reductions or discontinuation should be considered in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

No unique safety concerns were identified in the 21 patients > 65 years of age receiving DEPACON in clinical trials.

ADVERSE REACTIONS

The adverse events that can result from DEPACON use include all of those associated with oral forms of valproate. The following describes experience specifically with DEPACON. DEPACON has been generally well tolerated in clinical trials involving 111 healthy adult male volunteers and 352 patients with epilepsy, given at doses of 125 to 6000 mg (total daily dose). A total of 2% of patients discontinued treatment with DEPACON due to adverse events. The most common adverse events leading to discontinuation were 2 cases each of nausea/vomiting and elevated amylase. Other adverse events leading to discontinuation were hallucinations, pneumonia, headache, injection site reaction, and abnormal gait. Dizziness and injection site pain were observed more frequently at a 100 mg/min infusion rate than at rates up to 33 mg/min. At a 200 mg/min rate, dizziness and taste perversion occurred more frequently than at a 100 mg/min rate. The maximum rate of infusion studied was 200 mg/min.

Adverse events reported by at least 0.5% of all subjects/patients in clinical trials of DEPACON are summarized in Table 1.

Table 1. Adverse Events Reported During Studies of DEPACON

Body System/Event	N = 463
Body as a Whole	
Chest Pain	1.7%
Headache	4.3%
Injection Site Inflammation	0.6%
Injection Site Pain	2.6%
Injection Site Reaction	2.4%
Pain (unspecified)	1.3%
Cardiovascular	
Vasodilation	0.9%
Dermatologic	
Sweating	0.9%
Digestive System	
Abdominal Pain	1.1%
Diarrhea	0.9%
Nausea	3.2%
Vomiting	1.3%
Nervous System	
Dizziness	5.2%
Euphoria	0.9%
Hypesthesia	0.6%
Nervousness	0.9%
Paresthesia	0.9%
Somnolence	1.7%
Tremor	0.6%
Respiratory	
Pharyngitis	0.6%
Special Senses	
Taste Perversion	1.9%

In a separate clinical safety trial, 112 patients with epilepsy were given infusions of DEPACON (up to 15 mg/kg) over 5 to 10 minutes (1.5-3.0 mg/kg/min). The common adverse events (> 2%) were somnolence (10.7%), dizziness (7.1%), paresthesia (7.1%), asthenia (7.1%), nausea (6.3%), and headache (2.7%). While the incidence of these adverse events was generally higher than in Table 1 (experience encompassing the standard, much slower infusion rates), e.g., somnolence (1.7%), dizziness (5.2%), paresthesia (0.9%), asthenia (0%), nausea (3.2%), and headache (4.3%), a direct comparison between the incidence of adverse events in the 2 cohorts cannot be made because of differences in patient populations and study designs.

Ammonia levels have not been systematically studied after IV valproate, so that an estimate of the incidence of hyperammonemia after IV DEPACON cannot be provided. Hyperammonemia with encephalopathy has been reported in 2 patients after infusions of DEPACON.

Epilepsy

Based on a placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures, DEPAKOTE (divalproex sodium) was generally well tolerated with most adverse events rated as mild to moderate in severity. Intolerance was the primary reason for discontinuation in the DEPAKOTE-treated patients (6%), compared to 1% of placebo-treated patients.

Table 2 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of DEPAKOTE-treated patients and for which the incidence was greater than in the placebo group, in the placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures. Since patients were also treated with other antiepilepsy drugs, it is not possible, in most cases, to determine whether the following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 2. Adverse Events Reported by $\geq 5\%$ of Patients Treated with DEPAKOTE During Placebo-Controlled Trial of Adjunctive Therapy for Complex Partial Seizures

Body System/Event	Depakote (%) (n = 77)	Placebo (%) (n = 70)
Body as a Whole		
Headache	31	21
Asthenia	27	7
Fever	6	4
Gastrointestinal System		
Nausea	48	14
Vomiting	27	7
Abdominal Pain	23	6
Diarrhea	13	6
Anorexia	12	0
Dyspepsia	8	4
Constipation	5	1
Nervous System		
Somnolence	27	11
Tremor	25	6
Dizziness	25	13
Diplopia	16	9
Amblyopia/Blurred Vision	12	9
Ataxia	8	1
Nystagmus	8	1
Emotional Lability	6	4
Thinking Abnormal	6	0
Amnesia	5	1
Respiratory System		
Flu Syndrome	12	9
Infection	12	6
Bronchitis	5	1
Rhinitis	5	4
Other		
Alopecia	6	1
Weight Loss	6	0

Table 3 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of patients in the high dose DEPAKOTE group, and for which the incidence was greater than in the low dose group, in a controlled trial of DEPAKOTE monotherapy treatment of complex partial seizures. Since patients were being titrated off another antiepilepsy drug during the first portion of the trial, it is not possible, in many cases, to determine whether the following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 3. Adverse Events Reported by $\geq 5\%$ of Patients in the High Dose Group in the Controlled Trial of DEPAKOTE Monotherapy for Complex Partial Seizures¹

Body System/Event	High Dose (%) (n = 131)	Low Dose (%) (n = 134)
Body as a Whole		
Asthenia	21	10
Digestive System		
Nausea	34	26
Diarrhea	23	19
Vomiting	23	15
Abdominal Pain	12	9
Anorexia	11	4
Dyspepsia	11	10
Hemic/Lymphatic System		
Thrombocytopenia	24	1
Ecchymosis	5	4
Metabolic/Nutritional		
Weight Gain	9	4
Peripheral Edema	8	3
Nervous System		
Tremor	57	19
Somnolence	30	18
Dizziness	18	13
Insomnia	15	9
Nervousness	11	7
Amnesia	7	4
Nystagmus	7	1
Depression	5	4
Respiratory System		
Infection	20	13
Pharyngitis	8	2
Dyspnea	5	1
Skin and Appendages		
Alopecia	24	13
Special Senses		
Amblyopia/Blurred Vision	8	4
Tinnitus	7	1

1 Headache was the only adverse event that occurred in $\geq 5\%$ of patients in the high dose group and at an equal or greater incidence in the low dose group.

The following additional adverse events were reported by greater than 1% but less than 5% of the 358 patients treated with DEPAKOTE in the controlled trials of complex partial seizures:

Body as a Whole

Back pain, chest pain, malaise.

Cardiovascular System

Tachycardia, hypertension, palpitation.

Digestive System

Increased appetite, flatulence, hematemesis, eructation, pancreatitis, periodontal abscess.

Hemic and Lymphatic System

Petechia.

Metabolic and Nutritional Disorders

SGOT increased, SGPT increased.

Musculoskeletal System

Myalgia, twitching, arthralgia, leg cramps, myasthenia.

Nervous System

Anxiety, confusion, abnormal gait, paresthesia, hypertonia, incoordination, abnormal dreams, personality disorder.

Respiratory System

Sinusitis, cough increased, pneumonia, epistaxis.

Skin and Appendages

Rash, pruritus, dry skin.

Special Senses

Taste perversion, abnormal vision, deafness, otitis media.

Urogenital System

Urinary incontinence, vaginitis, dysmenorrhea, amenorrhea, urinary frequency.

Other Patient Populations

Adverse events that have been reported with all dosage forms of valproate from epilepsy trials, spontaneous reports, and other sources are listed below by body system.

Gastrointestinal

The most commonly reported side effects at the initiation of therapy are nausea, vomiting, and indigestion. These effects are usually transient and rarely require discontinuation of therapy. Diarrhea, abdominal cramps, and constipation have been reported. Both anorexia with some weight loss and increased appetite with weight gain have also been reported. The administration of delayed-release divalproex sodium may result in reduction of gastrointestinal side effects in some patients using oral therapy.

CNS Effects

Sedative effects have occurred in patients receiving valproate alone but occur most often in patients receiving combination therapy. Sedation usually abates upon reduction of other antiepileptic medication. Tremor (may be dose-related), hallucinations, ataxia, headache, nystagmus, diplopia, asterixis, "spots before eyes," dysarthria, dizziness, confusion, hypesthesia, vertigo, incoordination, and parkinsonism have been reported with the use of valproate. Rare cases of coma have occurred in patients receiving valproate alone or in conjunction with phenobarbital. In rare instances encephalopathy with or without fever has developed shortly after the introduction of valproate monotherapy without evidence of hepatic dysfunction or inappropriately high plasma valproate levels. Although recovery has been described following drug withdrawal, there have been fatalities in patients with

hyperammonemic encephalopathy, particularly in patients with underlying urea cycle disorders (see **WARNINGS – Urea Cycle Disorders** and **PRECAUTIONS**).

Several reports have noted reversible cerebral atrophy and dementia in association with valproate therapy.

Dermatologic

Transient hair loss, skin rash, photosensitivity, generalized pruritus, erythema multiforme, and Stevens-Johnson syndrome. Rare cases of toxic epidermal necrolysis have been reported including a fatal case in a 6 month old infant taking valproate and several other concomitant medications. An additional case of toxic epidermal necrosis resulting in death was reported in a 35 year old patient with AIDS taking several concomitant medications and with a history of multiple cutaneous drug reactions. Serious skin reactions have been reported with concomitant administration of lamotrigine and valproate (see **PRECAUTIONS - Drug Interactions**).

Psychiatric

Emotional upset, depression, psychosis, aggression, hyperactivity, hostility, and behavioral deterioration.

Musculoskeletal

Weakness.

Hematologic

Thrombocytopenia and inhibition of the secondary phase of platelet aggregation may be reflected in altered bleeding time, petechiae, bruising, hematoma formation, epistaxis, and frank hemorrhage (see **PRECAUTIONS - General** and **Drug Interactions**). Relative lymphocytosis, macrocytosis, hypofibrinogenemia, leukopenia, eosinophilia, anemia including macrocytic with or without folate deficiency, bone marrow suppression, pancytopenia, aplastic anemia, agranulocytosis, and acute intermittent porphyria.

Hepatic

Minor elevations of transaminases (e.g., SGOT and SGPT) and LDH are frequent and appear to be dose-related. Occasionally, laboratory test results include increases in serum bilirubin and abnormal changes in other liver function tests. These results may reflect potentially serious hepatotoxicity (see **WARNINGS**).

Endocrine

Irregular menses, secondary amenorrhea, breast enlargement, galactorrhea, and parotid gland swelling. Abnormal thyroid function tests (see **PRECAUTIONS**).

There have been rare spontaneous reports of polycystic ovary disease. A cause and effect relationship has not been established.

Pancreatic

Acute pancreatitis including fatalities (see **WARNINGS**).

Metabolic

Hyperammonemia (see **PRECAUTIONS**), hyponatremia, and inappropriate ADH secretion.

There have been rare reports of Fanconi's syndrome occurring chiefly in children.

Decreased carnitine concentrations have been reported although the clinical relevance is undetermined.

Hyperglycinemia has occurred and was associated with a fatal outcome in a patient with preexistent nonketotic hyperglycinemia.

Genitourinary

Enuresis and urinary tract infection.

Special Senses

Hearing loss, either reversible or irreversible, has been reported; however, a cause and effect relationship has not been established. Ear pain has also been reported.

Other

Allergic reaction, anaphylaxis, edema of the extremities, lupus erythematosus, bone pain, cough increased, pneumonia, otitis media, bradycardia, cutaneous vasculitis, fever, and hypothermia.

Mania

Although DEPACON has not been evaluated for safety and efficacy in the treatment of manic episodes associated with bipolar disorder, the following adverse events not listed above were reported by 1% or more of patients from two placebo-controlled clinical trials of DEPAKOTE (DIVALPROEX SODIUM) tablets.

Body as a Whole

Chills, neck pain, neck rigidity.

Cardiovascular System

Hypotension, postural hypotension, vasodilation.

Digestive System

Fecal incontinence, gastroenteritis, glossitis.

Musculoskeletal System

Arthrosis.

Nervous System

Agitation, catatonic reaction, hypokinesia, reflexes increased, tardive dyskinesia, vertigo.

Skin and Appendages

Furunculosis, maculopapular rash, seborrhea.

Special Senses

Conjunctivitis, dry eyes, eye pain.

Urogenital

Dysuria.

Migraine

Although DEPACON has not been evaluated for safety and efficacy in the prophylactic treatment of migraine headaches, the following adverse events not listed above were reported by 1% or more of patients from two placebo-controlled clinical trials of DEPAKOTE (DIVALPROEX SODIUM) tablets.

Body as a Whole

Face edema.

Digestive System

Dry mouth, stomatitis.

Urogenital System

Cystitis, metrorrhagia, and vaginal hemorrhage.

OVERDOSAGE

Overdosage with valproate may result in somnolence, heart block, and deep coma. Fatalities have been reported; however patients have recovered from valproate serum concentrations as high as 2120 µg/mL.

In overdose situations, the fraction of drug not bound to protein is high and hemodialysis or tandem hemodialysis plus hemoperfusion may result in significant removal of drug. General supportive measures should be applied with particular attention to the maintenance of adequate urinary output.

Naloxone has been reported to reverse the CNS depressant effects of valproate overdosage. Because naloxone could theoretically also reverse the antiepilepsy effects of valproate, it should be used with caution in patients with epilepsy.

DOSAGE AND ADMINISTRATION

DEPACON IS FOR INTRAVENOUS USE ONLY.

Use of DEPACON for periods of more than 14 days has not been studied. Patients should be switched to oral valproate products as soon as it is clinically feasible.

DEPACON should be administered as a 60 minute infusion (but not more than 20 mg/min) with the same frequency as the oral products, although plasma concentration monitoring and dosage adjustments may be necessary.

In one clinical safety study, approximately 90 patients with epilepsy and with no measurable plasma levels of valproate were given single infusions of DEPACON (up to 15 mg/kg and mean dose of 1184 mg) over 5-10 minutes (1.5-3.0 mg/kg/min). Patients generally tolerated the more rapid infusions well (see **ADVERSE REACTIONS**). This study was not designed to assess the effectiveness of these regimens. For

pharmacokinetics with rapid infusions, see **CLINICAL PHARMACOLOGY, Pharmacokinetics - Bioavailability.**

Initial Exposure to Valproate

The following dosage recommendations were obtained from studies utilizing oral divalproex sodium products.

Complex Partial Seizures

For adults and children 10 years of age or older.

Monotherapy (Initial Therapy)

DEPACON has not been systematically studied as initial therapy. Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made.

The probability of thrombocytopenia increases significantly at total trough valproate plasma concentrations above 110 µg/mL in females and 135 µg/mL in males. The benefit of improved seizure control with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

Conversion to Monotherapy

Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50-100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. Concomitant antiepilepsy drug (AED) dosage can ordinarily be reduced by approximately 25% every 2 weeks. This reduction may be started at initiation of DEPACON therapy, or delayed by 1 to 2 weeks if there is a concern that seizures are likely to occur with a reduction. The speed and duration of withdrawal of the concomitant AED can be highly variable, and patients should be monitored closely during this period for increased seizure frequency.

Adjunctive Therapy

DEPACON may be added to the patient's regimen at a dosage of 10 to 15 mg/kg/day. The dosage may be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. If the total daily dose exceeds 250 mg, it should be given in divided doses.

In a study of adjunctive therapy for complex partial seizures in which patients were receiving either carbamazepine or phenytoin in addition to DEPAKOTE (divalproex

sodium), no adjustment of carbamazepine or phenytoin dosage was needed (see **CLINICAL STUDIES**). However, since valproate may interact with these or other concurrently administered AEDs as well as other drugs (see **Drug Interactions**), periodic plasma concentration determinations of concomitant AEDs are recommended during the early course of therapy (see **PRECAUTIONS - Drug Interactions**).

Simple and Complex Absence Seizures

The recommended initial dose is 15 mg/kg/day, increasing at one week intervals by 5 to 10 mg/kg/day until seizures are controlled or side effects preclude further increases. The maximum recommended dosage is 60 mg/kg/day. If the total daily dose exceeds 250 mg, it should be given in divided doses.

A good correlation has not been established between daily dose, serum concentrations, and therapeutic effect. However, therapeutic valproate serum concentrations for most patients with absence seizures is considered to range from 50 to 100 µg/mL. Some patients may be controlled with lower or higher serum concentrations (see **CLINICAL PHARMACOLOGY**).

As the DEPACON dosage is titrated upward, blood concentrations of phenobarbital and/or phenytoin may be affected (see **PRECAUTIONS**).

Antiepilepsy drugs should not be abruptly discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life.

Replacement Therapy

When switching from oral valproate products, the total daily dose of DEPACON should be equivalent to the total daily dose of the oral valproate product (see **CLINICAL PHARMACOLOGY**), and should be administered as a 60 minute infusion (but not more than 20 mg/min) with the same frequency as the oral products, although plasma concentration monitoring and dosage adjustments may be necessary. Patients receiving doses near the maximum recommended daily dose of 60 mg/kg/day, particularly those not receiving enzyme-inducing drugs, should be monitored more closely. If the total daily dose exceeds 250 mg, it should be given in a divided regimen. There is no experience with more rapid infusions in patients receiving DEPACON as replacement therapy. However, the equivalence shown between DEPACON and oral valproate products (DEPAKOTE) at steady state was only evaluated in an every 6 hour regimen. Whether, when DEPACON is given less frequently (i.e., twice or three times a day), trough levels fall below those that result from an oral dosage form given via the same regimen, is unknown. For this reason, when DEPACON is given twice or three times a day, close monitoring of trough plasma levels may be needed.

General Dosing Advice

Dosing in Elderly Patients

Due to a decrease in unbound clearance of valproate and possibly a greater sensitivity to somnolence in the elderly, the starting dose should be reduced in these patients. Dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence. The ultimate therapeutic dose should be achieved on the basis of both tolerability and clinical response (see **WARNINGS**).

Dose-Related Adverse Events

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia) may be dose-related. The probability of thrombocytopenia appears to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males) (see **PRECAUTIONS**). The benefit of improved therapeutic effect with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

Administration

Rapid infusion of DEPACON has been associated with an increase in adverse events. There is limited experience with infusion times of less than 60 minutes or rates of infusion $> 20 \text{ mg/min}$ in patients with epilepsy (see **ADVERSE REACTIONS**).

DEPACON should be administered intravenously as a 60 minute infusion, as noted above. It should be diluted with at least 50 mL of a compatible diluent. Any unused portion of the vial contents should be discarded.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit.

Compatibility and Stability

DEPACON was found to be physically compatible and chemically stable in the following parenteral solutions for at least 24 hours when stored in glass or polyvinyl chloride (PVC) bags at controlled room temperature 15-30°C (59-86°F).

- dextrose (5%) injection, USP
- sodium chloride (0.9%) injection, USP
- lactated ringer's injection, USP

HOW SUPPLIED

DEPACON (valproate sodium injection), equivalent to 100 mg of valproic acid per mL, is a clear, colorless solution in 5 mL single-dose vials, available in trays of 10 vials (**NDC** 0074-1564-10).

Recommended storage: Store vials at controlled room temperature 15-30°C (59-86°F). No preservatives have been added. Unused portion of container should be discarded.

Manufactured by
Hospira, Inc.
Lake Forest, IL 60045 USA

For

Abbott Laboratories

North Chicago, IL 60064, U.S.A.

DEPAKOTE® Sprinkle Capsules (divalproex sodium coated particles in capsules)

BOX WARNING

HEPATOTOXICITY:

HEPATIC FAILURE RESULTING IN FATALITIES HAS OCCURRED IN PATIENTS RECEIVING VALPROIC ACID AND ITS DERIVATIVES. EXPERIENCE HAS INDICATED THAT CHILDREN UNDER THE AGE OF TWO YEARS ARE AT A CONSIDERABLY INCREASED RISK OF DEVELOPING FATAL HEPATOTOXICITY, ESPECIALLY THOSE ON MULTIPLE ANTICONVULSANTS, THOSE WITH CONGENITAL METABOLIC DISORDERS, THOSE WITH SEVERE SEIZURE DISORDERS ACCOMPANIED BY MENTAL RETARDATION, AND THOSE WITH ORGANIC BRAIN DISEASE. WHEN DEPAKOTE IS USED IN THIS PATIENT GROUP, IT SHOULD BE USED WITH EXTREME CAUTION AND AS A SOLE AGENT. THE BENEFITS OF THERAPY SHOULD BE WEIGHED AGAINST THE RISKS. ABOVE THIS AGE GROUP, EXPERIENCE IN EPILEPSY HAS INDICATED THAT THE INCIDENCE OF FATAL HEPATOTOXICITY DECREASES CONSIDERABLY IN PROGRESSIVELY OLDER PATIENT GROUPS.

THESE INCIDENTS USUALLY HAVE OCCURRED DURING THE FIRST SIX MONTHS OF TREATMENT. SERIOUS OR FATAL HEPATOTOXICITY MAY BE PRECEDED BY NON-SPECIFIC SYMPTOMS SUCH AS MALAISE, WEAKNESS, LETHARGY, FACIAL EDEMA, ANOREXIA, AND VOMITING. IN PATIENTS WITH EPILEPSY, A LOSS OF SEIZURE CONTROL MAY ALSO OCCUR. PATIENTS SHOULD BE MONITORED CLOSELY FOR APPEARANCE OF THESE SYMPTOMS. LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS.

TERATOGENICITY:

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS SUCH AS NEURAL TUBE DEFECTS (E.G., SPINA BIFIDA). ACCORDINGLY, THE USE OF VALPROATE PRODUCTS IN WOMEN OF CHILDBEARING POTENTIAL REQUIRES THAT THE BENEFITS OF ITS USE BE WEIGHED AGAINST THE RISK OF INJURY TO THE FETUS. THIS IS ESPECIALLY IMPORTANT WHEN THE TREATMENT OF A SPONTANEOUSLY REVERSIBLE CONDITION NOT ORDINARILY ASSOCIATED WITH PERMANENT INJURY OR RISK OF DEATH (E.G., MIGRAINE) IS CONTEMPLATED. SEE WARNINGS, INFORMATION FOR PATIENTS.

AN INFORMATION SHEET DESCRIBING THE TERATOGENIC POTENTIAL OF VALPROATE IS AVAILABLE FOR PATIENTS.

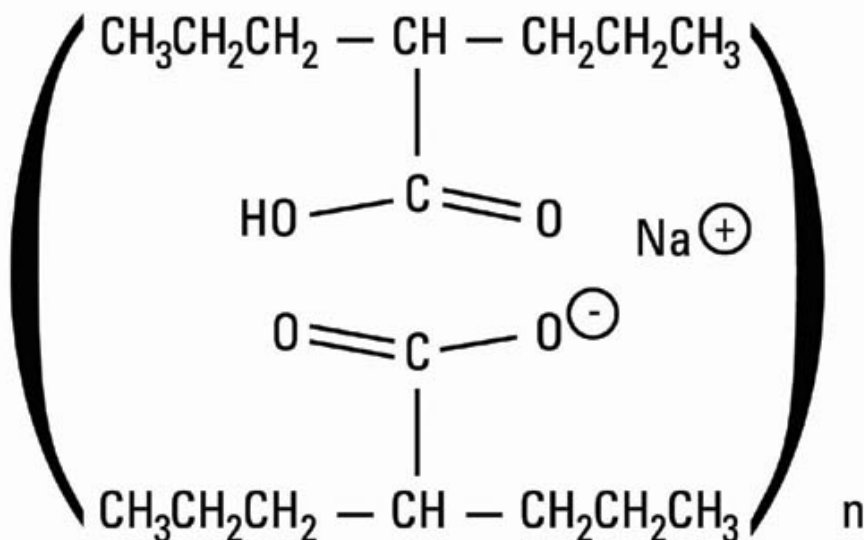
PANCREATITIS:

CASES OF LIFE-THREATENING PANCREATITIS HAVE BEEN REPORTED IN BOTH CHILDREN AND ADULTS RECEIVING VALPROATE. SOME OF THE CASES HAVE BEEN DESCRIBED AS HEMORRHAGIC WITH A RAPID PROGRESSION FROM INITIAL SYMPTOMS TO DEATH. CASES HAVE BEEN REPORTED SHORTLY AFTER INITIAL USE AS WELL AS AFTER SEVERAL YEARS OF USE. PATIENTS AND GUARDIANS SHOULD BE WARNED THAT ABDOMINAL PAIN, NAUSEA, VOMITING, AND/OR ANOREXIA CAN BE SYMPTOMS OF PANCREATITIS THAT REQUIRE PROMPT MEDICAL EVALUATION. IF PANCREATITIS IS DIAGNOSED, VALPROATE

SHOULD ORDINARILY BE DISCONTINUED. ALTERNATIVE TREATMENT FOR THE UNDERLYING MEDICAL CONDITION SHOULD BE INITIATED AS CLINICALLY INDICATED. (See **WARNINGS** and **PRECAUTIONS** .)

DESCRIPTION

Divalproex sodium is a stable co-ordination compound comprised of sodium valproate and valproic acid in a 1:1 molar relationship and formed during the partial neutralization of valproic acid with 0.5 equivalent of sodium hydroxide. Chemically it is designated as sodium hydrogen bis (2-propylpentanoate). Divalproex sodium has the following structure:



Divalproex sodium occurs as a white powder with a characteristic odor.

DEPAKOTE Sprinkle Capsules are for oral administration. DEPAKOTE Sprinkle Capsules contain specially coated particles of divalproex sodium equivalent to 125 mg of valproic acid in a hard gelatin capsule.

Inactive Ingredients

125 mg DEPAKOTE Sprinkle Capsules: cellulosic polymers, D&C Red No. 28, FD&C Blue No. 1, gelatin, iron oxide, magnesium stearate, silica gel, titanium dioxide, and triethyl citrate.

CLINICAL PHARMACOLOGY

Pharmacodynamics

Divalproex sodium dissociates to the valproate ion in the gastrointestinal tract. The mechanisms by which valproate exerts its therapeutic effects have not been established. It has been suggested that its activity in epilepsy is related to increased brain concentrations of gamma-aminobutyric acid (GABA).

Pharmacokinetics

Absorption/Bioavailability

Equivalent oral doses of DEPAKOTE (divalproex sodium) products and DEPAKENE (valproic acid) capsules deliver equivalent quantities of valproate ion systemically. Although the rate of valproate ion absorption may vary with the formulation administered (liquid, solid, or sprinkle), conditions of use (e.g., fasting or postprandial) and the method of administration (e.g., whether the contents of the capsule are sprinkled on food or the capsule is taken intact), these differences should be of minor clinical importance under the steady state conditions achieved in chronic use in the treatment of epilepsy.

However, it is possible that differences among the various valproate products in T_{max} and C_{max} could be important upon initiation of treatment. For example, in single dose studies, the effect of feeding had a greater influence on the rate of absorption of the tablet (increase in T_{max} from 4 to 8 hours) than on the absorption of the sprinkle capsules (increase in T_{max} from 3.3 to 4.8 hours).

While the absorption rate from the G.I. tract and fluctuation in valproate plasma concentrations vary with dosing regimen and formulation, the efficacy of valproate as an anticonvulsant in chronic use is unlikely to be affected. Experience employing dosing regimens from once-a-day to four-times-a-day, as well as studies in primate epilepsy models involving constant rate infusion, indicate that total daily systemic bioavailability (extent of absorption) is the primary determinant of seizure control and that differences in the ratios of plasma peak to trough concentrations between valproate formulations are inconsequential from a practical clinical standpoint.

Co-administration of oral valproate products with food and substitution among the various DEPAKOTE and DEPAKENE formulations should cause no clinical problems in the management of patients with epilepsy (see **DOSAGE AND ADMINISTRATION**). Nonetheless, any changes in dosage administration, or the addition or discontinuance of concomitant drugs should ordinarily be accompanied by close monitoring of clinical status and valproate plasma concentrations.

Distribution

Protein Binding

The plasma protein binding of valproate is concentration dependent and the free fraction increases from approximately 10% at 40 $\mu\text{g/mL}$ to 18.5% at 130 $\mu\text{g/mL}$. Protein binding of valproate is reduced in the elderly, in patients with chronic hepatic diseases, in patients with renal impairment, and in the presence of other drugs (e.g., aspirin). Conversely, valproate may displace certain protein-bound drugs (e.g., phenytoin, carbamazepine, warfarin, and tolbutamide). (See **PRECAUTIONS, Drug Interactions** for more detailed information on the pharmacokinetic interactions of valproate with other drugs.)

CNS Distribution

Valproate concentrations in cerebrospinal fluid (CSF) approximate unbound concentrations in plasma (about 10% of total concentration).

Metabolism

Valproate is metabolized almost entirely by the liver. In adult patients on monotherapy, 30-50% of an administered dose appears in urine as a glucuronide conjugate. Mitochondrial β -oxidation is the other major metabolic pathway, typically accounting for over 40% of the dose. Usually, less than 15-20% of the dose is eliminated by other oxidative mechanisms. Less than 3% of an administered dose is excreted unchanged in urine.

The relationship between dose and total valproate concentration is nonlinear; concentration does not increase proportionally with the dose, but rather, increases to a lesser extent due to saturable plasma protein binding. The kinetics of unbound drug are linear.

Elimination

Mean plasma clearance and volume of distribution for total valproate are 0.56 L/hr/1.73 m² and 11 L/1.73 m², respectively. Mean plasma clearance and volume of distribution for free valproate are 4.6 L/hr/1.73 m² and 92 L/1.73 m². Mean terminal half-life for valproate monotherapy ranged from 9 to 16 hours following oral dosing regimens of 250 to 1000 mg.

The estimates cited apply primarily to patients who are not taking drugs that affect hepatic metabolizing enzyme systems. For example, patients taking enzyme-inducing antiepileptic drugs (carbamazepine, phenytoin, and phenobarbital) will clear valproate more rapidly. Because of these changes in valproate clearance, monitoring of antiepileptic concentrations should be intensified whenever concomitant antiepileptics are introduced or withdrawn.

Special Populations

Effect of Age

Neonates

Children within the first two months of life have a markedly decreased ability to eliminate valproate compared to older children and adults. This is a result of reduced clearance (perhaps due to delay in development of glucuronosyltransferase and other enzyme systems involved in valproate elimination) as well as increased volume of distribution (in part due to decreased plasma protein binding). For example, in one study, the half-life in children under 10 days ranged from 10 to 67 hours compared to a range of 7 to 13 hours in children greater than 2 months.

Children

Pediatric patients (i.e., between 3 months and 10 years) have 50% higher clearances expressed on weight (i.e., mL/min/kg) than do adults. Over the age of 10 years, children have pharmacokinetic parameters that approximate those of adults.

Elderly

The capacity of elderly patients (age range: 68 to 89 years) to eliminate valproate has been shown to be reduced compared to younger adults (age range: 22 to 26). Intrinsic clearance is reduced by 39%; the free fraction is increased by 44%. Accordingly, the initial dosage should be reduced in the elderly (see **DOSAGE AND ADMINISTRATION**).

Effect of Gender

There are no differences in the body surface area adjusted unbound clearance between males and females (4.8 ± 0.17 and 4.7 ± 0.07 L/hr per 1.73 m², respectively).

Effect of Race

The effects of race on the kinetics of valproate have not been studied.

Effect of Disease

Liver Disease

(see **BOXED WARNING, CONTRAINDICATIONS**, and **WARNINGS**). Liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 patients with acute hepatitis, compared with 6 healthy subjects. In that study, the half-life of valproate was increased from 12 to 18 hours. Liver disease is also associated with decreased albumin concentrations and larger unbound fractions (2 to 2.6 fold increase) of valproate. Accordingly, monitoring of total concentrations may be misleading since free concentrations may be substantially elevated in patients with hepatic disease whereas total concentrations may appear to be normal.

Renal Disease

A slight reduction (27%) in the unbound clearance of valproate has been reported in patients with renal failure (creatinine clearance < 10 mL/minute); however, hemodialysis typically reduces valproate concentrations by about 20%. Therefore, no dosage adjustment appears to be necessary in patients with renal failure. Protein binding in these patients is substantially reduced; thus, monitoring total concentrations may be misleading.

Plasma Levels and Clinical Effect

The relationship between plasma concentration and clinical response is not well documented. One contributing factor is the nonlinear, concentration dependent protein binding of valproate which affects the clearance of the drug. Thus, monitoring of total serum valproate cannot provide a reliable index of the bioactive valproate species.

For example, because the plasma protein binding of valproate is concentration dependent, the free fraction increases from approximately 10% at 40 µg/mL to 18.5% at 130 µg/mL. Higher than expected free fractions occur in the elderly, in hyperlipidemic patients, and in patients with hepatic and renal diseases.

Epilepsy

The therapeutic range in epilepsy is commonly considered to be 50 to 100 µg/mL of total valproate, although some patients may be controlled with lower or higher plasma concentrations.

CLINICAL STUDIES

Epilepsy

The efficacy of DEPAKOTE in reducing the incidence of complex partial seizures (CPS) that occur in isolation or in association with other seizure types was established in two controlled trials.

In one, multiclinic, placebo controlled study employing an add-on design (adjunctive therapy), 144 patients who continued to suffer eight or more CPS per 8 weeks during an 8 week period of monotherapy with doses of either carbamazepine or phenytoin sufficient to assure plasma concentrations within the "therapeutic range" were randomized to receive, in addition to their original antiepilepsy drug (AED), either DEPAKOTE or placebo. Randomized patients were to be followed for a total of 16 weeks. The following table presents the findings.

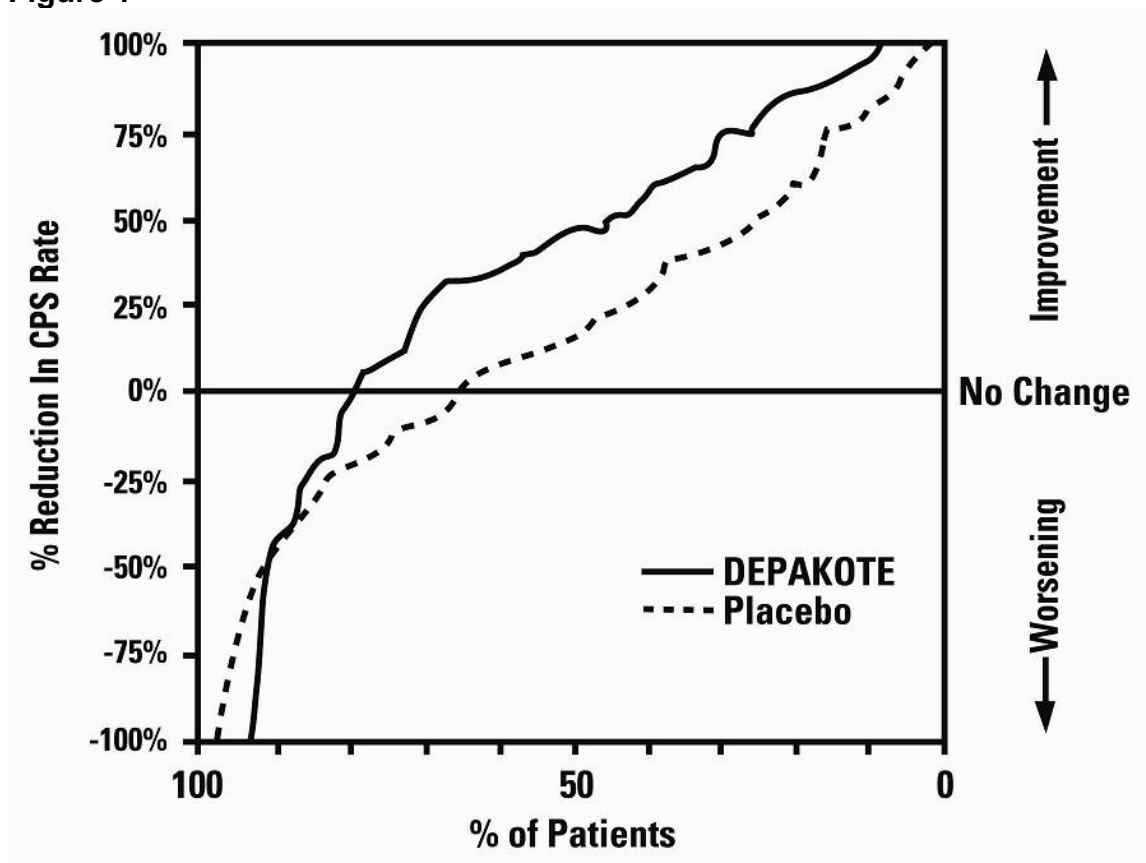
Adjunctive Therapy Study Median Incidence of CPS per 8 Weeks

Add-on Treatment	Number of Patients	Baseline Incidence	Experimental Incidence
DEPAKOTE	75	16.0	8.9*
Placebo	69	14.5	11.5

* Reduction from baseline statistically significantly greater for DEPAKOTE than placebo at $p \leq 0.05$ level.

Figure 1 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the adjunctive therapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for an effective treatment is shifted to the left of the curve for placebo. This figure shows that the proportion of patients achieving any particular level of improvement was consistently higher for DEPAKOTE than for placebo. For example, 45% of patients treated with DEPAKOTE had a $\geq 50\%$ reduction in complex partial seizure rate compared to 23% of patients treated with placebo.

Figure 1



The second study assessed the capacity of DEPAKOTE to reduce the incidence of CPS when administered as the sole AED. The study compared the incidence of CPS among patients randomized to either a high or low dose treatment arm. Patients qualified for entry into the randomized comparison phase of this study only if 1) they continued to experience 2 or more CPS per 4 weeks during an 8 to 12 week long period of monotherapy with adequate doses of an AED (i.e., phenytoin, carbamazepine, phenobarbital, or primidone) and 2) they made a successful transition over a two week interval to DEPAKOTE. Patients entering the randomized phase were then brought to their assigned target dose, gradually

tapered off their concomitant AED and followed for an interval as long as 22 weeks. Less than 50% of the patients randomized, however, completed the study. In patients converted to DEPAKOTE monotherapy, the mean total valproate concentrations during monotherapy were 71 and 123 µg/mL in the low dose and high dose groups, respectively.

The following table presents the findings for all patients randomized who had at least one post-randomization assessment.

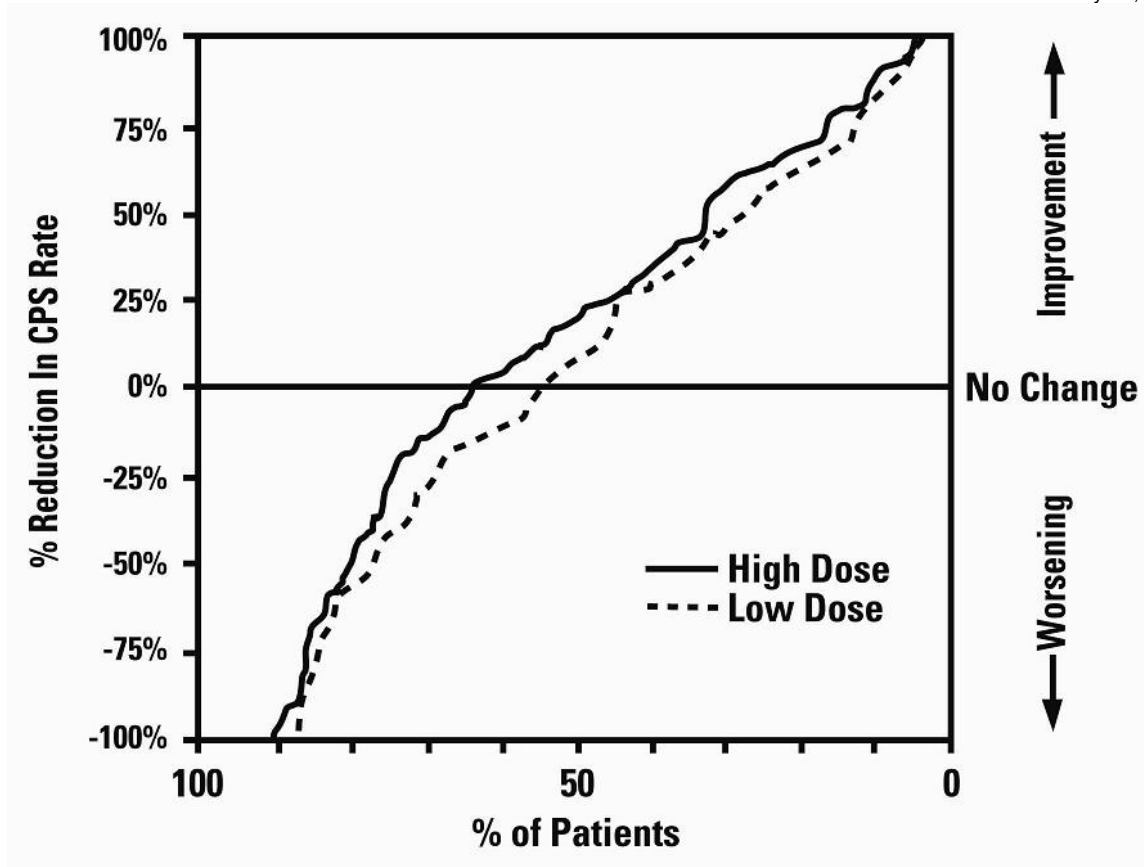
Monotherapy Study Median Incidence of CPS per 8 Weeks

Treatment	Number of Patients	Baseline Incidence	Randomized Phase Incidence
High dose DEPAKOTE	131	13.2	10.7*
Low dose DEPAKOTE	134	14.2	13.8

* Reduction from baseline statistically significantly greater for high dose than low dose at $p \leq 0.05$ level.

Figure 2 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the monotherapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for a more effective treatment is shifted to the left of the curve for a less effective treatment. This figure shows that the proportion of patients achieving any particular level of reduction was consistently higher for high dose DEPAKOTE than for low dose DEPAKOTE. For example, when switching from carbamazepine, phenytoin, phenobarbital or primidone monotherapy to high dose DEPAKOTE monotherapy, 63% of patients experienced no change or a reduction in complex partial seizure rates compared to 54% of patients receiving low dose DEPAKOTE.

Figure 2



INDICATIONS AND USAGE

DEPAKOTE Sprinkle Capsules are indicated as monotherapy and adjunctive therapy in the treatment of patients with complex partial seizures that occur either in isolation or in association with other types of seizure. DEPAKOTE Sprinkle Capsules are also indicated for use as sole and adjunctive therapy in the treatment of simple and complex absence seizures, and adjunctively in patients with multiple seizure types that include absence seizures.

Simple absence is defined as very brief clouding of the sensorium or loss of consciousness accompanied by certain generalized epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

SEE **WARNINGS** FOR STATEMENT REGARDING FATAL HEPATIC DYSFUNCTION.

CONTRAINDICATIONS

DIVALPROEX SODIUM SHOULD NOT BE ADMINISTERED TO PATIENTS WITH HEPATIC DISEASE OR SIGNIFICANT HEPATIC DYSFUNCTION.

Divalproex sodium is contraindicated in patients with known hypersensitivity to the drug.

Divalproex sodium is contraindicated in patients with known urea cycle disorders (see **WARNINGS**).

WARNINGS

Hepatotoxicity

Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid. These incidents usually have occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as malaise, weakness, lethargy, facial edema, anorexia, and vomiting. In patients with epilepsy, a loss of seizure control may also occur. Patients should be monitored closely for appearance of these symptoms. Liver function tests should be performed prior to therapy and at frequent intervals thereafter, especially during the first six months. However, physicians should not rely totally on serum biochemistry since these tests may not be abnormal in all instances, but should also consider the results of careful interim medical history and physical examination.

Caution should be observed when administering DEPAKOTE products to patients with a prior history of hepatic disease. Patients on multiple anticonvulsants, children, those with congenital metabolic disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease may be at particular risk. Experience has indicated that children under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions. When DEPAKOTE is used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above this age group, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of drug.

Pancreatitis

Cases of life-threatening pancreatitis have been reported in both children and adults receiving valproate. Some of the cases have been described as hemorrhagic with rapid progression from initial symptoms to death. Some cases have occurred shortly after initial use as well as after several years of use. The rate based upon the reported cases exceeds that expected in the general population and there have been cases in which pancreatitis recurred after rechallenge with valproate. In clinical trials, there were 2 cases of pancreatitis without alternative etiology in 2416 patients, representing 1044 patient-years experience. Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical evaluation. If pancreatitis is diagnosed, valproate should ordinarily be discontinued. Alternative treatment for the underlying medical condition should be initiated as clinically indicated (see **BOXED WARNING**).

Urea Cycle Disorders (UCD)

Divalproex sodium is contraindicated in patients with known urea cycle disorders.

Hyperammonemic encephalopathy, sometimes fatal, has been reported following initiation of valproate therapy in patients with urea cycle disorders, a group of uncommon genetic abnormalities, particularly ornithine transcarbamylase deficiency. Prior to the initiation of

valproate therapy, evaluation for UCD should be considered in the following patients: 1) those with a history of unexplained encephalopathy or coma, encephalopathy associated with a protein load, pregnancy-related or post-partum encephalopathy, unexplained mental retardation, or history of elevated plasma ammonia or glutamine; 2) those with cyclical vomiting and lethargy, episodic extreme irritability, ataxia, low BUN, or protein avoidance; 3) those with a family history of UCD or a family history of unexplained infant deaths (particularly males); 4) those with other signs or symptoms of UCD. Patients who develop symptoms of unexplained hyperammonemic encephalopathy while receiving valproate therapy should receive prompt treatment (including discontinuation of valproate therapy) and be evaluated for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **PRECAUTIONS**).

Somnolence in the Elderly

In a double-blind, multicenter trial of valproate in elderly patients with dementia (mean age = 83 years), doses were increased by 125 mg/day to a target dose of 20 mg/kg/day. A significantly higher proportion of valproate patients had somnolence compared to placebo, and although not statistically significant, there was a higher proportion of patients with dehydration. Discontinuations for somnolence were also significantly higher than with placebo. In some patients with somnolence (approximately one-half), there was associated reduced nutritional intake and weight loss. There was a trend for the patients who experienced these events to have a lower baseline albumin concentration, lower valproate clearance, and a higher BUN. In elderly patients, dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

Thrombocytopenia

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia [see **PRECAUTIONS**]) may be dose-related. In a clinical trial of DEPAKOTE (divalproex sodium) as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). The therapeutic benefit which may accompany the higher doses should therefore be weighed against the possibility of a greater incidence of adverse effects.

Usage In Pregnancy

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS. DATA SUGGEST THAT THERE IS AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS ASSOCIATED WITH THE USE OF VALPROATE BY WOMEN WITH SEIZURE DISORDERS DURING PREGNANCY WHEN COMPARED TO THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO DO NOT USE ANTIEPILEPTIC DRUGS DURING PREGNANCY, THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO USE OTHER ANTIEPILEPTIC DRUGS, AND THE BACKGROUND INCIDENCE FOR THE GENERAL POPULATION. THEREFORE, VALPROATE SHOULD BE CONSIDERED FOR WOMEN OF CHILDBEARING POTENTIAL ONLY AFTER THE

RISKS HAVE BEEN THOROUGHLY DISCUSSED WITH THE PATIENT AND WEIGHED AGAINST THE POTENTIAL BENEFITS OF TREATMENT.

THERE ARE MULTIPLE REPORTS IN THE CLINICAL LITERATURE THAT INDICATE THE USE OF ANTIEPILEPTIC DRUGS DURING PREGNANCY RESULTS IN AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS IN OFFSPRING. ANTIEPILEPTIC DRUGS, INCLUDING VALPROATE, SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING POTENTIAL ONLY IF THEY ARE CLEARLY SHOWN TO BE ESSENTIAL IN THE MANAGEMENT OF THEIR MEDICAL CONDITION.

Antiepileptic drugs should not be discontinued abruptly in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

HUMAN DATA

Congenital Malformations

The North American Antiepileptic Drug Pregnancy Registry reported 16 cases of congenital malformations among the offspring of 149 women with epilepsy who were exposed to valproic acid monotherapy during the first trimester of pregnancy at doses of approximately 1,000 mg per day, for a prevalence rate of 10.7% (95% CI 6.3%-16.9%). Three of the 149 offspring (2%) had neural tube defects and 6 of the 149 (4%) had less severe malformations. Among epileptic women who were exposed to other antiepileptic drug monotherapies during pregnancy (1,048 patients) the malformation rate was 2.9% (95% CI 2.0% to 4.1%). There was a 4-fold increase in congenital malformations among infants with valproic acid-exposed mothers compared with those treated with other antiepileptic monotherapies as a group (Odds Ratio 4.0; 95% CI 2.1 to 7.4). This increased risk does not reflect a comparison versus any specific antiepileptic drug, but the risk versus the heterogeneous group of all other antiepileptic drug monotherapies combined. The increased teratogenic risk from valproic acid in women with epilepsy is expected to be reflected in an increased risk in other indications (e.g., migraine or bipolar disorder).

THE STRONGEST ASSOCIATION OF MATERNAL VALPROATE USAGE WITH CONGENITAL MALFORMATIONS IS WITH NEURAL TUBE DEFECTS (AS DISCUSSED UNDER THE NEXT SUBHEADING). HOWEVER, OTHER CONGENITAL ANOMALIES (E.G. CRANIOFACIAL DEFECTS, CARDIOVASCULAR MALFORMATIONS AND ANOMALIES INVOLVING VARIOUS BODY SYSTEMS), COMPATIBLE AND INCOMPATIBLE WITH LIFE, HAVE BEEN REPORTED. SUFFICIENT DATA TO DETERMINE THE INCIDENCE OF THESE CONGENITAL ANOMALIES IS NOT AVAILABLE.

Neural Tube Defects

THE INCIDENCE OF NEURAL TUBE DEFECTS IN THE FETUS IS INCREASED IN MOTHERS RECEIVING VALPROATE DURING THE FIRST TRIMESTER OF PREGNANCY. THE CENTERS FOR DISEASE CONTROL (CDC) HAS ESTIMATED THE RISK OF VALPROIC ACID EXPOSED WOMEN HAVING CHILDREN WITH SPINA BIFIDA TO BE APPROXIMATELY 1 TO 2%. THE AMERICAN COLLEGE OF

OBSTETRICIANS AND GYNECOLOGISTS (ACOG) ESTIMATES THE GENERAL POPULATION RISK FOR CONGENITAL NEURAL TUBE DEFECTS AS 0.14% TO 0.2%.

Tests to detect neural tube and other defects using current accepted procedures should be considered a part of routine prenatal care in pregnant women receiving valproate.

Evidence suggests that pregnant women who receive folic acid supplementation may be at decreased risk for congenital neural tube defects in their offspring compared to pregnant women not receiving folic acid. Whether the risk of neural tube defects in the offspring of women receiving valproate specifically is reduced by folic acid supplementation is unknown. DIETARY FOLIC ACID SUPPLEMENTATION BOTH PRIOR TO AND DURING PREGNANCY SHOULD BE ROUTINELY RECOMMENDED TO PATIENTS CONTEMPLATING PREGNANCY.

Other Adverse Pregnancy Effects

PATIENTS TAKING VALPROATE MAY DEVELOP CLOTTING ABNORMALITIES (SEE **PRECAUTIONS - GENERAL AND WARNINGS**). A PATIENT WHO HAD LOW FIBRINOGEN WHEN TAKING MULTIPLE ANTICONVULSANTS INCLUDING VALPROATE GAVE BIRTH TO AN INFANT WITH AFIBRINOGENEMIA WHO SUBSEQUENTLY DIED OF HEMORRHAGE. IF VALPROATE IS USED IN PREGNANCY, THE CLOTTING PARAMETERS SHOULD BE MONITORED CAREFULLY.

PATIENTS TAKING VALPROATE MAY DEVELOP HEPATIC FAILURE (SEE **WARNINGS - HEPATOTOXICITY AND BOX WARNING**). FATAL HEPATIC FAILURES, IN A NEWBORN AND IN AN INFANT, HAVE BEEN REPORTED FOLLOWING THE MATERNAL USE OF VALPROATE DURING PREGNANCY.

ANIMAL DATA

Animal studies have demonstrated valproate-induced teratogenicity. Increased frequencies of malformations, as well as intrauterine growth retardation and death, have been observed in mice, rats, rabbits, and monkeys following prenatal exposure to valproate. Malformations of the skeletal system are the most common structural abnormalities produced in experimental animals, but neural tube closure defects have been seen in mice exposed to maternal plasma valproate concentrations exceeding 230 µg/mL (2.3 times the upper limit of the human therapeutic range) during susceptible periods of embryonic development. Administration of an oral dose of 200 mg/kg/day or greater (50% of the maximum human daily dose or greater on a mg/m² basis) to pregnant rats during organogenesis produced malformations (skeletal, cardiac, and urogenital) and growth retardation in the offspring. These doses resulted in peak maternal plasma valproate levels of approximately 340 µg/mL or greater (3.4 times the upper limit of the human therapeutic range or greater). Behavioral deficits have been reported in the offspring of rats given a dose of 200 mg/kg/day throughout most of pregnancy. An oral dose of 350 mg/kg/day (approximately 2 times the maximum human daily dose on a mg/m² basis) produced skeletal and visceral malformations in rabbits exposed during organogenesis. Skeletal malformations, growth retardation, and death were observed in rhesus monkeys following administration of an oral dose of 200 mg/kg/day (equal to the maximum human daily dose on a mg/m² basis) during organogenesis. This dose resulted in peak maternal plasma valproate levels of approximately 280 µg/mL (2.8 times the upper limit of the human therapeutic range).

PRECAUTIONS

Hepatic Dysfunction

See **BOXED WARNING, CONTRAINDICATIONS** and **WARNINGS**.

Pancreatitis

See **BOXED WARNING** and **WARNINGS**.

Hyperammonemia

Hyperammonemia has been reported in association with valproate therapy and may be present despite normal liver function tests. In patients who develop unexplained lethargy and vomiting or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. If ammonia is increased, valproate therapy should be discontinued. Appropriate interventions for treatment of hyperammonemia should be initiated, and such patients should undergo investigation for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **WARNINGS – Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

Asymptomatic elevations of ammonia are more common and when present, require close monitoring of plasma ammonia levels. If the elevation persists, discontinuation of valproate therapy should be considered.

Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use

Concomitant administration of topiramate and valproic acid has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. Clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level of consciousness and/or cognitive function with lethargy or vomiting.

In most cases, symptoms and signs abated with discontinuation of either drug. This adverse event is not due to a pharmacokinetic interaction. It is not known if topiramate monotherapy is associated with hyperammonemia. Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, an interaction of topiramate and valproic acid may exacerbate existing defects or unmask deficiencies in susceptible persons. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured.(see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia**).

General

Because of reports of thrombocytopenia (see **WARNINGS**), inhibition of the secondary phase of platelet aggregation, and abnormal coagulation parameters, (e.g., low fibrinogen), platelet counts and coagulation tests are recommended before initiating therapy and at periodic intervals. It is recommended that patients receiving DEPAKOTE be monitored for platelet count and coagulation parameters prior to planned surgery. In a clinical trial of DEPAKOTE as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued,

with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). Evidence of hemorrhage, bruising, or a disorder of hemostasis/coagulation is an indication for reduction of the dosage or withdrawal of therapy.

Since DEPAKOTE may interact with concurrently administered drugs which are capable of enzyme induction, periodic plasma concentration determinations of valproate and concomitant drugs are recommended during the early course of therapy. (See **PRECAUTIONS - Drug Interactions.**)

Valproate is partially eliminated in the urine as a keto-metabolite which may lead to a false interpretation of the urine ketone test.

There have been reports of altered thyroid function tests associated with valproate. The clinical significance of these is unknown.

There are *in vitro* studies that suggest valproate stimulates the replication of the HIV and CMV viruses under certain experimental conditions. The clinical consequence, if any, is not known. Additionally, the relevance of these *in vitro* findings is uncertain for patients receiving maximally suppressive antiretroviral therapy. Nevertheless, these data should be borne in mind when interpreting the results from regular monitoring of the viral load in HIV infected patients receiving valproate or when following CMV infected patients clinically.

Multi-organ Hypersensitivity Reaction

Multi-organ hypersensitivity reactions have been rarely reported in close temporal association to the initiation of valproate therapy in adult and pediatric patients (median time to detection 21 days; range 1 to 40 days). Although there have been a limited number of reports, many of these cases resulted in hospitalization and at least one death has been reported. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement. Other associated manifestations may include lymphadenopathy, hepatitis, liver function test abnormalities, hematological abnormalities (e.g., eosinophilia, thrombocytopenia, neutropenia), pruritis, nephritis, oliguria, hepatorenal syndrome, arthralgia, and asthenia. Because the disorder is variable in its expression, other organ system symptoms and signs, not noted here, may occur. If this reaction is suspected, valproate should be discontinued and an alternative treatment started. Although the existence of cross sensitivity with other drugs that produce this syndrome is unclear, the experience amongst drugs associated with multi-organ hypersensitivity would indicate this to be a possibility.

Information for Patients

Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis and, therefore, require further medical evaluation promptly.

Patients should be informed of the signs and symptoms associated with hyperammonemic encephalopathy (see **PRECAUTIONS – Hyperammonemia**) and be told to inform the prescriber if any of these symptoms occur.

Since DEPAKOTE products may produce CNS depression, especially when combined with another CNS depressant (e.g., alcohol), patients should be advised not to engage in

hazardous activities, such as driving an automobile or operating dangerous machinery, until it is known that they do not become drowsy from the drug.

The specially coated particles in DEPAKOTE Sprinkle Capsules have been observed in the stool, but this occurrence has not been associated with clinically significant effects.

Since DEPAKOTE Sprinkle Capsules has been associated with certain types of birth defects, female patients of child-bearing age considering the use of DEPAKOTE Sprinkle Capsules should be advised of the risk and of alternative therapeutic options and to read the **Patient Information Leaflet**, which appears as the last section of the labeling. This is especially important when the treatment of a spontaneously reversible condition not ordinarily associated with permanent injury or risk of death (e.g., migraine) is considered.

Patients should be instructed that a fever associated with other organ system involvement (rash, lymphadenopathy, etc.) may be drug-related and should be reported to the physician immediately (see **PRECAUTIONS - Multi-organ Hypersensitivity Reaction**).

Drug Interactions

Effects of Co-Administered Drugs on Valproate Clearance

Drugs that affect the level of expression of hepatic enzymes, particularly those that elevate levels of glucuronosyltransferases, may increase the clearance of valproate. For example, phenytoin, carbamazepine, and phenobarbital (or primidone) can double the clearance of valproate. Thus, patients on monotherapy will generally have longer half-lives and higher concentrations than patients receiving polytherapy with antiepilepsy drugs.

In contrast, drugs that are inhibitors of cytochrome P450 isozymes, e.g., antidepressants, may be expected to have little effect on valproate clearance because cytochrome P450 microsomal mediated oxidation is a relatively minor secondary metabolic pathway compared to glucuronidation and beta-oxidation.

Because of these changes in valproate clearance, monitoring of valproate and concomitant drug concentrations should be increased whenever enzyme inducing drugs are introduced or withdrawn.

The following list provides information about the potential for an influence of several commonly prescribed medications on valproate pharmacokinetics. The list is not exhaustive nor could it be, since new interactions are continuously being reported.

Drugs for Which a Potentially Important Interaction Has Been Observed

Aspirin

A study involving the co-administration of aspirin at antipyretic doses (11 to 16 mg/kg) with valproate to pediatric patients (n=6) revealed a decrease in protein binding and an inhibition of metabolism of valproate. Valproate free fraction was increased 4-fold in the presence of aspirin compared to valproate alone. The β -oxidation pathway consisting of 2-E-valproic acid, 3-OH-valproic acid, and 3-keto valproic acid was decreased from 25% of total metabolites excreted on valproate alone to 8.3% in the presence of aspirin. Caution should be observed if valproate and aspirin are to be co-administered.

Felbamate

A study involving the co-administration of 1200 mg/day of felbamate with valproate to patients with epilepsy (n=10) revealed an increase in mean valproate peak concentration

by 35% (from 86 to 115 µg/mL) compared to valproate alone. Increasing the felbamate dose to 2400 mg/day increased the mean valproate peak concentration to 133 µg/mL (another 16% increase). A decrease in valproate dosage may be necessary when felbamate therapy is initiated.

Meropenem

Subtherapeutic valproic acid levels have been reported when meropenem was co-administered.

Rifampin

A study involving the administration of a single dose of valproate (7 mg/kg) 36 hours after 5 nights of daily dosing with rifampin (600 mg) revealed a 40% increase in the oral clearance of valproate. Valproate dosage adjustment may be necessary when it is co-administered with rifampin.

Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

Antacids

A study involving the co-administration of valproate 500 mg with commonly administered antacids (Maalox, Trisogel, and Titralac - 160 mEq doses) did not reveal any effect on the extent of absorption of valproate.

Chlorpromazine

A study involving the administration of 100 to 300 mg/day of chlorpromazine to schizophrenic patients already receiving valproate (200 mg BID) revealed a 15% increase in trough plasma levels of valproate.

Haloperidol

A study involving the administration of 6 to 10 mg/day of haloperidol to schizophrenic patients already receiving valproate (200 mg BID) revealed no significant changes in valproate trough plasma levels.

Cimetidine and Ranitidine

Cimetidine and ranitidine do not affect the clearance of valproate.

Effects of Valproate on Other Drugs

Valproate has been found to be a weak inhibitor of some P450 isozymes, epoxide hydrase, and glucuronosyltransferases.

The following list provides information about the potential for an influence of valproate co-administration on the pharmacokinetics or pharmacodynamics of several commonly prescribed medications. The list is not exhaustive, since new interactions are continuously being reported.

Drugs for Which a Potentially Important Valproate Interaction Has Been Observed

Amitriptyline/Nortriptyline

Administration of a single oral 50 mg dose of amitriptyline to 15 normal volunteers (10 males and 5 females) who received valproate (500 mg BID) resulted in a 21% decrease in plasma clearance of amitriptyline and a 34% decrease in the net clearance of nortriptyline. Rare postmarketing reports of concurrent use of valproate and amitriptyline resulting in an increased amitriptyline level have been received. Concurrent use of valproate and amitriptyline has rarely been associated with toxicity. Monitoring of amitriptyline levels should be considered for patients taking valproate concomitantly with amitriptyline. Consideration should be given to lowering the dose of amitriptyline/nortriptyline in the presence of valproate.

Carbamazepine/carbamazepine-10,11-Epoxyde

Serum levels of carbamazepine (CBZ) decreased 17% while that of carbamazepine-10,11-epoxide (CBZ-E) increased by 45% upon co-administration of valproate and CBZ to epileptic patients.

Clonazepam

The concomitant use of valproic acid and clonazepam may induce absence status in patients with a history of absence type seizures.

Diazepam

Valproate displaces diazepam from its plasma albumin binding sites and inhibits its metabolism. Co-administration of valproate (1500 mg daily) increased the free fraction of diazepam (10 mg) by 90% in healthy volunteers (n=6). Plasma clearance and volume of distribution for free diazepam were reduced by 25% and 20%, respectively, in the presence of valproate. The elimination half-life of diazepam remained unchanged upon addition of valproate.

Ethosuximide

Valproate inhibits the metabolism of ethosuximide. Administration of a single ethosuximide dose of 500 mg with valproate (800 to 1600 mg/day) to healthy volunteers (n=6) was accompanied by a 25% increase in elimination half-life of ethosuximide and a 15% decrease in its total clearance as compared to ethosuximide alone. Patients receiving valproate and ethosuximide, especially along with other anticonvulsants, should be monitored for alterations in serum concentrations of both drugs.

Lamotrigine

In a steady-state study involving 10 healthy volunteers, the elimination half-life of lamotrigine increased from 26 to 70 hours with valproate co-administration (a 165% increase). The dose of lamotrigine should be reduced when co-administered with valproate. Serious skin reactions (such as Stevens-Johnson Syndrome and toxic epidermal necrolysis) have been reported with concomitant lamotrigine and valproate administration. See lamotrigine package insert for details on lamotrigine dosing with concomitant valproate administration.

Phenobarbital

Valproate was found to inhibit the metabolism of phenobarbital. Co-administration of valproate (250 mg BID for 14 days) with phenobarbital to normal subjects (n=6) resulted in a 50% increase in half-life and a 30% decrease in plasma clearance of phenobarbital (60

mg single-dose). The fraction of phenobarbital dose excreted unchanged increased by 50% in presence of valproate.

There is evidence for severe CNS depression, with or without significant elevations of barbiturate or valproate serum concentrations. All patients receiving concomitant barbiturate therapy should be closely monitored for neurological toxicity. Serum barbiturate concentrations should be obtained, if possible, and the barbiturate dosage decreased, if appropriate.

Primidone, which is metabolized to a barbiturate, may be involved in a similar interaction with valproate.

Phenytoin

Valproate displaces phenytoin from its plasma albumin binding sites and inhibits its hepatic metabolism. Co-administration of valproate (400 mg TID) with phenytoin (250 mg) in normal volunteers (n=7) was associated with a 60% increase in the free fraction of phenytoin. Total plasma clearance and apparent volume of distribution of phenytoin increased 30% in the presence of valproate. Both the clearance and apparent volume of distribution of free phenytoin were reduced by 25%.

In patients with epilepsy, there have been reports of breakthrough seizures occurring with the combination of valproate and phenytoin. The dosage of phenytoin should be adjusted as required by the clinical situation.

Tolbutamide

From *in vitro* experiments, the unbound fraction of tolbutamide was increased from 20% to 50% when added to plasma samples taken from patients treated with valproate. The clinical relevance of this displacement is unknown.

Topiramate

Concomitant administration of valproic acid and topiramate has been associated with hyperammonemia with and without encephalopathy (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia and - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

Warfarin

In an *in vitro* study, valproate increased the unbound fraction of warfarin by up to 32.6%. The therapeutic relevance of this is unknown; however, coagulation tests should be monitored if DEPAKOTE therapy is instituted in patients taking anticoagulants.

Zidovudine

In six patients who were seropositive for HIV, the clearance of zidovudine (100 mg q8h) was decreased by 38% after administration of valproate (250 or 500 mg q8h); the half-life of zidovudine was unaffected.

Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

Acetaminophen

Valproate had no effect on any of the pharmacokinetic parameters of acetaminophen when it was concurrently administered to three epileptic patients.

Clozapine

In psychotic patients (n=11), no interaction was observed when valproate was co-administered with clozapine.

Lithium

Co-administration of valproate (500 mg BID) and lithium carbonate (300 mg TID) to normal male volunteers (n=16) had no effect on the steady-state kinetics of lithium.

Lorazepam

Concomitant administration of valproate (500 mg BID) and lorazepam (1 mg BID) in normal male volunteers (n=9) was accompanied by a 17% decrease in the plasma clearance of lorazepam.

Oral Contraceptive Steroids

Administration of a single-dose of ethinylloestradiol (50 µg)/levonorgestrel (250 µg) to 6 women on valproate (200 mg BID) therapy for 2 months did not reveal any pharmacokinetic interaction.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Valproic acid was administered orally to Sprague Dawley rats and ICR (HA/ICR) mice at doses of 80 and 170 mg/kg/day (approximately 10 to 50% of the maximum human daily dose on a mg/m² basis) for two years. A variety of neoplasms were observed in both species. The chief findings were a statistically significant increase in the incidence of subcutaneous fibrosarcomas in high dose male rats receiving valproic acid and a statistically significant dose-related trend for benign pulmonary adenomas in male mice receiving valproic acid. The significance of these findings for humans is unknown.

Mutagenesis

Valproate was not mutagenic in an *in vitro* bacterial assay (Ames test), did not produce dominant lethal effects in mice, and did not increase chromosome aberration frequency in an *in vivo* cytogenetic study in rats. Increased frequencies of sister chromatid exchange (SCE) have been reported in a study of epileptic children taking valproate, but this association was not observed in another study conducted in adults. There is some evidence that increased SCE frequencies may be associated with epilepsy. The biological significance of an increase in SCE frequency is not known.

Fertility

Chronic toxicity studies in juvenile and adult rats and dogs demonstrated reduced spermatogenesis and testicular atrophy at oral doses of 400 mg/kg/day or greater in rats (approximately equivalent to or greater than the maximum human daily dose on a mg/m² basis) and 150 mg/kg/day or greater in dogs (approximately 1.4 times the maximum human daily dose or greater on a mg/m² basis). Segment I fertility studies in rats have shown oral doses up to 350 mg/kg/day (approximately equal to the maximum human daily

dose on a mg/m² basis) for 60 days to have no effect on fertility. THE EFFECT OF VALPROATE ON TESTICULAR DEVELOPMENT AND ON SPERM PRODUCTION AND FERTILITY IN HUMANS IS UNKNOWN.

Pregnancy

Pregnancy Category D: See **WARNINGS** .

Nursing Mothers

Valproate is excreted in breast milk. Concentrations in breast milk have been reported to be 1-10% of serum concentrations. It is not known what effect this would have on a nursing infant. Consideration should be given to discontinuing nursing when divalproex sodium is administered to a nursing woman.

Pediatric Use

Experience has indicated that pediatric patients under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions (see **BOXED WARNING**). When DEPAKOTE is used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above the age of 2 years, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

Younger children, especially those receiving enzyme-inducing drugs, will require larger maintenance doses to attain targeted total and unbound valproic acid concentrations.

The variability in free fraction limits the clinical usefulness of monitoring total serum valproic acid concentrations. Interpretation of valproic acid concentrations in children should include consideration of factors that affect hepatic metabolism and protein binding.

The basic toxicology and pathologic manifestations of valproate sodium in neonatal (4-day old) and juvenile (14-day old) rats are similar to those seen in young adult rats. However, additional findings, including renal alterations in juvenile rats and renal alterations and retinal dysplasia in neonatal rats, have been reported. These findings occurred at 240 mg/kg/day, a dosage approximately equivalent to the human maximum recommended daily dose on a mg/m² basis. They were not seen at 90 mg/kg, or 40% of the maximum human daily dose on a mg/m² basis.

Geriatric Use

No patients above the age of 65 years were enrolled in double-blind prospective clinical trials of mania associated with bipolar illness. In a case review study of 583 patients, 72 patients (12%) were greater than 65 years of age. A higher percentage of patients above 65 years of age reported accidental injury, infection, pain, somnolence, and tremor. Discontinuation of valproate was occasionally associated with the latter two events. It is not clear whether these events indicate additional risk or whether they result from preexisting medical illness and concomitant medication use among these patients.

A study of elderly patients with dementia revealed drug related somnolence and discontinuation for somnolence (see **WARNINGS – Somnolence in the Elderly**). The starting dose should be reduced in these patients, and dosage reductions or discontinuation should be considered in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

ADVERSE REACTIONS

Epilepsy

Based on a placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures, DEPAKOTE was generally well tolerated with most adverse events rated as mild to moderate in severity. Intolerance was the primary reason for discontinuation in the DEPAKOTE-treated patients (6%), compared to 1% of placebo-treated patients.

Table 1 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of DEPAKOTE-treated patients and for which the incidence was greater than in the placebo group, in the placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures. Since patients were also treated with other antiepilepsy drugs, it is not possible, in most cases, to determine whether the following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 1 Adverse Events Reported by $\geq 5\%$ of Patients Treated with DEPAKOTE During Placebo-Controlled Trial of Adjunctive Therapy for Complex Partial Seizures

Body System/Event	Depakote (%) (n = 77)	Placebo (%) (n = 70)
Body as a Whole		
Headache	31	21
Asthenia	27	7
Fever	6	4
Gastrointestinal System		
Nausea	48	14
Vomiting	27	7
Abdominal Pain	23	6
Diarrhea	13	6
Anorexia	12	0
Dyspepsia	8	4
Constipation	5	1
Nervous System		
Somnolence	27	11
Tremor	25	6
Dizziness	25	13
Diplopia	16	9
Amblyopia/Blurred Vision	12	9
Ataxia	8	1
Nystagmus	8	1
Emotional Lability	6	4
Thinking Abnormal	6	0
Amnesia	5	1
Respiratory System		
Flu Syndrome	12	9
Infection	12	6
Bronchitis	5	1
Rhinitis	5	4
Other		
Alopecia	6	1
Weight Loss	6	0

Table 2 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of patients in the high dose DEPAKOTE group, and for which the incidence was greater than in the

low dose group, in a controlled trial of DEPAKOTE monotherapy treatment of complex partial seizures. Since patients were being titrated off another antiepilepsy drug during the first portion of the trial, it is not possible, in many cases, to determine whether the following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 2 Adverse Events Reported by \geq 5% of Patients in the High Dose Group in the Controlled Trial of DEPAKOTE Monotherapy for Complex Partial Seizures¹

Body System/Event	High Dose (%) (n = 131)	Low Dose (%) (n = 134)
Body as a Whole		
Asthenia	21	10
Digestive System		
Nausea	34	26
Diarrhea	23	19
Vomiting	23	15
Abdominal Pain	12	9
Anorexia	11	4
Dyspepsia	11	10
Hemic/Lymphatic System		
Thrombocytopenia	24	1
Ecchymosis	5	4
Metabolic/Nutritional		
Weight Gain	9	4
Peripheral Edema	8	3
Nervous System		
Tremor	57	19
Somnolence	30	18
Dizziness	18	13
Insomnia	15	9
Nervousness	11	7
Amnesia	7	4
Nystagmus	7	1
Depression	5	4
Respiratory System		
Infection	20	13
Pharyngitis	8	2
Dyspnea	5	1
Skin and Appendages		
Alopecia	24	13
Special Senses		
Amblyopia/Blurred Vision	8	4
Tinnitus	7	1

1. Headache was the only adverse event that occurred in \geq 5% of patients in the high dose group and at an equal or greater incidence in the low dose group.

The following additional adverse events were reported by greater than 1% but less than 5% of the 358 patients treated with DEPAKOTE in the controlled trials of complex partial seizures:

Body as a Whole

Back pain, chest pain, malaise.

Cardiovascular System

Tachycardia, hypertension, palpitation.

Digestive System

Increased appetite, flatulence, hematemesis, eructation, pancreatitis, periodontal abscess.

Hemic and Lymphatic System

Petechia.

Metabolic and Nutritional Disorders

SGOT increased, SGPT increased.

Musculoskeletal System

Myalgia, twitching, arthralgia, leg cramps, myasthenia.

Nervous System

Anxiety, confusion, abnormal gait, paresthesia, hypertonia, incoordination, abnormal dreams, personality disorder.

Respiratory System

Sinusitis, cough increased, pneumonia, epistaxis.

Skin and Appendages

Rash, pruritus, dry skin.

Special Senses

Taste perversion, abnormal vision, deafness, otitis media.

Urogenital System

Urinary incontinence, vaginitis, dysmenorrhea, amenorrhea, urinary frequency.

Other Patient Populations

Adverse events that have been reported with all dosage forms of valproate from epilepsy trials, spontaneous reports, and other sources are listed below by body system.

Gastrointestinal

The most commonly reported side effects at the initiation of therapy are nausea, vomiting, and indigestion. These effects are usually transient and rarely require discontinuation of therapy. Diarrhea, abdominal cramps, and constipation have been reported. Both anorexia with some weight loss and increased appetite with weight gain have also been reported. The administration of delayed-release divalproex sodium may result in reduction of gastrointestinal side effects in some patients.

CNS Effects

Sedative effects have occurred in patients receiving valproate alone but occur most often in patients receiving combination therapy. Sedation usually abates upon reduction of other antiepileptic medication. Tremor (may be dose-related), hallucinations, ataxia, headache, nystagmus, diplopia, asterixis, "spots before eyes", dysarthria, dizziness, confusion, hypesthesia, vertigo, incoordination, and parkinsonism have been reported with the use of valproate. Rare cases of coma have occurred in patients receiving valproate alone or in conjunction with phenobarbital. In rare instances encephalopathy with or without fever has developed shortly after the introduction of valproate monotherapy without evidence of hepatic dysfunction or inappropriately high plasma valproate levels. Although recovery has been described following drug withdrawal, there have been fatalities in patients with hyperammonemic encephalopathy, particularly in patients with underlying urea cycle disorders (see **WARNINGS – Urea Cycle Disorders** and **PRECAUTIONS**).

Several reports have noted reversible cerebral atrophy and dementia in association with valproate therapy.

Dermatologic

Transient hair loss, skin rash, photosensitivity, generalized pruritus, erythema multiforme, and Stevens-Johnson syndrome. Rare cases of toxic epidermal necrolysis have been reported including a fatal case in a 6 month old infant taking valproate and several other concomitant medications. An additional case of toxic epidermal necrosis resulting in death was reported in a 35 year old patient with AIDS taking several concomitant medications and with a history of multiple cutaneous drug reactions. Serious skin reactions have been reported with concomitant administration of lamotrigine and valproate (see **PRECAUTIONS - Drug Interactions**).

Psychiatric

Emotional upset, depression, psychosis, aggression, hyperactivity, hostility, and behavioral deterioration.

Musculoskeletal

Weakness.

Hematologic

Thrombocytopenia and inhibition of the secondary phase of platelet aggregation may be reflected in altered bleeding time, petechiae, bruising, hematoma formation, epistaxis, and frank hemorrhage (see **PRECAUTIONS - General** and **Drug Interactions**). Relative lymphocytosis, macrocytosis, hypofibrinogenemia, leukopenia, eosinophilia, anemia including macrocytic with or without folate deficiency, bone marrow suppression, pancytopenia, aplastic anemia, agranulocytosis and acute intermittent porphyria.

Hepatic

Minor elevations of transaminases (eg, SGOT and SGPT) and LDH are frequent and appear to be dose-related. Occasionally, laboratory test results include increases in serum bilirubin and abnormal changes in other liver function tests. These results may reflect potentially serious hepatotoxicity (see **WARNINGS**).

Endocrine

Irregular menses, secondary amenorrhea, breast enlargement, galactorrhea, and parotid gland swelling. Abnormal thyroid function tests (see **PRECAUTIONS**).

There have been rare spontaneous reports of polycystic ovary disease. A cause and effect relationship has not been established.

Pancreatic

Acute pancreatitis including fatalities (see **WARNINGS**).

Metabolic

Hyperammonemia (see **PRECAUTIONS**), hyponatremia, and inappropriate ADH secretion.

There have been rare reports of Fanconi's syndrome occurring chiefly in children.

Decreased carnitine concentrations have been reported although the clinical relevance is undetermined.

Hyperglycinemia has occurred and was associated with a fatal outcome in a patient with preexistent nonketotic hyperglycinemia.

Genitourinary

Enuresis and urinary tract infection.

Special Senses

Hearing loss, either reversible or irreversible, has been reported; however, a cause and effect relationship has not been established. Ear pain has also been reported.

Other

Allergic reaction, anaphylaxis, edema of the extremities, lupus erythematosus, bone pain, cough increased, pneumonia, otitis media, bradycardia, cutaneous vasculitis, fever, and hypothermia.

Mania

Although DEPAKOTE Sprinkle Capsules have not been evaluated for safety and efficacy in the treatment of manic episodes associated with bipolar disorder, the following adverse events not listed above were reported by 1% or more of patients from two placebo-controlled clinical trials of DEPAKOTE tablets.

Body as a Whole

Chills, neck pain, neck rigidity.

Cardiovascular System

Hypotension, postural hypotension, vasodilation.

Digestive System

Fecal incontinence, gastroenteritis, glossitis.

Musculoskeletal System

Arthrosis.

Nervous System

Agitation, catatonic reaction, hypokinesia, reflexes increased, tardive dyskinesia, vertigo.

Skin and Appendages

Furunculosis, maculopapular rash, seborrhea.

Special Senses

Conjunctivitis, dry eyes, eye pain.

Urogenital System

Dysuria.

Migraine

Although DEPAKOTE Sprinkle Capsules have not been evaluated for safety and efficacy in the treatment of prophylaxis of migraine headaches, the following adverse events not listed above were reported by 1% or more of patients from two placebo-controlled clinical trials of DEPAKOTE tablets.

Body as a Whole

Face edema.

Digestive System

Dry mouth, stomatitis.

Urogenital System

Cystitis, metrorrhagia, and vaginal hemorrhage.

OVERDOSAGE

Overdosage with valproate may result in somnolence, heart block, and deep coma. Fatalities have been reported; however patients have recovered from valproate levels as high as 2120 µg/mL.

In overdose situations, the fraction of drug not bound to protein is high and hemodialysis or tandem hemodialysis plus hemoperfusion may result in significant removal of drug. The benefit of gastric lavage or emesis will vary with the time since ingestion. General supportive measures should be applied with particular attention to the maintenance of adequate urinary output.

Naloxone has been reported to reverse the CNS depressant effects of valproate overdose. Because naloxone could theoretically also reverse the antiepileptic effects of valproate, it should be used with caution in patients with epilepsy.

DOSAGE AND ADMINISTRATION

Epilepsy

DEPAKOTE Sprinkle Capsules are administered orally. DEPAKOTE is indicated as monotherapy and adjunctive therapy in complex partial seizures in adults and pediatric patients down to the age of 10 years, and in simple and complex absence seizures. As the DEPAKOTE dosage is titrated upward, concentrations of phenobarbital, carbamazepine, and/or phenytoin may be affected (see **PRECAUTIONS - Drug Interactions**).

Complex Partial Seizures

For adults and children 10 years of age or older.

Monotherapy (Initial Therapy)

DEPAKOTE has not been systematically studied as initial therapy. Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made.

The probability of thrombocytopenia increases significantly at total trough valproate plasma concentrations above 110 µg/mL in females and 135 µg/mL in males. The benefit of improved seizure control with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

Conversion to Monotherapy

Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 - 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. Concomitant antiepilepsy drug (AED) dosage can ordinarily be reduced by approximately 25% every 2 weeks. This reduction may be started at initiation of DEPAKOTE therapy, or delayed by 1 to 2 weeks if there is a concern that seizures are likely to occur with a reduction. The speed and duration of withdrawal of the concomitant AED can be highly variable, and patients should be monitored closely during this period for increased seizure frequency.

Adjunctive Therapy

DEPAKOTE may be added to the patient's regimen at a dosage of 10 to 15 mg/kg/day. The dosage may be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. If the total daily dose exceeds 250 mg, it should be given in divided doses.

In a study of adjunctive therapy for complex partial seizures in which patients were receiving either carbamazepine or phenytoin in addition to DEPAKOTE, no adjustment of carbamazepine or phenytoin dosage was needed (see **CLINICAL STUDIES**). However, since valproate may interact with these or other concurrently administered AEDs as well

as other drugs (see **Drug Interactions**), periodic plasma concentration determinations of concomitant AEDs are recommended during the early course of therapy (see **PRECAUTIONS - Drug Interactions**).

Simple and Complex Absence Seizures

The recommended initial dose is 15 mg/kg/day, increasing at one week intervals by 5 to 10 mg/kg/day until seizures are controlled or side effects preclude further increases. The maximum recommended dosage is 60 mg/kg/day. If the total daily dose exceeds 250 mg, it should be given in divided doses.

A good correlation has not been established between daily dose, serum concentrations, and therapeutic effect. However, therapeutic valproate serum concentrations for most patients with absence seizures is considered to range from 50 to 100 µg/mL. Some patients may be controlled with lower or higher serum concentrations (see **CLINICAL PHARMACOLOGY**).

As the DEPAKOTE dosage is titrated upward, blood concentrations of phenobarbital and/or phenytoin may be affected (see **PRECAUTIONS**).

Antiepilepsy drugs should not be abruptly discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life.

In epileptic patients previously receiving DEPAKENE (valproic acid) therapy, DEPAKOTE Sprinkle Capsules should be initiated at the same daily dose and dosing schedule. After the patient is stabilized on DEPAKOTE Sprinkle Capsules, a dosing schedule of two or three times a day may be elected in selected patients.

General Dosing Advice

Dosing in Elderly Patients

Due to a decrease in unbound clearance of valproate and possibly a greater sensitivity to somnolence in the elderly, the starting dose should be reduced in these patients. Dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence. The ultimate therapeutic dose should be achieved on the basis of both tolerability and clinical response (see **WARNINGS**).

Dose-Related Adverse Events

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia) may be dose-related. The probability of thrombocytopenia appears to increase significantly at total valproate concentrations of ≥ 110 µg/mL (females) or ≥ 135 µg/mL (males) (see **PRECAUTIONS**). The benefit of improved therapeutic effect with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

G.I. Irritation

Patients who experience G.I. irritation may benefit from administration of the drug with food or by slowly building up the dose from an initial low level.

Administration of Sprinkle Capsules

DEPAKOTE Sprinkle Capsules may be swallowed whole or may be administered by carefully opening the capsule and sprinkling the entire contents on a small amount (teaspoonful) of soft food such as applesauce or pudding. The drug/food mixture should be swallowed immediately (avoid chewing) and not stored for future use. Each capsule is oversized to allow ease of opening.

HOW SUPPLIED

DEPAKOTE Sprinkle Capsules (divalproex sodium coated particles in capsules), 125 mg, are white opaque and blue, and are supplied in bottles of 100 (**NDC 0074-6114-13**) and Abbo-Pac[®] unit dose packages of 100 (**NDC 0074-6114-11**).

Recommended Storage

Store capsules below 77°F (25°C).

Abbott Laboratories

North Chicago, IL 60064, U.S.A.

Patient Information Leaflet

Important Information for Women Who Could Become Pregnant About the Use of DEPAKOTE[®], DEPAKOTE[®] ER, DEPAKOTE[®] Sprinkle Capsules, and DEPAKENE[®].

Please read this leaflet carefully before you take any of these medications. This leaflet provides a summary of important information about taking these medications to women who could become pregnant. If you have any questions or concerns, or want more information about these medications, contact your doctor or pharmacist.

Information For Women Who Could Become Pregnant

These medications can be obtained only by prescription from your doctor. The decision to use any of these medications is one that you and your doctor should make together, taking into account your individual needs and medical condition.

Before using any of these medications, women who can become pregnant should consider the fact that these medications have been associated with birth defects, in particular, with spina bifida and other defects related to failure of the spinal canal to close normally. Approximately 1 to 2% of children born to women with epilepsy taking DEPAKOTE in the first 12 weeks of pregnancy had these defects (based on data from the Centers for Disease Control, a U.S. agency based in Atlanta). The incidence in the general population is 0.1 to 0.2%.

These medications have also been associated with other birth defects such as defects of the heart, the bones, and other parts of the body. Information suggests that birth defects may be more likely to occur with these medications than some other drugs that treat your medical condition.

Information For Women Who Are Planning to Get Pregnant

- Women taking any of these medications who are planning to get pregnant should discuss the treatment options with their doctor.

Information For Women Who Become Pregnant

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- If you become pregnant while taking any of these medications , you should contact your doctor immediately.

Other Important Information

- Your medication should be taken exactly as prescribed by your doctor to get the most benefit from your medication and reduce the risk of side effects.
- If you have taken more than the prescribed dose of your medication, contact your hospital emergency room or local poison center immediately.
- Your medication was prescribed for your particular condition. Do not use it for another condition or give the drug to others.

Facts About Birth Defects

It is important to know that birth defects may occur even in children of individuals not taking any medications or without any additional risk factors.

This summary provides important information about the use of DEPAKOTE®, DEPAKOTE® ER, DEPAKOTE® Sprinkle Capsules, and DEPAKENE® to women who could become pregnant. If you would like more information about the other potential risks and benefits of these medications, ask your doctor or pharmacist to let you read the professional labeling and then discuss it with them. If you have any questions or concerns about taking these medications, you should discuss them with your doctor.

Abbott Laboratories

North Chicago, IL 60064, U.S.A.

DEPAKOTE® Tablets
(divalproex sodium)
delayed-release tablets

BOX WARNING

HEPATOTOXICITY

HEPATIC FAILURE RESULTING IN FATALITIES HAS OCCURRED IN PATIENTS RECEIVING VALPROIC ACID AND ITS DERIVATIVES. EXPERIENCE HAS INDICATED THAT CHILDREN UNDER THE AGE OF TWO YEARS ARE AT A CONSIDERABLY INCREASED RISK OF DEVELOPING FATAL HEPATOTOXICITY, ESPECIALLY THOSE ON MULTIPLE ANTICONVULSANTS, THOSE WITH CONGENITAL METABOLIC DISORDERS, THOSE WITH SEVERE SEIZURE DISORDERS ACCOMPANIED BY MENTAL RETARDATION, AND THOSE WITH ORGANIC BRAIN DISEASE. WHEN DEPAKOTE IS USED IN THIS PATIENT GROUP, IT SHOULD BE USED WITH EXTREME CAUTION AND AS A SOLE AGENT. THE BENEFITS OF THERAPY SHOULD BE WEIGHED AGAINST THE RISKS. ABOVE THIS AGE GROUP, EXPERIENCE IN EPILEPSY HAS INDICATED THAT THE INCIDENCE OF FATAL HEPATOTOXICITY DECREASES CONSIDERABLY IN PROGRESSIVELY OLDER PATIENT GROUPS.

THESE INCIDENTS USUALLY HAVE OCCURRED DURING THE FIRST SIX MONTHS OF TREATMENT. SERIOUS OR FATAL HEPATOTOXICITY MAY BE PRECEDED BY NON-SPECIFIC SYMPTOMS SUCH AS MALAISE, WEAKNESS, LETHARGY, FACIAL EDEMA, ANOREXIA, AND VOMITING. IN PATIENTS WITH EPILEPSY, A LOSS OF SEIZURE CONTROL MAY ALSO OCCUR. PATIENTS SHOULD BE MONITORED CLOSELY FOR APPEARANCE OF THESE SYMPTOMS. LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS.

TERATOGENICITY

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS SUCH AS NEURAL TUBE DEFECTS (E.G., SPINA BIFIDA). ACCORDINGLY, THE USE OF DEPAKOTE TABLETS IN WOMEN OF CHILDBEARING POTENTIAL REQUIRES THAT THE BENEFITS OF ITS USE BE WEIGHED AGAINST THE RISK OF INJURY TO THE FETUS. THIS IS ESPECIALLY IMPORTANT WHEN THE TREATMENT OF A SPONTANEOUSLY REVERSIBLE CONDITION NOT ORDINARILY ASSOCIATED WITH PERMANENT INJURY OR RISK OF DEATH (E.G., MIGRAINE) IS CONTEMPLATED. SEE WARNINGS, INFORMATION FOR PATIENTS.

AN INFORMATION SHEET DESCRIBING THE TERATOGENIC POTENTIAL OF VALPROATE IS AVAILABLE FOR PATIENTS.

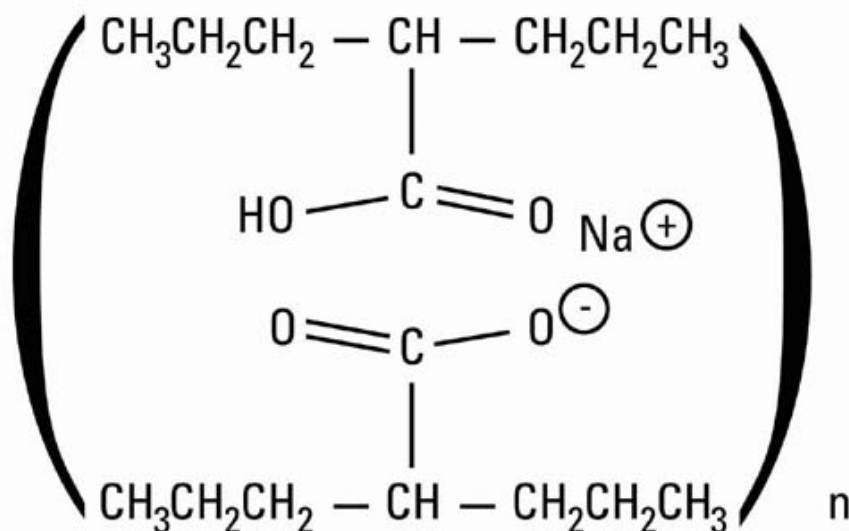
PANCREATITIS

CASES OF LIFE-THREATENING PANCREATITIS HAVE BEEN REPORTED IN BOTH CHILDREN AND ADULTS RECEIVING VALPROATE. SOME OF THE CASES HAVE BEEN DESCRIBED AS HEMORRHAGIC WITH A RAPID PROGRESSION FROM INITIAL SYMPTOMS TO DEATH. CASES HAVE BEEN REPORTED SHORTLY AFTER INITIAL USE AS WELL AS AFTER SEVERAL YEARS OF USE. PATIENTS AND GUARDIANS SHOULD BE WARNED THAT ABDOMINAL PAIN, NAUSEA, VOMITING, AND/OR ANOREXIA CAN BE SYMPTOMS OF PANCREATITIS THAT REQUIRE

PROMPT MEDICAL EVALUATION. IF PANCREATITIS IS DIAGNOSED, VALPROATE SHOULD ORDINARILY BE DISCONTINUED. ALTERNATIVE TREATMENT FOR THE UNDERLYING MEDICAL CONDITION SHOULD BE INITIATED AS CLINICALLY INDICATED. (See **WARNINGS** and **PRECAUTIONS** .)

DESCRIPTION

Divalproex sodium is a stable co-ordination compound comprised of sodium valproate and valproic acid in a 1:1 molar relationship and formed during the partial neutralization of valproic acid with 0.5 equivalent of sodium hydroxide. Chemically it is designated as sodium hydrogen bis(2-propylpentanoate). Divalproex sodium has the following structure:



Divalproex sodium occurs as a white powder with a characteristic odor.

DEPAKOTE tablets are for oral administration. DEPAKOTE tablets are supplied in three dosage strengths containing divalproex sodium equivalent to 125 mg, 250 mg, or 500 mg of valproic acid.

Inactive Ingredients

DEPAKOTE tablets: cellulosic polymers, diacetylated monoglycerides, povidone, pregelatinized starch (contains corn starch), silica gel, talc, titanium dioxide, and vanillin.

In addition, individual tablets contain:

125 mg tablets: FD&C Blue No. 1 and FD&C Red No. 40.

250 mg tablets: FD&C Yellow No. 6 and iron oxide.

500 mg tablets: D&C Red No. 30, FD&C Blue No. 2, and iron oxide.

CLINICAL PHARMACOLOGY

Pharmacodynamics

Divalproex sodium dissociates to the valproate ion in the gastrointestinal tract. The mechanisms by which valproate exerts its therapeutic effects have not been established. It

has been suggested that its activity in epilepsy is related to increased brain concentrations of gamma-aminobutyric acid (GABA).

Pharmacokinetics

Absorption/Bioavailability

Equivalent oral doses of DEPAKOTE (divalproex sodium) products and DEPAKENE (valproic acid) capsules deliver equivalent quantities of valproate ion systemically. Although the rate of valproate ion absorption may vary with the formulation administered (liquid, solid, or sprinkle), conditions of use (e.g., fasting or postprandial) and the method of administration (e.g., whether the contents of the capsule are sprinkled on food or the capsule is taken intact), these differences should be of minor clinical importance under the steady state conditions achieved in chronic use in the treatment of epilepsy.

However, it is possible that differences among the various valproate products in T_{max} and C_{max} could be important upon initiation of treatment. For example, in single dose studies, the effect of feeding had a greater influence on the rate of absorption of the tablet (increase in T_{max} from 4 to 8 hours) than on the absorption of the sprinkle capsules (increase in T_{max} from 3.3 to 4.8 hours).

While the absorption rate from the G.I. tract and fluctuation in valproate plasma concentrations vary with dosing regimen and formulation, the efficacy of valproate as an anticonvulsant in chronic use is unlikely to be affected. Experience employing dosing regimens from once-a-day to four-times-a-day, as well as studies in primate epilepsy models involving constant rate infusion, indicate that total daily systemic bioavailability (extent of absorption) is the primary determinant of seizure control and that differences in the ratios of plasma peak to trough concentrations between valproate formulations are inconsequential from a practical clinical standpoint. Whether or not rate of absorption influences the efficacy of valproate as an antimanic or antimigraine agent is unknown.

Co-administration of oral valproate products with food and substitution among the various DEPAKOTE and DEPAKENE formulations should cause no clinical problems in the management of patients with epilepsy (see **DOSAGE AND ADMINISTRATION**). Nonetheless, any changes in dosage administration, or the addition or discontinuance of concomitant drugs should ordinarily be accompanied by close monitoring of clinical status and valproate plasma concentrations.

Distribution

Protein Binding

The plasma protein binding of valproate is concentration dependent and the free fraction increases from approximately 10% at 40 $\mu\text{g/mL}$ to 18.5% at 130 $\mu\text{g/mL}$. Protein binding of valproate is reduced in the elderly, in patients with chronic hepatic diseases, in patients with renal impairment, and in the presence of other drugs (e.g., aspirin). Conversely, valproate may displace certain protein-bound drugs (e.g., phenytoin, carbamazepine, warfarin, and tolbutamide). (See **PRECAUTIONS - Drug Interactions** for more detailed information on the pharmacokinetic interactions of valproate with other drugs.)

CNS Distribution

Valproate concentrations in cerebrospinal fluid (CSF) approximate unbound concentrations in plasma (about 10% of total concentration).

Metabolism

Valproate is metabolized almost entirely by the liver. In adult patients on monotherapy, 30-50% of an administered dose appears in urine as a glucuronide conjugate. Mitochondrial β -oxidation is the other major metabolic pathway, typically accounting for over 40% of the dose. Usually, less than 15-20% of the dose is eliminated by other oxidative mechanisms. Less than 3% of an administered dose is excreted unchanged in urine.

The relationship between dose and total valproate concentration is nonlinear; concentration does not increase proportionally with the dose, but rather, increases to a lesser extent due to saturable plasma protein binding. The kinetics of unbound drug are linear.

Elimination

Mean plasma clearance and volume of distribution for total valproate are 0.56 L/hr/1.73 m² and 11 L/1.73 m², respectively. Mean plasma clearance and volume of distribution for free valproate are 4.6 L/hr/1.73 m² and 92 L/1.73 m². Mean terminal half-life for valproate monotherapy ranged from 9 to 16 hours following oral dosing regimens of 250 to 1000 mg.

The estimates cited apply primarily to patients who are not taking drugs that affect hepatic metabolizing enzyme systems. For example, patients taking enzyme-inducing antiepileptic drugs (carbamazepine, phenytoin, and phenobarbital) will clear valproate more rapidly. Because of these changes in valproate clearance, monitoring of antiepileptic concentrations should be intensified whenever concomitant antiepileptics are introduced or withdrawn.

Special Populations

Effect of Age

Neonates

Children within the first two months of life have a markedly decreased ability to eliminate valproate compared to older children and adults. This is a result of reduced clearance (perhaps due to delay in development of glucuronosyltransferase and other enzyme systems involved in valproate elimination) as well as increased volume of distribution (in part due to decreased plasma protein binding). For example, in one study, the half-life in children under 10 days ranged from 10 to 67 hours compared to a range of 7 to 13 hours in children greater than 2 months.

Children

Pediatric patients (i.e., between 3 months and 10 years) have 50% higher clearances expressed on weight (i.e., mL/min/kg) than do adults. Over the age of 10 years, children have pharmacokinetic parameters that approximate those of adults.

Elderly

The capacity of elderly patients (age range: 68 to 89 years) to eliminate valproate has been shown to be reduced compared to younger adults (age range: 22 to 26). Intrinsic clearance is reduced by 39%; the free fraction is increased by 44%. Accordingly, the initial dosage should be reduced in the elderly (See **DOSAGE AND ADMINISTRATION**).

Effect of Gender

There are no differences in the body surface area adjusted unbound clearance between males and females (4.8 ± 0.17 and 4.7 ± 0.07 L/hr per 1.73 m^2 , respectively).

Effect of Race

The effects of race on the kinetics of valproate have not been studied.

Effect of Disease

Liver Disease

(See **BOXED WARNING, CONTRAINDICATIONS, and WARNINGS**). Liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 patients with acute hepatitis, compared with 6 healthy subjects. In that study, the half-life of valproate was increased from 12 to 18 hours. Liver disease is also associated with decreased albumin concentrations and larger unbound fractions (2 to 2.6 fold increase) of valproate. Accordingly, monitoring of total concentrations may be misleading since free concentrations may be substantially elevated in patients with hepatic disease whereas total concentrations may appear to be normal.

Renal Disease

A slight reduction (27%) in the unbound clearance of valproate has been reported in patients with renal failure (creatinine clearance < 10 mL/minute); however, hemodialysis typically reduces valproate concentrations by about 20%. Therefore, no dosage adjustment appears to be necessary in patients with renal failure. Protein binding in these patients is substantially reduced; thus, monitoring total concentrations may be misleading.

Plasma Levels and Clinical Effect

The relationship between plasma concentration and clinical response is not well documented. One contributing factor is the nonlinear, concentration dependent protein binding of valproate which affects the clearance of the drug. Thus, monitoring of total serum valproate cannot provide a reliable index of the bioactive valproate species.

For example, because the plasma protein binding of valproate is concentration dependent, the free fraction increases from approximately 10% at 40 $\mu\text{g/mL}$ to 18.5% at 130 $\mu\text{g/mL}$. Higher than expected free fractions occur in the elderly, in hyperlipidemic patients, and in patients with hepatic and renal diseases.

Epilepsy

The therapeutic range in epilepsy is commonly considered to be 50 to 100 $\mu\text{g/mL}$ of total valproate, although some patients may be controlled with lower or higher plasma concentrations.

Mania

In placebo-controlled clinical trials of acute mania, patients were dosed to clinical response with trough plasma concentrations between 50 and 125 $\mu\text{g/mL}$ (See **DOSAGE AND ADMINISTRATION**).

Clinical Trials

Mania

The effectiveness of DEPAKOTE for the treatment of acute mania was demonstrated in two 3-week, placebo controlled, parallel group studies.

(1) Study 1: The first study enrolled adult patients who met DSM-III-R criteria for Bipolar Disorder and who were hospitalized for acute mania. In addition, they had a history of failing to respond to or not tolerating previous lithium carbonate treatment. DEPAKOTE was initiated at a dose of 250 mg tid and adjusted to achieve serum valproate concentrations in a range of 50-100 µg/mL by day 7. Mean DEPAKOTE doses for completers in this study were 1118, 1525, and 2402 mg/day at Days 7, 14, and 21, respectively. Patients were assessed on the Young Mania Rating Scale (YMRS; score ranges from 0-60), an augmented Brief Psychiatric Rating Scale (BPRS-A), and the Global Assessment Scale (GAS). Baseline scores and change from baseline in the Week 3 endpoint (last-observation-carry-forward) analysis were as follows:

Study 1			
YMRS Total Score			
Group	Baseline¹	BL to Wk 3²	Difference³
Placebo	28.8	+ 0.2	
DEPAKOTE	28.5	- 9.5	9.7
BPRS-A Total Score			
Group	Baseline¹	BL to Wk 3²	Difference³
Placebo	76.2	+ 1.8	
DEPAKOTE	76.4	-17.0	18.8
GAS Score			
Group	Baseline¹	BL to Wk 3²	Difference³
Placebo	31.8	0.0	
DEPAKOTE	30.3	+ 18.1	18.1

1. Mean score at baseline

2. Change from baseline to Week 3 (LOCF)

3. Difference in change from baseline to Week 3 endpoint (LOCF) between DEPAKOTE and placebo

DEPAKOTE was statistically significantly superior to placebo on all three measures of outcome.

(2) Study 2: The second study enrolled adult patients who met Research Diagnostic Criteria for manic disorder and who were hospitalized for acute mania. DEPAKOTE was initiated at a dose of 250 mg tid and adjusted within a dose range of 750-2500 mg/day to achieve serum valproate concentrations in a range of 40-150 µg/mL. Mean DEPAKOTE doses for completers in this study were 1116, 1683, and 2006 mg/day at Days 7, 14, and 21, respectively. Study 2 also included a lithium group for which lithium doses for completers were 1312, 1869, and 1984 mg/day at Days 7, 14, and 21, respectively. Patients were assessed on the Manic Rating Scale (MRS; score ranges from 11-63), and the primary outcome measures were the total MRS score, and scores for two subscales of the MRS, i.e., the Manic Syndrome Scale (MSS) and the Behavior and Ideation Scale (BIS). Baseline scores and change from baseline in the Week 3 endpoint (last-observation-carry-forward) analysis were as follows:

Study 2			
MRS Total Score			
Group	Baseline¹	BL to Day 21²	Difference³

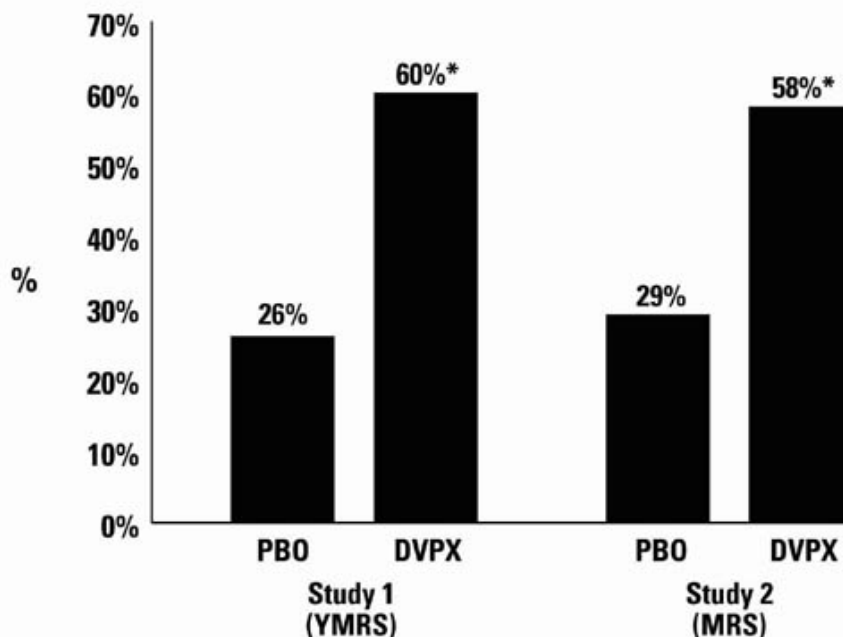
Placebo	38.9	- 4.4	
Lithium	37.9	-10.5	6.1
DEPAKOTE	38.1	- 9.5	5.1
MSS Total Score			
Group	Baseline¹	BL to Day 21²	Difference³
Placebo	18.9	- 2.5	
Lithium	18.5	- 6.2	3.7
DEPAKOTE	18.9	- 6.0	3.5
BIS Total Score			
Group	Baseline¹	BL to Day 21²	Difference³
Placebo	16.4	- 1.4	
Lithium	16.0	- 3.8	2.4
DEPAKOTE	15.7	- 3.2	1.8

1. Mean score at baseline
2. Change from baseline to Day 21 (LOCF)
3. Difference in change from baseline to Day 21 endpoint (LOCF) between DEPAKOTE and placebo and lithium and placebo

DEPAKOTE was statistically significantly superior to placebo on all three measures of outcome. An exploratory analysis for age and gender effects on outcome did not suggest any differential responsiveness on the basis of age or gender.

A comparison of the percentage of patients showing $\geq 30\%$ reduction in the symptom score from baseline in each treatment group, separated by study, is shown in Figure 1.

Figure 1. Percentage of Patients Achieving $\geq 30\%$ Reduction in Symptom Score From Baseline



* $p < 0.05$

PBO = placebo, DVPX = DEPAKOTE

Migraine

The results of two multicenter, randomized, double-blind, placebo-controlled clinical trials established the effectiveness of DEPAKOTE in the prophylactic treatment of migraine headache.

Both studies employed essentially identical designs and recruited patients with a history of migraine with or without aura (of at least 6 months in duration) who were experiencing at least 2 migraine headaches a month during the 3 months prior to enrollment. Patients with cluster headaches were excluded. Women of childbearing potential were excluded entirely from one study, but were permitted in the other if they were deemed to be practicing an effective method of contraception.

In each study following a 4-week single-blind placebo baseline period, patients were randomized, under double blind conditions, to DEPAKOTE or placebo for a 12-week treatment phase, comprised of a 4-week dose titration period followed by an 8-week maintenance period. Treatment outcome was assessed on the basis of 4-week migraine headache rates during the treatment phase.

In the first study, a total of 107 patients (24 M, 83 F), ranging in age from 26 to 73 were randomized 2:1, DEPAKOTE to placebo. Ninety patients completed the 8-week maintenance period. Drug dose titration, using 250 mg tablets, was individualized at the investigator's discretion. Adjustments were guided by actual/sham trough total serum valproate levels in order to maintain the study blind. In patients on DEPAKOTE doses ranged from 500 to 2500 mg a day. Doses over 500 mg were given in three divided doses (TID). The mean dose during the treatment phase was 1087 mg/day resulting in a mean trough total valproate level of 72.5 µg/mL, with a range of 31 to 133 µg/mL.

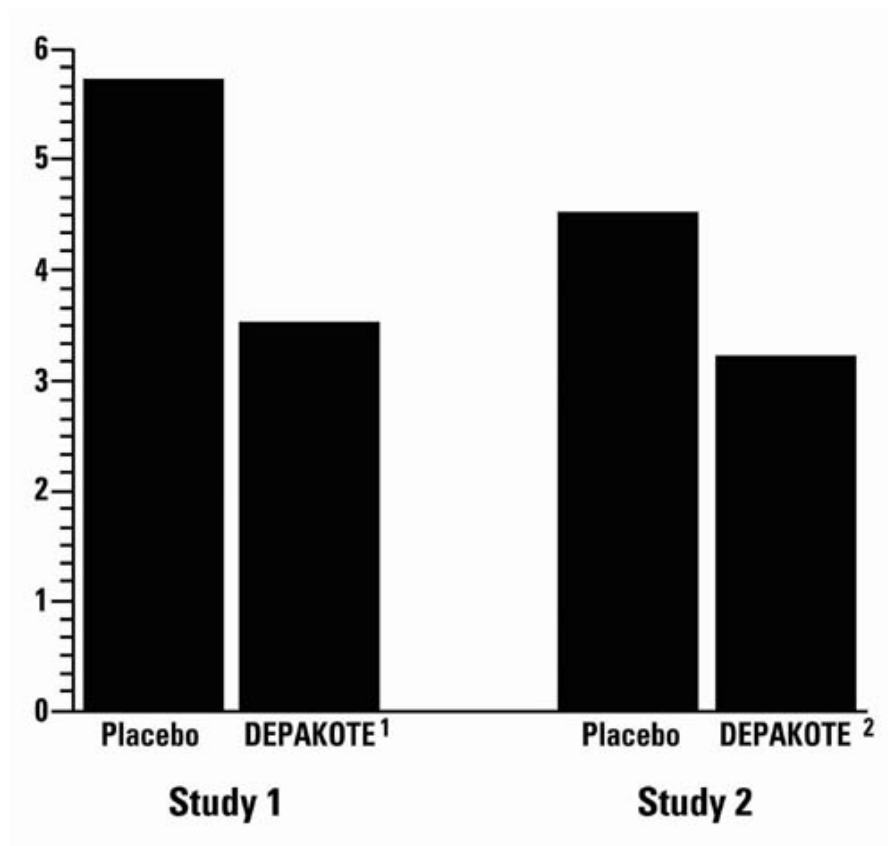
The mean 4-week migraine headache rate during the treatment phase was 5.7 in the placebo group compared to 3.5 in the DEPAKOTE group (see Figure 2). These rates were significantly different.

In the second study, a total of 176 patients (19 males and 157 females), ranging in age from 17 to 76 years, were randomized equally to one of three DEPAKOTE dose groups (500, 1000, or 1500 mg/day) or placebo. The treatments were given in two divided doses (BID). One hundred thirty-seven patients completed the 8-week maintenance period. Efficacy was to be determined by a comparison of the 4-week migraine headache rate in the combined 1000/1500 mg/day group and placebo group.

The initial dose was 250 mg daily. The regimen was advanced by 250 mg every 4 days (8 days for 500 mg/day group), until the randomized dose was achieved. The mean trough total valproate levels during the treatment phase were 39.6, 62.5, and 72.5 µg/mL in the DEPAKOTE 500, 1000, and 1500 mg/day groups, respectively.

The mean 4-week migraine headache rates during the treatment phase, adjusted for differences in baseline rates, were 4.5 in the placebo group, compared to 3.3, 3.0, and 3.3 in the DEPAKOTE 500, 1000, and 1500 mg/day groups, respectively, based on intent-to-treat results (see Figure 2). Migraine headache rates in the combined DEPAKOTE 1000/1500 mg group were significantly lower than in the placebo group.

Figure 2. Mean 4-week Migraine Rates



¹ Mean dose of DEPAKOTE was 1087 mg/day.

² Dose of DEPAKOTE was 500 or 1000 mg/day.

Epilepsy

The efficacy of DEPAKOTE in reducing the incidence of complex partial seizures (CPS) that occur in isolation or in association with other seizure types was established in two controlled trials.

In one, multiclinic, placebo controlled study employing an add-on design, (adjunctive therapy) 144 patients who continued to suffer eight or more CPS per 8 weeks during an 8 week period of monotherapy with doses of either carbamazepine or phenytoin sufficient to assure plasma concentrations within the "therapeutic range" were randomized to receive, in addition to their original antiepilepsy drug (AED), either DEPAKOTE or placebo. Randomized patients were to be followed for a total of 16 weeks. The following table presents the findings.

Adjunctive Therapy Study Median Incidence of CPS per 8 Weeks

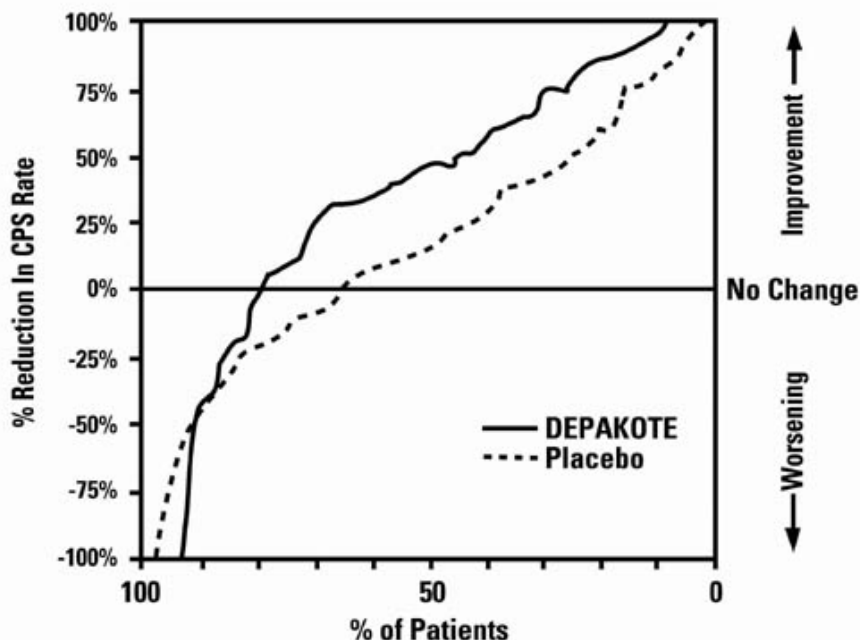
Add-on Treatment	Number of Patients	Baseline Incidence	Experimental Incidence
DEPAKOTE	75	16.0	8.9*
Placebo	69	14.5	11.5

* Reduction from baseline statistically significantly greater for DEPAKOTE than placebo at $p \leq 0.05$ level.

Figure 3 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the

Y axis in the adjunctive therapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for an effective treatment is shifted to the left of the curve for placebo. This figure shows that the proportion of patients achieving any particular level of improvement was consistently higher for DEPAKOTE than for placebo. For example, 45% of patients treated with DEPAKOTE had a $\geq 50\%$ reduction in complex partial seizure rate compared to 23% of patients treated with placebo.

Figure 3.



The second study assessed the capacity of DEPAKOTE to reduce the incidence of CPS when administered as the sole AED. The study compared the incidence of CPS among patients randomized to either a high or low dose treatment arm. Patients qualified for entry into the randomized comparison phase of this study only if 1) they continued to experience 2 or more CPS per 4 weeks during an 8 to 12 week long period of monotherapy with adequate doses of an AED (i.e., phenytoin, carbamazepine, phenobarbital, or primidone) and 2) they made a successful transition over a two week interval to DEPAKOTE. Patients entering the randomized phase were then brought to their assigned target dose, gradually tapered off their concomitant AED and followed for an interval as long as 22 weeks. Less than 50% of the patients randomized, however, completed the study. In patients converted to DEPAKOTE monotherapy, the mean total valproate concentrations during monotherapy were 71 and 123 $\mu\text{g/mL}$ in the low dose and high dose groups, respectively.

The following table presents the findings for all patients randomized who had at least one post-randomization assessment.

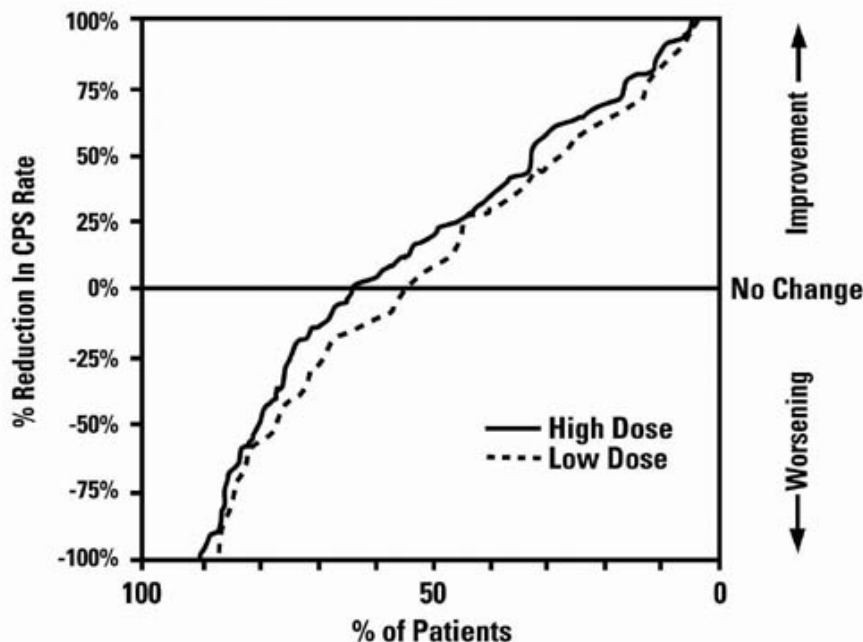
Monotherapy Study Median Incidence of CPS per 8 Weeks

Treatment	Number of Patients	Baseline Incidence	Randomized Phase Incidence
High dose DEPAKOTE	131	13.2	10.7*
Low dose DEPAKOTE	134	14.2	13.8

* Reduction from baseline statistically significantly greater for high dose than low dose at $p \leq 0.05$ level.

Figure 4 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the monotherapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for a more effective treatment is shifted to the left of the curve for a less effective treatment. This figure shows that the proportion of patients achieving any particular level of reduction was consistently higher for high dose DEPAKOTE than for low dose DEPAKOTE. For example, when switching from carbamazepine, phenytoin, phenobarbital or primidone monotherapy to high dose DEPAKOTE monotherapy, 63% of patients experienced no change or a reduction in complex partial seizure rates compared to 54% of patients receiving low dose DEPAKOTE.

Figure 4.



INDICATIONS AND USAGE

Mania

DEPAKOTE (divalproex sodium) is indicated for the treatment of the manic episodes associated with bipolar disorder. A manic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood. Typical symptoms of mania include pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, poor judgement, aggressiveness, and possible hostility.

The efficacy of DEPAKOTE was established in 3-week trials with patients meeting DSM-III-R criteria for bipolar disorder who were hospitalized for acute mania (See **Clinical Trials** under **CLINICAL PHARMACOLOGY**).

The safety and effectiveness of DEPAKOTE for long-term use in mania, i.e., more than 3 weeks, has not been systematically evaluated in controlled clinical trials. Therefore,

physicians who elect to use DEPAKOTE for extended periods should continually reevaluate the long-term usefulness of the drug for the individual patient.

Epilepsy

DEPAKOTE (divalproex sodium) is indicated as monotherapy and adjunctive therapy in the treatment of patients with complex partial seizures that occur either in isolation or in association with other types of seizures. DEPAKOTE (divalproex sodium) is also indicated for use as sole and adjunctive therapy in the treatment of simple and complex absence seizures, and adjunctively in patients with multiple seizure types that include absence seizures.

Simple absence is defined as very brief clouding of the sensorium or loss of consciousness accompanied by certain generalized epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

Migraine

DEPAKOTE is indicated for prophylaxis of migraine headaches. There is no evidence that DEPAKOTE is useful in the acute treatment of migraine headaches. Because valproic acid may be a hazard to the fetus, DEPAKOTE should be considered for women of childbearing potential only after this risk has been thoroughly discussed with the patient and weighed against the potential benefits of treatment (see **WARNINGS - Usage In Pregnancy, PRECAUTIONS - Information for Patients**).

SEE **WARNINGS** FOR STATEMENT REGARDING FATAL HEPATIC DYSFUNCTION.

CONTRAINDICATIONS

DIVALPROEX SODIUM SHOULD NOT BE ADMINISTERED TO PATIENTS WITH HEPATIC DISEASE OR SIGNIFICANT HEPATIC DYSFUNCTION.

Divalproex sodium is contraindicated in patients with known hypersensitivity to the drug.

Divalproex sodium is contraindicated in patients with known urea cycle disorders (See **WARNINGS**).

WARNINGS

Hepatotoxicity

Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid. These incidents usually have occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as malaise, weakness, lethargy, facial edema, anorexia, and vomiting. In patients with epilepsy, a loss of seizure control may also occur. Patients should be monitored closely for appearance of these symptoms. Liver function tests should be performed prior to therapy and at frequent intervals thereafter, especially during the first six months. However, physicians should not rely totally on serum biochemistry since these tests may not be abnormal in all instances, but should also consider the results of careful interim medical history and physical examination.

Caution should be observed when administering DEPAKOTE products to patients with a prior history of hepatic disease. Patients on multiple anticonvulsants, children, those with congenital metabolic disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease may be at particular risk. Experience has indicated that children under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions. When DEPAKOTE is used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above this age group, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of drug.

Pancreatitis

Cases of life-threatening pancreatitis have been reported in both children and adults receiving valproate. Some of the cases have been described as hemorrhagic with rapid progression from initial symptoms to death. Some cases have occurred shortly after initial use as well as after several years of use. The rate based upon the reported cases exceeds that expected in the general population and there have been cases in which pancreatitis recurred after rechallenge with valproate. In clinical trials, there were 2 cases of pancreatitis without alternative etiology in 2416 patients, representing 1044 patient-years experience. Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical evaluation. If pancreatitis is diagnosed, valproate should ordinarily be discontinued. Alternative treatment for the underlying medical condition should be initiated as clinically indicated (see **BOXED WARNING**).

Urea Cycle Disorders (UCD)

Divalproex sodium is contraindicated in patients with known urea cycle disorders. Hyperammonemic encephalopathy, sometimes fatal, has been reported following initiation of valproate therapy in patients with urea cycle disorders, a group of uncommon genetic abnormalities, particularly ornithine transcarbamylase deficiency. Prior to the initiation of valproate therapy, evaluation for UCD should be considered in the following patients: 1) those with a history of unexplained encephalopathy or coma, encephalopathy associated with a protein load, pregnancy-related or postpartum encephalopathy, unexplained mental retardation, or history of elevated plasma ammonia or glutamine; 2) those with cyclical vomiting and lethargy, episodic extreme irritability, ataxia, low BUN, or protein avoidance; 3) those with a family history of UCD or a family history of unexplained infant deaths (particularly males); 4) those with other signs or symptoms of UCD. Patients who develop symptoms of unexplained hyperammonemic encephalopathy while receiving valproate therapy should receive prompt treatment (including discontinuation of valproate therapy) and be evaluated for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **PRECAUTIONS**).

Somnolence in the Elderly

In a double-blind, multicenter trial of valproate in elderly patients with dementia (mean age = 83 years), doses were increased by 125 mg/day to a target dose of 20 mg/kg/day. A significantly higher proportion of valproate patients had somnolence compared to

placebo, and although not statistically significant, there was a higher proportion of patients with dehydration. Discontinuations for somnolence were also significantly higher than with placebo. In some patients with somnolence (approximately one-half), there was associated reduced nutritional intake and weight loss. There was a trend for the patients who experienced these events to have a lower baseline albumin concentration, lower valproate clearance, and a higher BUN. In elderly patients, dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

Thrombocytopenia

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia [see **PRECAUTIONS**]) may be dose-related. In a clinical trial of DEPAKOTE as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). The therapeutic benefit which may accompany the higher doses should therefore be weighed against the possibility of a greater incidence of adverse effects.

Usage In Pregnancy

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS. DATA SUGGEST THAT THERE IS AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS ASSOCIATED WITH THE USE OF VALPROATE BY WOMEN WITH SEIZURE DISORDERS DURING PREGNANCY WHEN COMPARED TO THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO DO NOT USE ANTIEPILEPTIC DRUGS DURING PREGNANCY, THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO USE OTHER ANTIEPILEPTIC DRUGS, AND THE BACKGROUND INCIDENCE FOR THE GENERAL POPULATION. THEREFORE, VALPROATE SHOULD BE CONSIDERED FOR WOMEN OF CHILDBEARING POTENTIAL ONLY AFTER THE RISKS HAVE BEEN THOROUGHLY DISCUSSED WITH THE PATIENT AND WEIGHED AGAINST THE POTENTIAL BENEFITS OF TREATMENT.

THERE ARE MULTIPLE REPORTS IN THE CLINICAL LITERATURE THAT INDICATE THE USE OF ANTIEPILEPTIC DRUGS DURING PREGNANCY RESULTS IN AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS IN OFFSPRING. ANTIEPILEPTIC DRUGS, INCLUDING VALPROATE, SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING POTENTIAL ONLY IF THEY ARE CLEARLY SHOWN TO BE ESSENTIAL IN THE MANAGEMENT OF THEIR MEDICAL CONDITION.

Antiepileptic drugs should not be discontinued abruptly in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

HUMAN DATA

Congenital Malformations

The North American Antiepileptic Drug Pregnancy Registry reported 16 cases of congenital malformations among the offspring of 149 women with epilepsy who were exposed to valproic acid monotherapy during the first trimester of pregnancy at doses of approximately 1,000 mg per day, for a prevalence rate of 10.7% (95% CI 6.3%-16.9%). Three of the 149 offspring (2%) had neural tube defects and 6 of the 149 (4%) had less severe malformations. Among epileptic women who were exposed to other antiepileptic drug monotherapies during pregnancy (1,048 patients) the malformation rate was 2.9% (95% CI 2.0% to 4.1%). There was a 4-fold increase in congenital malformations among infants with valproic acid-exposed mothers compared with those treated with other antiepileptic monotherapies as a group (Odds Ratio 4.0; 95% CI 2.1 to 7.4). This increased risk does not reflect a comparison versus any specific antiepileptic drug, but the risk versus the heterogeneous group of all other antiepileptic drug monotherapies combined. The increased teratogenic risk from valproic acid in women with epilepsy is expected to be reflected in an increased risk in other indications (e.g., migraine or bipolar disorder).

THE STRONGEST ASSOCIATION OF MATERNAL VALPROATE USAGE WITH CONGENITAL MALFORMATIONS IS WITH NEURAL TUBE DEFECTS (AS DISCUSSED UNDER THE NEXT SUBHEADING). HOWEVER, OTHER CONGENITAL ANOMALIES (E.G. CRANIOFACIAL DEFECTS, CARDIOVASCULAR MALFORMATIONS AND ANOMALIES INVOLVING VARIOUS BODY SYSTEMS), COMPATIBLE AND INCOMPATIBLE WITH LIFE, HAVE BEEN REPORTED. SUFFICIENT DATA TO DETERMINE THE INCIDENCE OF THESE CONGENITAL ANOMALIES IS NOT AVAILABLE.

Neural Tube Defects

THE INCIDENCE OF NEURAL TUBE DEFECTS IN THE FETUS IS INCREASED IN MOTHERS RECEIVING VALPROATE DURING THE FIRST TRIMESTER OF PREGNANCY. THE CENTERS FOR DISEASE CONTROL (CDC) HAS ESTIMATED THE RISK OF VALPROIC ACID EXPOSED WOMEN HAVING CHILDREN WITH SPINA BIFIDA TO BE APPROXIMATELY 1 TO 2%. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG) ESTIMATES THE GENERAL POPULATION RISK FOR CONGENITAL NEURAL TUBE DEFECTS AS 0.14% TO 0.2%.

Tests to detect neural tube and other defects using current accepted procedures should be considered a part of routine prenatal care in pregnant women receiving valproate.

Evidence suggests that pregnant women who receive folic acid supplementation may be at decreased risk for congenital neural tube defects in their offspring compared to pregnant women not receiving folic acid. Whether the risk of neural tube defects in the offspring of women receiving valproate specifically is reduced by folic acid supplementation is unknown. DIETARY FOLIC ACID SUPPLEMENTATION BOTH PRIOR TO AND DURING PREGNANCY SHOULD BE ROUTINELY RECOMMENDED TO PATIENTS CONTEMPLATING PREGNANCY.

Other Adverse Pregnancy Effects

PATIENTS TAKING VALPROATE MAY DEVELOP CLOTTING ABNORMALITIES (SEE **PRECAUTIONS - GENERAL AND WARNINGS**). A PATIENT WHO HAD LOW FIBRINOGEN WHEN TAKING MULTIPLE ANTICONVULSANTS INCLUDING VALPROATE GAVE BIRTH TO AN INFANT WITH AFIBRINOGENEMIA WHO SUBSEQUENTLY DIED OF HEMORRHAGE. IF VALPROATE IS USED IN

PREGNANCY, THE CLOTTING PARAMETERS SHOULD BE MONITORED CAREFULLY.

PATIENTS TAKING VALPROATE MAY DEVELOP HEPATIC FAILURE (SEE **WARNINGS - HEPATOTOXICITY AND BOX WARNING**). FATAL HEPATIC FAILURES, IN A NEWBORN AND IN AN INFANT, HAVE BEEN REPORTED FOLLOWING THE MATERNAL USE OF VALPROATE DURING PREGNANCY.

ANIMAL DATA

Animal studies have demonstrated valproate-induced teratogenicity. Increased frequencies of malformations, as well as intrauterine growth retardation and death, have been observed in mice, rats, rabbits, and monkeys following prenatal exposure to valproate. Malformations of the skeletal system are the most common structural abnormalities produced in experimental animals, but neural tube closure defects have been seen in mice exposed to maternal plasma valproate concentrations exceeding 230 µg/mL (2.3 times the upper limit of the human therapeutic range) during susceptible periods of embryonic development. Administration of an oral dose of 200 mg/kg/day or greater (50% of the maximum human daily dose or greater on a mg/m² basis) to pregnant rats during organogenesis produced malformations (skeletal, cardiac, and urogenital) and growth retardation in the offspring. These doses resulted in peak maternal plasma valproate levels of approximately 340 µg/mL or greater (3.4 times the upper limit of the human therapeutic range or greater). Behavioral deficits have been reported in the offspring of rats given a dose of 200 mg/kg/day throughout most of pregnancy. An oral dose of 350 mg/kg/day (approximately 2 times the maximum human daily dose on a mg/m² basis) produced skeletal and visceral malformations in rabbits exposed during organogenesis. Skeletal malformations, growth retardation, and death were observed in rhesus monkeys following administration of an oral dose of 200 mg/kg/day (equal to the maximum human daily dose on a mg/m² basis) during organogenesis. This dose resulted in peak maternal plasma valproate levels of approximately 280 µg/mL (2.8 times the upper limit of the human therapeutic range).

PRECAUTIONS

Hepatic Dysfunction

See **BOXED WARNING, CONTRAINDICATIONS** and **WARNINGS** .

Pancreatitis

See **BOXED WARNING** and **WARNINGS**.

Hyperammonemia

Hyperammonemia has been reported in association with valproate therapy and may be present despite normal liver function tests. In patients who develop unexplained lethargy and vomiting or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. If ammonia is increased, valproate therapy should be discontinued. Appropriate interventions for treatment of hyperammonemia should be initiated, and such patients should undergo investigation for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **WARNINGS – Urea**

Cycle Disorders and PRECAUTIONS - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use).

Asymptomatic elevations of ammonia are more common and when present, require close monitoring of plasma ammonia levels. If the elevation persists, discontinuation of valproate therapy should be considered. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia**).

Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use

Concomitant administration of topiramate and valproic acid has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. Clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level of consciousness and/or cognitive function with lethargy or vomiting. In most cases, symptoms and signs abated with discontinuation of either drug. This adverse event is not due to a pharmacokinetic interaction. It is not known if topiramate monotherapy is associated with hyperammonemia. Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, an interaction of topiramate and valproic acid may exacerbate existing defects or unmask deficiencies in susceptible persons. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia**)

General

Because of reports of thrombocytopenia (see **WARNINGS**), inhibition of the secondary phase of platelet aggregation, and abnormal coagulation parameters, (e.g., low fibrinogen), platelet counts and coagulation tests are recommended before initiating therapy and at periodic intervals. It is recommended that patients receiving DEPAKOTE be monitored for platelet count and coagulation parameters prior to planned surgery. In a clinical trial of DEPAKOTE as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). Evidence of hemorrhage, bruising, or a disorder of hemostasis/coagulation is an indication for reduction of the dosage or withdrawal of therapy.

Since DEPAKOTE may interact with concurrently administered drugs which are capable of enzyme induction, periodic plasma concentration determinations of valproate and concomitant drugs are recommended during the early course of therapy. (See **PRECAUTIONS - Drug Interactions**.)

Valproate is partially eliminated in the urine as a keto-metabolite which may lead to a false interpretation of the urine ketone test.

There have been reports of altered thyroid function tests associated with valproate. The clinical significance of these is unknown.

Suicidal ideation may be a manifestation of certain psychiatric disorders, and may persist until significant remission of symptoms occurs. Close supervision of high risk patients should accompany initial drug therapy.

There are *in vitro* studies that suggest valproate stimulates the replication of the HIV and CMV viruses under certain experimental conditions. The clinical consequence, if any, is not known. Additionally, the relevance of these *in vitro* findings is uncertain for patients receiving maximally suppressive antiretroviral therapy. Nevertheless, these data should be borne in mind when interpreting the results from regular monitoring of the viral load in HIV infected patients receiving valproate or when following CMV infected patients clinically.

Multi-organ Hypersensitivity Reaction

Multi-organ hypersensitivity reactions have been rarely reported in close temporal association to the initiation of valproate therapy in adult and pediatric patients (median time to detection 21 days; range 1 to 40 days). Although there have been a limited number of reports, many of these cases resulted in hospitalization and at least one death has been reported. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement. Other associated manifestations may include lymphadenopathy, hepatitis, liver function test abnormalities, hematological abnormalities (e.g., eosinophilia, thrombocytopenia, neutropenia), pruritis, nephritis, oliguria, hepatorenal syndrome, arthralgia, and asthenia. Because the disorder is variable in its expression, other organ system symptoms and signs, not noted here, may occur. If this reaction is suspected, valproate should be discontinued and an alternative treatment started. Although the existence of cross sensitivity with other drugs that produce this syndrome is unclear, the experience amongst drugs associated with multi-organ hypersensitivity would indicate this to be a possibility.

Information for Patients

Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis and, therefore, require further medical evaluation promptly.

Patients should be informed of the signs and symptoms associated with hyperammonemic encephalopathy (see **PRECAUTIONS – Hyperammonemia**) and be told to inform the prescriber if any of these symptoms occur.

Since DEPAKOTE products may produce CNS depression, especially when combined with another CNS depressant (eg, alcohol), patients should be advised not to engage in hazardous activities, such as driving an automobile or operating dangerous machinery, until it is known that they do not become drowsy from the drug.

Since DEPAKOTE has been associated with certain types of birth defects, female patients of child-bearing age considering the use of DEPAKOTE should be advised of the risk and of alternative therapeutic options and to read the **Patient Information Leaflet**, which appears as the last section of the labeling. This is especially important when the treatment of a spontaneously reversible condition not ordinarily associated with permanent injury or risk of death (e.g., migraine) is considered.

Patients should be instructed that a fever associated with other organ system involvement (rash, lymphadenopathy, etc.) may be drug-related and should be reported to the physician immediately (see **PRECAUTIONS - Multi-organ Hypersensitivity Reaction**).

Drug Interactions

Effects of Co-Administered Drugs on Valproate Clearance

Drugs that affect the level of expression of hepatic enzymes, particularly those that elevate levels of glucuronosyltransferases, may increase the clearance of valproate. For example, phenytoin, carbamazepine, and phenobarbital (or primidone) can double the clearance of valproate. Thus, patients on monotherapy will generally have longer half-lives and higher concentrations than patients receiving polytherapy with antiepilepsy drugs.

In contrast, drugs that are inhibitors of cytochrome P450 isozymes, e.g., antidepressants, may be expected to have little effect on valproate clearance because cytochrome P450 microsomal mediated oxidation is a relatively minor secondary metabolic pathway compared to glucuronidation and beta-oxidation.

Because of these changes in valproate clearance, monitoring of valproate and concomitant drug concentrations should be increased whenever enzyme inducing drugs are introduced or withdrawn.

The following list provides information about the potential for an influence of several commonly prescribed medications on valproate pharmacokinetics. The list is not exhaustive nor could it be, since new interactions are continuously being reported.

Drugs for which a potentially important interaction has been observed

Aspirin

A study involving the co-administration of aspirin at antipyretic doses (11 to 16 mg/kg) with valproate to pediatric patients (n=6) revealed a decrease in protein binding and an inhibition of metabolism of valproate. Valproate free fraction was increased 4-fold in the presence of aspirin compared to valproate alone. The β -oxidation pathway consisting of 2-E-valproic acid, 3-OH-valproic acid, and 3-keto valproic acid was decreased from 25% of total metabolites excreted on valproate alone to 8.3% in the presence of aspirin. Caution should be observed if valproate and aspirin are to be co-administered.

Felbamate

A study involving the co-administration of 1200 mg/day of felbamate with valproate to patients with epilepsy (n=10) revealed an increase in mean valproate peak concentration by 35% (from 86 to 115 μ g/mL) compared to valproate alone. Increasing the felbamate dose to 2400 mg/day increased the mean valproate peak concentration to 133 μ g/mL (another 16% increase). A decrease in valproate dosage may be necessary when felbamate therapy is initiated.

Meropenem

Subtherapeutic valproic acid levels have been reported when meropenem was coadministered.

Rifampin

A study involving the administration of a single dose of valproate (7 mg/kg) 36 hours after 5 nights of daily dosing with rifampin (600 mg) revealed a 40% increase in the oral clearance of valproate. Valproate dosage adjustment may be necessary when it is co-administered with rifampin.

Drugs for which either no interaction or a likely clinically unimportant interaction has been observed

Antacids

A study involving the co-administration of valproate 500 mg with commonly administered antacids (Maalox, Trisogel, and Titalac - 160 mEq doses) did not reveal any effect on the extent of absorption of valproate.

Chlorpromazine

A study involving the administration of 100 to 300 mg/day of chlorpromazine to schizophrenic patients already receiving valproate (200 mg BID) revealed a 15% increase in trough plasma levels of valproate.

Haloperidol

A study involving the administration of 6 to 10 mg/day of haloperidol to schizophrenic patients already receiving valproate (200 mg BID) revealed no significant changes in valproate trough plasma levels.

Cimetidine and Ranitidine

Cimetidine and ranitidine do not affect the clearance of valproate.

Effects of Valproate on Other Drugs

Valproate has been found to be a weak inhibitor of some P450 isozymes, epoxide hydrase, and glucuronosyltransferases.

The following list provides information about the potential for an influence of valproate co-administration on the pharmacokinetics or pharmacodynamics of several commonly prescribed medications. The list is not exhaustive, since new interactions are continuously being reported.

Drugs for which a potentially important valproate interaction has been observed

Amitriptyline/Nortriptyline

Administration of a single oral 50 mg dose of amitriptyline to 15 normal volunteers (10 males and 5 females) who received valproate (500 mg BID) resulted in a 21% decrease in plasma clearance of amitriptyline and a 34% decrease in the net clearance of nortriptyline. Rare postmarketing reports of concurrent use of valproate and amitriptyline resulting in an increased amitriptyline level have been received. Concurrent use of valproate and amitriptyline has rarely been associated with toxicity. Monitoring of amitriptyline levels should be considered for patients taking valproate concomitantly with amitriptyline. Consideration should be given to lowering the dose of amitriptyline/nortriptyline in the presence of valproate.

Carbamazepine/carbamazepine-10,11-Epoxyde

Serum levels of carbamazepine (CBZ) decreased 17% while that of carbamazepine-10,11-epoxide (CBZ-E) increased by 45% upon co-administration of valproate and CBZ to epileptic patients.

Clonazepam

The concomitant use of valproic acid and clonazepam may induce absence status in patients with a history of absence type seizures.

Diazepam

Valproate displaces diazepam from its plasma albumin binding sites and inhibits its metabolism. Co-administration of valproate (1500 mg daily) increased the free fraction of diazepam (10 mg) by 90% in healthy volunteers (n=6). Plasma clearance and volume of distribution for free diazepam were reduced by 25% and 20%, respectively, in the presence of valproate. The elimination half-life of diazepam remained unchanged upon addition of valproate.

Ethosuximide

Valproate inhibits the metabolism of ethosuximide. Administration of a single ethosuximide dose of 500 mg with valproate (800 to 1600 mg/day) to healthy volunteers (n=6) was accompanied by a 25% increase in elimination half-life of ethosuximide and a 15% decrease in its total clearance as compared to ethosuximide alone. Patients receiving valproate and ethosuximide, especially along with other anticonvulsants, should be monitored for alterations in serum concentrations of both drugs.

Lamotrigine

In a steady-state study involving 10 healthy volunteers, the elimination half-life of lamotrigine increased from 26 to 70 hours with valproate co-administration (a 165% increase). The dose of lamotrigine should be reduced when co-administered with valproate. Serious skin reactions (such as Stevens-Johnson Syndrome and toxic epidermal necrolysis) have been reported with concomitant lamotrigine and valproate administration. See lamotrigine package insert for details on lamotrigine dosing with concomitant valproate administration.

Phenobarbital

Valproate was found to inhibit the metabolism of phenobarbital. Co-administration of valproate (250 mg BID for 14 days) with phenobarbital to normal subjects (n=6) resulted in a 50% increase in half-life and a 30% decrease in plasma clearance of phenobarbital (60 mg single-dose). The fraction of phenobarbital dose excreted unchanged increased by 50% in presence of valproate.

There is evidence for severe CNS depression, with or without significant elevations of barbiturate or valproate serum concentrations. All patients receiving concomitant barbiturate therapy should be closely monitored for neurological toxicity. Serum barbiturate concentrations should be obtained, if possible, and the barbiturate dosage decreased, if appropriate.

Primidone, which is metabolized to a barbiturate, may be involved in a similar interaction with valproate.

Phenytoin

Valproate displaces phenytoin from its plasma albumin binding sites and inhibits its hepatic metabolism. Co-administration of valproate (400 mg TID) with phenytoin (250 mg) in normal volunteers (n=7) was associated with a 60% increase in the free fraction of phenytoin. Total plasma clearance and apparent volume of distribution of phenytoin increased 30% in the presence of valproate. Both the clearance and apparent volume of distribution of free phenytoin were reduced by 25%.

In patients with epilepsy, there have been reports of breakthrough seizures occurring with the combination of valproate and phenytoin. The dosage of phenytoin should be adjusted as required by the clinical situation.

Tolbutamide

From *in vitro* experiments, the unbound fraction of tolbutamide was increased from 20% to 50% when added to plasma samples taken from patients treated with valproate. The clinical relevance of this displacement is unknown.

Topiramate

Concomitant administration of valproic acid and topiramate has been associated with hyperammonemia with and without encephalopathy (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia and - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

Warfarin

In an *in vitro* study, valproate increased the unbound fraction of warfarin by up to 32.6%. The therapeutic relevance of this is unknown; however, coagulation tests should be monitored if DEPAKOTE therapy is instituted in patients taking anticoagulants.

Zidovudine

In six patients who were seropositive for HIV, the clearance of zidovudine (100 mg q8h) was decreased by 38% after administration of valproate (250 or 500 mg q8h); the half-life of zidovudine was unaffected.

Drugs for which either no interaction or a likely clinically unimportant interaction has been observed

Acetaminophen

Valproate had no effect on any of the pharmacokinetic parameters of acetaminophen when it was concurrently administered to three epileptic patients.

Clozapine

In psychotic patients (n=11), no interaction was observed when valproate was co-administered with clozapine.

Lithium

Co-administration of valproate (500 mg BID) and lithium carbonate (300 mg TID) to normal male volunteers (n=16) had no effect on the steady-state kinetics of lithium.

Lorazepam

Concomitant administration of valproate (500 mg BID) and lorazepam (1 mg BID) in normal male volunteers (n=9) was accompanied by a 17% decrease in the plasma clearance of lorazepam.

Oral Contraceptive Steroids

Administration of a single-dose of ethinylloestradiol (50 µg)/levonorgestrel (250 µg) to 6 women on valproate (200 mg BID) therapy for 2 months did not reveal any pharmacokinetic interaction.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Valproic acid was administered orally to Sprague Dawley rats and ICR (HA/ICR) mice at doses of 80 and 170 mg/kg/day (approximately 10 to 50% of the maximum human daily dose on a mg/m² basis) for two years. A variety of neoplasms were observed in both species. The chief findings were a statistically significant increase in the incidence of subcutaneous fibrosarcomas in high dose male rats receiving valproic acid and a statistically significant dose-related trend for benign pulmonary adenomas in male mice receiving valproic acid. The significance of these findings for humans is unknown.

Mutagenesis

Valproate was not mutagenic in an *in vitro* bacterial assay (Ames test), did not produce dominant lethal effects in mice, and did not increase chromosome aberration frequency in an *in vivo* cytogenetic study in rats. Increased frequencies of sister chromatid exchange (SCE) have been reported in a study of epileptic children taking valproate, but this association was not observed in another study conducted in adults. There is some evidence that increased SCE frequencies may be associated with epilepsy. The biological significance of an increase in SCE frequency is not known.

Fertility

Chronic toxicity studies in juvenile and adult rats and dogs demonstrated reduced spermatogenesis and testicular atrophy at oral doses of 400 mg/kg/day or greater in rats (approximately equivalent to or greater than the maximum human daily dose on a mg/m² basis) and 150 mg/kg/day or greater in dogs (approximately 1.4 times the maximum human daily dose or greater on a mg/m² basis). Segment I fertility studies in rats have shown doses up to 350 mg/kg/day (approximately equal to the maximum human daily dose on a mg/m² basis) for 60 days to have no effect on fertility. THE EFFECT OF VALPROATE ON TESTICULAR DEVELOPMENT AND ON SPERM PRODUCTION AND FERTILITY IN HUMANS IS UNKNOWN.

Pregnancy

Pregnancy Category D: See **WARNINGS** .

Nursing Mothers

Valproate is excreted in breast milk. Concentrations in breast milk have been reported to be 1-10% of serum concentrations. It is not known what effect this would have on a nursing infant. Consideration should be given to discontinuing nursing when divalproex sodium is administered to a nursing woman.

Pediatric Use

Experience has indicated that pediatric patients under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions (see **BOXED WARNING**). When DEPAKOTE is used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above the age of 2 years, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

Younger children, especially those receiving enzyme-inducing drugs, will require larger maintenance doses to attain targeted total and unbound valproic acid concentrations.

The variability in free fraction limits the clinical usefulness of monitoring total serum valproic acid concentrations. Interpretation of valproic acid concentrations in children should include consideration of factors that affect hepatic metabolism and protein binding.

The safety and effectiveness of DEPAKOTE for the treatment of acute mania has not been studied in individuals below the age of 18 years.

The safety and effectiveness of DEPAKOTE for the prophylaxis of migraines has not been studied in individuals below the age of 16 years.

The basic toxicology and pathologic manifestations of valproate sodium in neonatal (4-day old) and juvenile (14-day old) rats are similar to those seen in young adult rats. However, additional findings, including renal alterations in juvenile rats and renal alterations and retinal dysplasia in neonatal rats, have been reported. These findings occurred at 240 mg/kg/day, a dosage approximately equivalent to the human maximum recommended daily dose on a mg/m² basis. They were not seen at 90 mg/kg, or 40% of the maximum human daily dose on a mg/m² basis.

Geriatric Use

No patients above the age of 65 years were enrolled in double-blind prospective clinical trials of mania associated with bipolar illness. In a case review study of 583 patients, 72 patients (12%) were greater than 65 years of age. A higher percentage of patients above 65 years of age reported accidental injury, infection, pain, somnolence, and tremor. Discontinuation of valproate was occasionally associated with the latter two events. It is not clear whether these events indicate additional risk or whether they result from preexisting medical illness and concomitant medication use among these patients.

A study of elderly patients with dementia revealed drug related somnolence and discontinuation for somnolence (see **WARNINGS—Somnolence in the Elderly**). The starting dose should be reduced in these patients, and dosage reductions or discontinuation should be considered in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

There is insufficient information available to discern the safety and effectiveness of DEPAKOTE for the prophylaxis of migraines in patients over 65.

ADVERSE REACTIONS

Mania

The incidence of treatment-emergent events has been ascertained based on combined data from two placebo-controlled clinical trials of DEPAKOTE in the treatment of manic

episodes associated with bipolar disorder. The adverse events were usually mild or moderate in intensity, but sometimes were serious enough to interrupt treatment. In clinical trials, the rates of premature termination due to intolerance were not statistically different between placebo, DEPAKOTE, and lithium carbonate. A total of 4%, 8% and 11% of patients discontinued therapy due to intolerance in the placebo, DEPAKOTE, and lithium carbonate groups, respectively.

Table 1 summarizes those adverse events reported for patients in these trials where the incidence rate in the DEPAKOTE-treated group was greater than 5% and greater than the placebo incidence, or where the incidence in the DEPAKOTE-treated group was statistically significantly greater than the placebo group. Vomiting was the only event that was reported by significantly ($p \leq 0.05$) more patients receiving DEPAKOTE compared to placebo.

Table 1. Adverse Events Reported by > 5% of DEPAKOTE-Treated Patients During Placebo-Controlled Trials of Acute Mania¹

Adverse Event	DEPAKOTE (n = 89)	Placebo (n = 97)
Nausea	22%	15%
Somnolence	19%	12%
Dizziness	12%	4%
Vomiting	12%	3%
Asthenia	10%	7%
Abdominal pain	9%	8%
Dyspepsia	9%	8%
Rash	6%	3%

1. The following adverse events occurred at an equal or greater incidence for placebo than for DEPAKOTE: back pain, headache, constipation, diarrhea, tremor, and pharyngitis.

The following additional adverse events were reported by greater than 1% but not more than 5% of the 89 divalproex sodium-treated patients in controlled clinical trials:

Body as a Whole

Chest pain, chills, chills and fever, fever, neck pain, neck rigidity.

Cardiovascular System

Hypertension, hypotension, palpitations, postural hypotension, tachycardia, vasodilation.

Digestive System

Anorexia, fecal incontinence, flatulence, gastroenteritis, glossitis, periodontal abscess.

Hemic and Lymphatic System

Ecchymosis.

Metabolic and Nutritional Disorders

Edema, peripheral edema.

Musculoskeletal System

Arthralgia, arthrosis, leg cramps, twitching.

Nervous System

Abnormal dreams, abnormal gait, agitation, ataxia, catatonic reaction, confusion, depression, diplopia, dysarthria, hallucinations, hypertonia, hypokinesia, insomnia, paresthesia, reflexes increased, tardive dyskinesia, thinking abnormalities, vertigo.

Respiratory System

Dyspnea, rhinitis.

Skin and Appendages

Alopecia, discoid lupus erythematosus, dry skin, furunculosis, maculopapular rash, seborrhea.

Special Senses

Amblyopia, conjunctivitis, deafness, dry eyes, ear pain, eye pain, tinnitus.

Urogenital System

Dysmenorrhea, dysuria, urinary incontinence.

Migraine

Based on two placebo-controlled clinical trials and their long term extension, DEPAKOTE was generally well tolerated with most adverse events rated as mild to moderate in severity. Of the 202 patients exposed to DEPAKOTE in the placebo-controlled trials, 17% discontinued for intolerance. This is compared to a rate of 5% for the 81 placebo patients. Including the long term extension study, the adverse events reported as the primary reason for discontinuation by $\geq 1\%$ of 248 DEPAKOTE-treated patients were alopecia (6%), nausea and/or vomiting (5%), weight gain (2%), tremor (2%), somnolence (1%), elevated SGOT and/or SGPT (1%), and depression (1%).

Table 2 includes those adverse events reported for patients in the placebo-controlled trials where the incidence rate in the DEPAKOTE-treated group was greater than 5% and was greater than that for placebo patients.

Table 2. Adverse Events Reported by > 5% of DEPAKOTE-Treated Patients During Migraine Placebo-Controlled Trials with a Greater Incidence Than Patients Taking Placebo¹

Body System Event	Depakote (N = 202)	Placebo (N = 81)
Gastrointestinal System		
Nausea	31%	10%
Dyspepsia	13%	9%
Diarrhea	12%	7%
Vomiting	11%	1%
Abdominal pain	9%	4%
Increased appetite	6%	4%
Nervous System		
Asthenia	20%	9%
Somnolence	17%	5%
Dizziness	12%	6%
Tremor	9%	0%
Other		
Weight gain	8%	2%
Back pain	8%	6%

Alopecia

7%

1%

-
1. The following adverse events occurred in at least 5% of DEPAKOTE-treated patients and at an equal or greater incidence for placebo than for DEPAKOTE: flu syndrome and pharyngitis.

The following additional adverse events were reported by greater than 1% but not more than 5% of the 202 divalproex sodium-treated patients in the controlled clinical trials:

Body as a Whole

Chest pain, chills, face edema, fever and malaise.

Cardiovascular System

Vasodilatation.

Digestive System

Anorexia, constipation, dry mouth, flatulence, gastrointestinal disorder (unspecified), and stomatitis.

Hemic and Lymphatic System

Ecchymosis.

Metabolic and Nutritional Disorders

Peripheral edema, SGOT increase, and SGPT increase.

Musculoskeletal System

Leg cramps and myalgia.

Nervous System

Abnormal dreams, amnesia, confusion, depression, emotional lability, insomnia, nervousness, paresthesia, speech disorder, thinking abnormalities, and vertigo.

Respiratory System

Cough increased, dyspnea, rhinitis, and sinusitis.

Skin and Appendages

Pruritus and rash.

Special Senses

Conjunctivitis, ear disorder, taste perversion, and tinnitus.

Urogenital System

Cystitis, metrorrhagia, and vaginal hemorrhage.

Epilepsy

Based on a placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures, DEPAKOTE was generally well tolerated with most adverse events rated as mild to moderate in severity. Intolerance was the primary reason for discontinuation in the DEPAKOTE-treated patients (6%), compared to 1% of placebo-treated patients.

Table 3 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of DEPAKOTE-treated patients and for which the incidence was greater than in the placebo group, in the placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures. Since patients were also treated with other antiepilepsy drugs, it is not possible, in most cases, to determine whether the following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 3. Adverse Events Reported by $\geq 5\%$ of Patients Treated with DEPAKOTE During Placebo-Controlled Trial of Adjunctive Therapy for Complex Partial Seizures

Body System/Event	Depakote (%) (n = 77)	Placebo (%) (n = 70)
Body as a Whole		
Headache	31	21
Asthenia	27	7
Fever	6	4
Gastrointestinal System		
Nausea	48	14
Vomiting	27	7
Abdominal Pain	23	6
Diarrhea	13	6
Anorexia	12	0
Dyspepsia	8	4
Constipation	5	1
Nervous System		
Somnolence	27	11
Tremor	25	6
Dizziness	25	13
Diplopia	16	9
Amblyopia/Blurred Vision	12	9
Ataxia	8	1
Nystagmus	8	1
Emotional Lability	6	4
Thinking Abnormal	6	0
Amnesia	5	1
Respiratory System		
Flu Syndrome	12	9
Infection	12	6
Bronchitis	5	1
Rhinitis	5	4
Other		
Alopecia	6	1
Weight Loss	6	0

Table 4 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of patients in the high dose DEPAKOTE group, and for which the incidence was greater than in the low dose group, in a controlled trial of DEPAKOTE monotherapy treatment of complex partial seizures. Since patients were being titrated off another antiepilepsy drug during the first portion of the trial, it is not possible, in many cases, to determine whether the

following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 4. Adverse Events Reported by \geq 5% of Patients in the High Dose Group in the Controlled Trial of DEPAKOTE Monotherapy for Complex Partial Seizures¹

Body System/Event	High Dose (%) (n = 131)	Low Dose (%) (n = 134)
Body as a Whole		
Asthenia	21	10
Digestive System		
Nausea	34	26
Diarrhea	23	19
Vomiting	23	15
Abdominal Pain	12	9
Anorexia	11	4
Dyspepsia	11	10
Hemic/Lymphatic System		
Thrombocytopenia	24	1
Ecchymosis	5	4
Metabolic/Nutritional		
Weight Gain	9	4
Peripheral Edema	8	3
Nervous System		
Tremor	57	19
Somnolence	30	18
Dizziness	18	13
Insomnia	15	9
Nervousness	11	7
Amnesia	7	4
Nystagmus	7	1
Depression	5	4
Respiratory System		
Infection	20	13
Pharyngitis	8	2
Dyspnea	5	1
Skin and Appendages		
Alopecia	24	13
Special Senses		
Amblyopia/Blurred Vision	8	4
Tinnitus	7	1

1. Headache was the only adverse event that occurred in \geq 5% of patients in the high dose group and at an equal or greater incidence in the low dose group.

The following additional adverse events were reported by greater than 1% but less than 5% of the 358 patients treated with DEPAKOTE in the controlled trials of complex partial seizures:

Body as a Whole

Back pain, chest pain, malaise.

Cardiovascular System

Tachycardia, hypertension, palpitation.

Digestive System

Increased appetite, flatulence, hematemesis, eructation, pancreatitis, periodontal abscess.

Hemic and Lymphatic System

Petechia.

Metabolic and Nutritional Disorders

SGOT increased, SGPT increased.

Musculoskeletal System

Myalgia, twitching, arthralgia, leg cramps, myasthenia.

Nervous System

Anxiety, confusion, abnormal gait, paresthesia, hypertonia, incoordination, abnormal dreams, personality disorder.

Respiratory System

Sinusitis, cough increased, pneumonia, epistaxis.

Skin and Appendages

Rash, pruritus, dry skin.

Special Senses

Taste perversion, abnormal vision, deafness, otitis media.

Urogenital System

Urinary incontinence, vaginitis, dysmenorrhea, amenorrhea, urinary frequency.

Other Patient Populations

Adverse events that have been reported with all dosage forms of valproate from epilepsy trials, spontaneous reports, and other sources are listed below by body system.

Gastrointestinal

The most commonly reported side effects at the initiation of therapy are nausea, vomiting, and indigestion. These effects are usually transient and rarely require discontinuation of therapy. Diarrhea, abdominal cramps, and constipation have been reported. Both anorexia with some weight loss and increased appetite with weight gain have also been reported. The administration of delayed-release divalproex sodium may result in reduction of gastrointestinal side effects in some patients.

CNS Effects

Sedative effects have occurred in patients receiving valproate alone but occur most often in patients receiving combination therapy. Sedation usually abates upon reduction of other antiepileptic medication. Tremor (may be dose-related), hallucinations, ataxia, headache, nystagmus, diplopia, asterixis, "spots before eyes", dysarthria, dizziness, confusion, hypesthesia, vertigo, incoordination, and parkinsonism have been reported with the use of

valproate. Rare cases of coma have occurred in patients receiving valproate alone or in conjunction with phenobarbital. In rare instances encephalopathy with or without fever has developed shortly after the introduction of valproate monotherapy without evidence of hepatic dysfunction or inappropriately high plasma valproate levels. Although recovery has been described following drug withdrawal, there have been fatalities in patients with hyperammonemic encephalopathy, particularly in patients with underlying urea cycle disorders (see **WARNINGS – Urea Cycle Disorders** and **PRECAUTIONS**).

Several reports have noted reversible cerebral atrophy and dementia in association with valproate therapy.

Dermatologic

Transient hair loss, skin rash, photosensitivity, generalized pruritus, erythema multiforme, and Stevens-Johnson syndrome. Rare cases of toxic epidermal necrolysis have been reported including a fatal case in a 6 month old infant taking valproate and several other concomitant medications. An additional case of toxic epidermal necrosis resulting in death was reported in a 35 year old patient with AIDS taking several concomitant medications and with a history of multiple cutaneous drug reactions. Serious skin reactions have been reported with concomitant administration of lamotrigine and valproate (see **PRECAUTIONS - Drug Interactions**).

Psychiatric

Emotional upset, depression, psychosis, aggression, hyperactivity, hostility, and behavioral deterioration.

Musculoskeletal

Weakness.

Hematologic

Thrombocytopenia and inhibition of the secondary phase of platelet aggregation may be reflected in altered bleeding time, petechiae, bruising, hematoma formation, epistaxis, and frank hemorrhage (see **PRECAUTIONS - General** and **Drug Interactions**). Relative lymphocytosis, macrocytosis, hypofibrinogenemia, leukopenia, eosinophilia, anemia including macrocytic with or without folate deficiency, bone marrow suppression, pancytopenia, aplastic anemia, agranulocytosis, and acute intermittent porphyria.

Hepatic

Minor elevations of transaminases (eg, SGOT and SGPT) and LDH are frequent and appear to be dose-related. Occasionally, laboratory test results include increases in serum bilirubin and abnormal changes in other liver function tests. These results may reflect potentially serious hepatotoxicity (see **WARNINGS**).

Endocrine

Irregular menses, secondary amenorrhea, breast enlargement, galactorrhea, and parotid gland swelling. Abnormal thyroid function tests (see **PRECAUTIONS**).

There have been rare spontaneous reports of polycystic ovary disease. A cause and effect relationship has not been established.

Pancreatic

Acute pancreatitis including fatalities (see **WARNINGS**) .

Metabolic

Hyperammonemia (see **PRECAUTIONS**) , hyponatremia, and inappropriate ADH secretion.

There have been rare reports of Fanconi's syndrome occurring chiefly in children.

Decreased carnitine concentrations have been reported although the clinical relevance is undetermined.

Hyperglycinemia has occurred and was associated with a fatal outcome in a patient with preexistent nonketotic hyperglycinemia.

Genitourinary

Enuresis and urinary tract infection.

Special Senses

Hearing loss, either reversible or irreversible, has been reported; however, a cause and effect relationship has not been established. Ear pain has also been reported.

Other

Allergic reaction, anaphylaxis, edema of the extremities, lupus erythematosus, bone pain, cough increased, pneumonia, otitis media, bradycardia, cutaneous vasculitis, fever, and hypothermia.

OVERDOSAGE

Overdosage with valproate may result in somnolence, heart block, and deep coma. Fatalities have been reported; however patients have recovered from valproate levels as high as 2120 µg/mL.

In overdose situations, the fraction of drug not bound to protein is high and hemodialysis or tandem hemodialysis plus hemoperfusion may result in significant removal of drug. The benefit of gastric lavage or emesis will vary with the time since ingestion. General supportive measures should be applied with particular attention to the maintenance of adequate urinary output.

Naloxone has been reported to reverse the CNS depressant effects of valproate overdose. Because naloxone could theoretically also reverse the antiepileptic effects of valproate, it should be used with caution in patients with epilepsy.

DOSAGE AND ADMINISTRATION

Mania

DEPAKOTE tablets are administered orally. The recommended initial dose is 750 mg daily in divided doses. The dose should be increased as rapidly as possible to achieve the lowest therapeutic dose which produces the desired clinical effect or the desired range of plasma concentrations. In placebo-controlled clinical trials of acute mania, patients were dosed to a clinical response with a trough plasma concentration between 50 and

125 µg/mL. Maximum concentrations were generally achieved within 14 days. The maximum recommended dosage is 60 mg/kg/day.

There is no body of evidence available from controlled trials to guide a clinician in the longer term management of a patient who improves during DEPAKOTE treatment of an acute manic episode. While it is generally agreed that pharmacological treatment beyond an acute response in mania is desirable, both for maintenance of the initial response and for prevention of new manic episodes, there are no systematically obtained data to support the benefits of DEPAKOTE in such longer-term treatment. Although there are no efficacy data that specifically address longer-term antimanic treatment with DEPAKOTE, the safety of DEPAKOTE in long-term use is supported by data from record reviews involving approximately 360 patients treated with DEPAKOTE for greater than 3 months.

Epilepsy

DEPAKOTE tablets are administered orally. DEPAKOTE is indicated as monotherapy and adjunctive therapy in complex partial seizures in adults and pediatric patients down to the age of 10 years, and in simple and complex absence seizures. As the DEPAKOTE dosage is titrated upward, concentrations of phenobarbital, carbamazepine, and/or phenytoin may be affected (see **PRECAUTIONS - Drug Interactions**).

Complex Partial Seizures

For adults and children 10 years of age or older.

Monotherapy (Initial Therapy)

DEPAKOTE has not been systematically studied as initial therapy. Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made.

The probability of thrombocytopenia increases significantly at total trough valproate plasma concentrations above 110 µg/mL in females and 135 µg/mL in males. The benefit of improved seizure control with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

Conversion to Monotherapy

Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 - 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. Concomitant antiepilepsy drug (AED) dosage can ordinarily be reduced by approximately 25% every 2 weeks. This reduction may be started at initiation of DEPAKOTE therapy, or delayed by 1 to 2 weeks if there is a concern that seizures are likely to occur with a reduction. The speed and duration of withdrawal of the concomitant AED can be highly variable, and patients should be monitored closely during this period for increased seizure frequency.

Adjunctive Therapy

DEPAKOTE may be added to the patient's regimen at a dosage of 10 to 15 mg/kg/day. The dosage may be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. If the total daily dose exceeds 250 mg, it should be given in divided doses.

In a study of adjunctive therapy for complex partial seizures in which patients were receiving either carbamazepine or phenytoin in addition to DEPAKOTE, no adjustment of carbamazepine or phenytoin dosage was needed (see **CLINICAL STUDIES**). However, since valproate may interact with these or other concurrently administered AEDs as well as other drugs (see **Drug Interactions**), periodic plasma concentration determinations of concomitant AEDs are recommended during the early course of therapy (see **PRECAUTIONS - Drug Interactions**).

Simple and Complex Absence Seizures

The recommended initial dose is 15 mg/kg/day, increasing at one week intervals by 5 to 10 mg/kg/day until seizures are controlled or side effects preclude further increases. The maximum recommended dosage is 60 mg/kg/day. If the total daily dose exceeds 250 mg, it should be given in divided doses.

A good correlation has not been established between daily dose, serum concentrations, and therapeutic effect. However, therapeutic valproate serum concentrations for most patients with absence seizures is considered to range from 50 to 100 µg/mL. Some patients may be controlled with lower or higher serum concentrations (see **CLINICAL PHARMACOLOGY**).

As the DEPAKOTE dosage is titrated upward, blood concentrations of phenobarbital and/or phenytoin may be affected (see **PRECAUTIONS**).

Antiepilepsy drugs should not be abruptly discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life.

In epileptic patients previously receiving DEPAKENE (valproic acid) therapy, DEPAKOTE tablets should be initiated at the same daily dose and dosing schedule. After the patient is stabilized on DEPAKOTE tablets, a dosing schedule of two or three times a day may be elected in selected patients.

Migraine

DEPAKOTE tablets are administered orally. The recommended starting dose is 250 mg twice daily. Some patients may benefit from doses up to 1000 mg/day. In the clinical trials, there was no evidence that higher doses led to greater efficacy.

General Dosing Advice

Dosing in Elderly Patients

Due to a decrease in unbound clearance of valproate and possibly a greater sensitivity to somnolence in the elderly, the starting dose should be reduced in these patients. Dosage

should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence. The ultimate therapeutic dose should be achieved on the basis of both tolerability and clinical response (see **WARNINGS**).

Dose-Related Adverse Events

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia) may be dose-related. The probability of thrombocytopenia appears to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males) (see **PRECAUTIONS**). The benefit of improved therapeutic effect with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

G.I. Irritation

Patients who experience G.I. irritation may benefit from administration of the drug with food or by slowly building up the dose from an initial low level.

HOW SUPPLIED

DEPAKOTE tablets (divalproex sodium delayed-release tablets) are supplied as:

125 mg salmon pink-colored tablets:

Bottles of 100.....(**NDC** 0074-6212-13)

Abbo-Pac[®] unit dose packages of 100.....(**NDC** 0074-6212-11).

250 mg peach-colored tablets:

Bottles of 100.....(**NDC** 0074-6214-13)

Bottles of 500.....(**NDC** 0074-6214-53)

Abbo-Pac[®] unit dose packages of 100.....(**NDC** 0074-6214-11).

500 mg lavender-colored tablets:

Bottles of 100.....(**NDC** 0074-6215-13)

Bottles of 500.....(**NDC** 0074-6215-53)

Abbo-Pac[®] unit dose packages of 100.....(**NDC** 0074-6215-11).

Recommended storage

Store tablets below 86°F (30°C).

Patient Information Leaflet

Important Information for Women Who Could Become Pregnant About the Use of DEPAKOTE®, DEPAKOTE® ER, DEPAKOTE® Sprinkle Capsules, and DEPAKENE®.

Please read this leaflet carefully before you take any of these medications. This leaflet provides a summary of important information about taking these medications to women

who could become pregnant. If you have any questions or concerns, or want more information about these medications, contact your doctor or pharmacist.

Information For Women Who Could Become Pregnant

These medications can be obtained only by prescription from your doctor. The decision to use any of these medications is one that you and your doctor should make together, taking into account your individual needs and medical condition.

Before using any of these medications, women who can become pregnant should consider the fact that these medications have been associated with birth defects, in particular, with spina bifida and other defects related to failure of the spinal canal to close normally. Approximately 1 to 2% of children born to women with epilepsy taking DEPAKOTE in the first 12 weeks of pregnancy had these defects (based on data from the Centers for Disease Control, a U.S. agency based in Atlanta). The incidence in the general population is 0.1 to 0.2%.

These medications have also been associated with other birth defects such as defects of the heart, the bones, and other parts of the body. Information suggests that birth defects may be more likely to occur with these medications than some other drugs that treat your medical condition.

Information For Women Who Are Planning to Get Pregnant

- Women taking any of these medications who are planning to get pregnant should discuss the treatment options with their doctor.

Information For Women Who Become Pregnant

- If you become pregnant while taking any of these medications you should contact your doctor immediately.

Other Important Information

- Your medication should be taken exactly as prescribed by your doctor to get the most benefit from your medication and reduce the risk of side effects.
- If you have taken more than the prescribed dose of your medication, contact your hospital emergency room or local poison center immediately.
- Your medication was prescribed for your particular condition. Do not use it for another condition or give the drug to others.

Facts About Birth Defects

It is important to know that birth defects may occur even in children of individuals not taking any medications or without any additional risk factors.

This summary provides important information about the use of DEPAKOTE®, DEPAKOTE® ER, DEPAKOTE® Sprinkle Capsules, and DEPAKENE® to women who could become pregnant. If you would like more information about the other potential risks and benefits of these medications, ask your doctor or pharmacist to let you read the professional labeling and then discuss it with them. If you have any questions or concerns about taking these medications, you should discuss them with your doctor.

Manufactured by Abbott Pharmaceuticals PR Ltd.

Barceloneta, PR 00617

DN1173V1 03-5466Depakote Tablets
July 12, 2006 Page 37 of 37

for

Abbott Laboratories

North Chicago, IL 60064, U.S.A.

DEPAKENE®
valproic acid
capsules and oral solution, USP

BOX WARNING

HEPATOTOXICITY

HEPATIC FAILURE RESULTING IN FATALITIES HAS OCCURRED IN PATIENTS RECEIVING VALPROIC ACID. EXPERIENCE HAS INDICATED THAT CHILDREN UNDER THE AGE OF TWO YEARS ARE AT A CONSIDERABLY INCREASED RISK OF DEVELOPING FATAL HEPATOTOXICITY, ESPECIALLY THOSE ON MULTIPLE ANTICONVULSANTS, THOSE WITH CONGENITAL METABOLIC DISORDERS, THOSE WITH SEVERE SEIZURE DISORDERS ACCOMPANIED BY MENTAL RETARDATION, AND THOSE WITH ORGANIC BRAIN DISEASE. WHEN DEPAKENE PRODUCTS ARE USED IN THIS PATIENT GROUP, THEY SHOULD BE USED WITH EXTREME CAUTION AND AS A SOLE AGENT. THE BENEFITS OF THERAPY SHOULD BE WEIGHED AGAINST THE RISKS. ABOVE THIS AGE GROUP, EXPERIENCE IN EPILEPSY HAS INDICATED THAT THE INCIDENCE OF FATAL HEPATOTOXICITY DECREASES CONSIDERABLY IN PROGRESSIVELY OLDER PATIENT GROUPS.

THESE INCIDENTS USUALLY HAVE OCCURRED DURING THE FIRST SIX MONTHS OF TREATMENT. SERIOUS OR FATAL HEPATOTOXICITY MAY BE PRECEDED BY NON-SPECIFIC SYMPTOMS SUCH AS MALAISE, WEAKNESS, LETHARGY, FACIAL EDEMA, ANOREXIA, AND VOMITING. IN PATIENTS WITH EPILEPSY, A LOSS OF SEIZURE CONTROL MAY ALSO OCCUR. PATIENTS SHOULD BE MONITORED CLOSELY FOR APPEARANCE OF THESE SYMPTOMS. LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS.

TERATOGENICITY

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS SUCH AS NEURAL TUBE DEFECTS (E.G., SPINA BIFIDA). ACCORDINGLY, THE USE OF VALPROATE PRODUCTS IN WOMEN OF CHILDBEARING POTENTIAL REQUIRES THAT THE BENEFITS OF ITS USE BE WEIGHED AGAINST THE RISK OF INJURY TO THE FETUS. THIS IS ESPECIALLY IMPORTANT WHEN THE TREATMENT OF A SPONTANEOUSLY REVERSIBLE CONDITION NOT ORDINARILY ASSOCIATED WITH PERMANENT INJURY OR RISK OF DEATH (E.G., MIGRAINE) IS CONTEMPLATED. SEE WARNINGS, INFORMATION FOR PATIENTS.

AN INFORMATION SHEET DESCRIBING THE TERATOGENIC POTENTIAL OF VALPROATE IS AVAILABLE FOR PATIENTS.

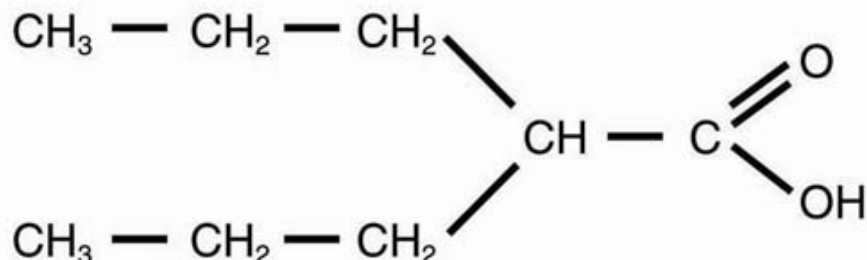
PANCREATITIS

CASES OF LIFE-THREATENING PANCREATITIS HAVE BEEN REPORTED IN BOTH CHILDREN AND ADULTS RECEIVING VALPROATE. SOME OF THE CASES HAVE BEEN DESCRIBED AS HEMORRHAGIC WITH A RAPID PROGRESSION FROM INITIAL SYMPTOMS TO DEATH. CASES HAVE BEEN REPORTED SHORTLY AFTER INITIAL USE AS WELL AS AFTER SEVERAL YEARS OF USE. PATIENTS AND GUARDIANS SHOULD BE WARNED THAT ABDOMINAL PAIN, NAUSEA, VOMITING, AND/OR ANOREXIA CAN BE SYMPTOMS OF PANCREATITIS THAT REQUIRE

PROMPT MEDICAL EVALUATION. IF PANCREATITIS IS DIAGNOSED, VALPROATE SHOULD ORDINARILY BE DISCONTINUED. ALTERNATIVE TREATMENT FOR THE UNDERLYING MEDICAL CONDITION SHOULD BE INITIATED AS CLINICALLY INDICATED. (See **WARNINGS** and **PRECAUTIONS** .)

DESCRIPTION

DEPAKENE (valproic acid) is a carboxylic acid designated as 2-propylpentanoic acid. It is also known as dipropylacetic acid. Valproic acid has the following structure:



Valproic acid (pKa 4.8) has a molecular weight of 144 and occurs as a colorless liquid with a characteristic odor. It is slightly soluble in water (1.3 mg/mL) and very soluble in organic solvents.

DEPAKENE capsules and syrup are antiepileptics for oral administration. Each soft elastic capsule contains 250 mg valproic acid. The syrup contains the equivalent of 250 mg valproic acid per 5 mL as the sodium salt.

Inactive Ingredients

250 mg capsules: corn oil, FD&C Yellow No. 6, gelatin, glycerin, iron oxide, methylparaben, propylparaben, and titanium dioxide.

Oral Solution: FD&C Red No. 40, glycerin, methylparaben, propylparaben, sorbitol, sucrose, water, and natural and artificial flavors.

CLINICAL PHARMACOLOGY

Pharmacodynamics

Valproic acid dissociates to the valproate ion in the gastrointestinal tract. The mechanisms by which valproate exerts its antiepileptic effects have not been established. It has been suggested that its activity in epilepsy is related to increased brain concentrations of gamma-aminobutyric acid (GABA).

Pharmacokinetics

Absorption/Bioavailability

Equivalent oral doses of DEPAKOTE (divalproex sodium) products and DEPAKENE (valproic acid) capsules deliver equivalent quantities of valproate ion systemically. Although the rate of valproate ion absorption may vary with the formulation administered

(liquid, solid, or sprinkle), conditions of use (e.g., fasting or postprandial) and the method of administration (e.g., whether the contents of the capsule are sprinkled on food or the capsule is taken intact), these differences should be of minor clinical importance under the steady state conditions achieved in chronic use in the treatment of epilepsy.

However, it is possible that differences among the various valproate products in T_{max} and C_{max} could be important upon initiation of treatment. For example, in single dose studies, the effect of feeding had a greater influence on the rate of absorption of the DEPAKOTE tablet (increase in T_{max} from 4 to 8 hours) than on the absorption of the DEPAKOTE sprinkle capsules (increase in T_{max} from 3.3 to 4.8 hours).

While the absorption rate from the G.I. tract and fluctuation in valproate plasma concentrations vary with dosing regimen and formulation, the efficacy of valproate as an anticonvulsant in chronic use is unlikely to be affected. Experience employing dosing regimens from once-a-day to four-times-a-day, as well as studies in primate epilepsy models involving constant rate infusion, indicate that total daily systemic bioavailability (extent of absorption) is the primary determinant of seizure control and that differences in the ratios of plasma peak to trough concentrations between valproate formulations are inconsequential from a practical clinical standpoint.

Co-administration of oral valproate products with food and substitution among the various DEPAKOTE and DEPAKENE formulations should cause no clinical problems in the management of patients with epilepsy (see **DOSAGE AND ADMINISTRATION**). Nonetheless, any changes in dosage administration, or the addition or discontinuance of concomitant drugs should ordinarily be accompanied by close monitoring of clinical status and valproate plasma concentrations.

Distribution

Protein Binding

The plasma protein binding of valproate is concentration dependent and the free fraction increases from approximately 10% at 40 $\mu\text{g/mL}$ to 18.5% at 130 $\mu\text{g/mL}$. Protein binding of valproate is reduced in the elderly, in patients with chronic hepatic diseases, in patients with renal impairment, and in the presence of other drugs (e.g., aspirin). Conversely, valproate may displace certain protein-bound drugs (e.g., phenytoin, carbamazepine, warfarin, and tolbutamide). (See **PRECAUTIONS - Drug Interactions** for more detailed information on the pharmacokinetic interactions of valproate with other drugs.)

CNS Distribution

Valproate concentrations in cerebrospinal fluid (CSF) approximate unbound concentrations in plasma (about 10% of total concentration).

Metabolism

Valproate is metabolized almost entirely by the liver. In adult patients on monotherapy, 30-50% of an administered dose appears in urine as a glucuronide conjugate. Mitochondrial β -oxidation is the other major metabolic pathway, typically accounting for over 40% of the dose. Usually, less than 15-20% of the dose is eliminated by other oxidative mechanisms. Less than 3% of an administered dose is excreted unchanged in urine.

The relationship between dose and total valproate concentration is nonlinear; concentration does not increase proportionally with the dose, but rather, increases to a

lesser extent due to saturable plasma protein binding. The kinetics of unbound drug are linear.

Elimination

Mean plasma clearance and volume of distribution for total valproate are 0.56 L/hr/1.73 m² and 11 L/1.73 m², respectively. Mean plasma clearance and volume of distribution for free valproate are 4.6 L/hr/1.73 m² and 92 L/1.73 m². Mean terminal half-life for valproate monotherapy ranged from 9 to 16 hours following oral dosing regimens of 250 to 1000 mg.

The estimates cited apply primarily to patients who are not taking drugs that affect hepatic metabolizing enzyme systems. For example, patients taking enzyme-inducing antiepileptic drugs (carbamazepine, phenytoin, and phenobarbital) will clear valproate more rapidly. Because of these changes in valproate clearance, monitoring of antiepileptic concentrations should be intensified whenever concomitant antiepileptics are introduced or withdrawn.

Special Populations

Effect of Age

Neonates

Children within the first two months of life have a markedly decreased ability to eliminate valproate compared to older children and adults. This is a result of reduced clearance (perhaps due to delay in development of glucuronosyltransferase and other enzyme systems involved in valproate elimination) as well as increased volume of distribution (in part due to decreased plasma protein binding). For example, in one study, the half-life in children under 10 days ranged from 10 to 67 hours compared to a range of 7 to 13 hours in children greater than 2 months.

Children

Pediatric patients (i.e., between 3 months and 10 years) have 50% higher clearances expressed on weight (i.e., mL/min/kg) than do adults. Over the age of 10 years, children have pharmacokinetic parameters that approximate those of adults.

Elderly

The capacity of elderly patients (age range: 68 to 89 years) to eliminate valproate has been shown to be reduced compared to younger adults (age range: 22 to 26). Intrinsic clearance is reduced by 39%; the free fraction is increased by 44%. Accordingly, the initial dosage should be reduced in the elderly. (See **DOSAGE AND ADMINISTRATION**).

Effect of Gender

There are no differences in the body surface area adjusted unbound clearance between males and females (4.8 ± 0.17 and 4.7 ± 0.07 L/hr per 1.73 m², respectively).

Effect of Race

The effects of race on the kinetics of valproate have not been studied.

Effect of Disease

Liver Disease

(See **BOXED WARNING**, **CONTRAINDICATIONS**, and **WARNINGS**). Liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 patients with acute hepatitis, compared with 6 healthy subjects. In that study, the half-life of valproate was increased from 12 to 18 hours. Liver disease is also associated with decreased albumin concentrations and larger unbound fractions (2 to 2.6 fold increase) of valproate. Accordingly, monitoring of total concentrations may be misleading since free concentrations may be substantially elevated in patients with hepatic disease whereas total concentrations may appear to be normal.

Renal Disease

A slight reduction (27%) in the unbound clearance of valproate has been reported in patients with renal failure (creatinine clearance < 10 mL/minute); however, hemodialysis typically reduces valproate concentrations by about 20%. Therefore, no dosage adjustment appears to be necessary in patients with renal failure. Protein binding in these patients is substantially reduced; thus, monitoring total concentrations may be misleading.

Plasma Levels and Clinical Effect

The relationship between plasma concentration and clinical response is not well documented. One contributing factor is the nonlinear, concentration dependent protein binding of valproate which affects the clearance of the drug. Thus, monitoring of total serum valproate cannot provide a reliable index of the bioactive valproate species.

For example, because the plasma protein binding of valproate is concentration dependent, the free fraction increases from approximately 10% at 40 µg/mL to 18.5% at 130 µg/mL. Higher than expected free fractions occur in the elderly, in hyperlipidemic patients, and in patients with hepatic and renal diseases.

Epilepsy

The therapeutic range is commonly considered to be 50 to 100 µg/mL of total valproate, although some patients may be controlled with lower or higher plasma concentrations.

Clinical Trials

The studies described in the following section were conducted using DEPAKOTE (divalproex sodium) tablets.

Epilepsy

The efficacy of DEPAKOTE in reducing the incidence of complex partial seizures (CPS) that occur in isolation or in association with other seizure types was established in two controlled trials.

In one, multiclinic, placebo controlled study employing an add-on design (adjunctive therapy), 144 patients who continued to suffer eight or more CPS per 8 weeks during an 8 week period of monotherapy with doses of either carbamazepine or phenytoin sufficient to assure plasma concentrations within the "therapeutic range" were randomized to receive, in addition to their original antiepilepsy drug (AED), either DEPAKOTE or placebo. Randomized patients were to be followed for a total of 16 weeks. The following table presents the findings.

Adjunctive Therapy Study Median Incidence of CPS per 8 Weeks

Add-on Treatment	Number of Patients	Baseline Incidence	Experimental Incidence
DEPAKOTE	75	16.0	8.9*
Placebo	69	14.5	11.5

* Reduction from baseline statistically significantly greater for DEPAKOTE than placebo at $p \leq 0.05$ level.

Figure 1 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the adjunctive therapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for an effective treatment is shifted to the left of the curve for placebo. This figure shows that the proportion of patients achieving any particular level of improvement was consistently higher for DEPAKOTE than for placebo. For example, 45% of patients treated with DEPAKOTE had a $\geq 50\%$ reduction in complex partial seizure rate compared to 23% of patients treated with placebo.

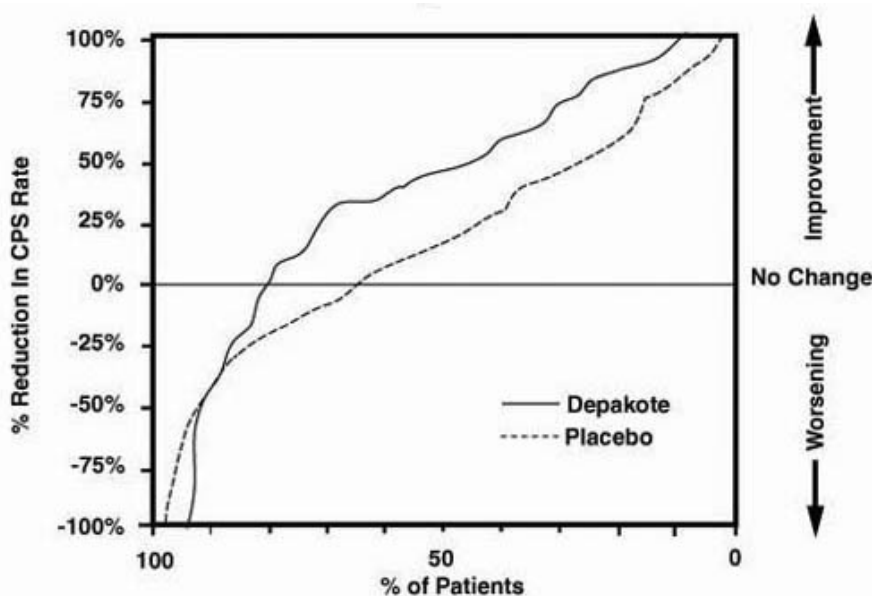


Figure 1.

The second study assessed the capacity of DEPAKOTE to reduce the incidence of CPS when administered as the sole AED. The study compared the incidence of CPS among patients randomized to either a high or low dose treatment arm. Patients qualified for entry into the randomized comparison phase of this study only if 1) they continued to experience 2 or more CPS per 4 weeks during an 8 to 12 week long period of monotherapy with adequate doses of an AED (i.e., phenytoin, carbamazepine, phenobarbital, or primidone) and 2) they made a successful transition over a two week interval to DEPAKOTE. Patients entering the randomized phase were then brought to their assigned target dose, gradually tapered off their concomitant AED and followed for an interval as long as 22 weeks. Less than 50% of the patients randomized, however, completed the study. In patients converted

to DEPAKOTE monotherapy, the mean total valproate concentrations during monotherapy were 71 and 123 µg/mL in the low dose and high dose groups, respectively.

The following table presents the findings for all patients randomized who had at least one post-randomization assessment.

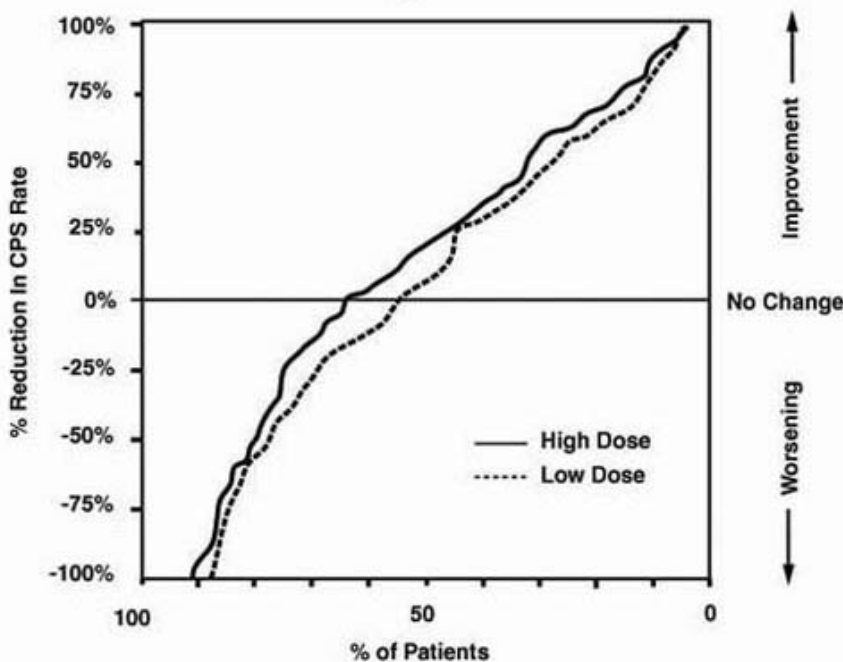
Monotherapy Study Median Incidence of CPS per 8 Weeks

Treatment	Number of Patients	Baseline Incidence	Randomized Phase Incidence
High dose DEPAKOTE	131	13.2	10.7*
Low dose DEPAKOTE	134	14.2	13.8

* Reduction from baseline statistically significantly greater for high dose than low dose at $p \leq 0.05$ level.

Figure 2 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the monotherapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency), while a negative percent reduction indicates worsening. Thus, in a display of this type, the curve for a more effective treatment is shifted to the left of the curve for a less effective treatment. This figure shows that the proportion of patients achieving any particular level of reduction was consistently higher for high dose DEPAKOTE than for low dose DEPAKOTE. For example, when switching from carbamazepine, phenytoin, phenobarbital or primidone monotherapy to high dose DEPAKOTE monotherapy, 63% of patients experienced no change or a reduction in complex partial seizure rates compared to 54% of patients receiving low dose DEPAKOTE.

Figure 2.



INDICATIONS AND USAGE

DEPAKENE (valproic acid) is indicated as monotherapy and adjunctive therapy in the treatment of patients with complex partial seizures that occur either in isolation or in association with other types of seizures. DEPAKENE (valproic acid) is indicated for use as sole and adjunctive therapy in the treatment of simple and complex absence seizures, and adjunctively in patients with multiple seizure types which include absence seizures.

Simple absence is defined as very brief clouding of the sensorium or loss of consciousness accompanied by certain generalized epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

SEE **WARNINGS** FOR STATEMENT REGARDING FATAL HEPATIC DYSFUNCTION.

CONTRAINDICATIONS

VALPROIC ACID SHOULD NOT BE ADMINISTERED TO PATIENTS WITH HEPATIC DISEASE OR SIGNIFICANT HEPATIC DYSFUNCTION.

Valproic acid is contraindicated in patients with known hypersensitivity to the drug.

Valproic acid is contraindicated in patients with known urea cycle disorders (see **WARNINGS**).

WARNINGS

Hepatotoxicity

Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid. These incidents usually have occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as malaise, weakness, lethargy, facial edema, anorexia, and vomiting. In patients with epilepsy, a loss of seizure control may also occur. Patients should be monitored closely for appearance of these symptoms. Liver function tests should be performed prior to therapy and at frequent intervals thereafter, especially during the first six months. However, physicians should not rely totally on serum biochemistry since these tests may not be abnormal in all instances, but should also consider the results of careful interim medical history and physical examination.

Caution should be observed when administering DEPAKENE (valproic acid) to patients with a prior history of hepatic disease. Patients on multiple anticonvulsants, children, those with congenital metabolic disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease may be at particular risk. Experience has indicated that children under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions. When DEPAKENE products are used in this patient group, they should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above this age group, experience has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of drug.

Pancreatitis

Cases of life-threatening pancreatitis have been reported in both children and adults receiving valproate. Some of the cases have been described as hemorrhagic with rapid progression from initial symptoms to death. Some cases have occurred shortly after initial use as well as after several years of use. The rate based upon the reported cases exceeds that expected in the general population and there have been cases in which pancreatitis recurred after rechallenge with valproate. In clinical trials, there were 2 cases of pancreatitis without alternative etiology in 2416 patients, representing 1044 patient-years experience. Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical evaluation. If pancreatitis is diagnosed, valproate should ordinarily be discontinued. Alternative treatment for the underlying medical condition should be initiated as clinically indicated (see **BOXED WARNING**).

Urea Cycle Disorders (UCD)

Valproic acid is contraindicated in patients with known urea cycle disorders.

Hyperammonemic encephalopathy, sometimes fatal, has been reported following initiation of valproate therapy in patients with urea cycle disorders, a group of uncommon genetic abnormalities, particularly ornithine transcarbamylase deficiency. Prior to the initiation of valproate therapy, evaluation for UCD should be considered in the following patients: 1) those with a history of unexplained encephalopathy or coma, encephalopathy associated with a protein load, pregnancy-related or postpartum encephalopathy, unexplained mental retardation, or history of elevated plasma ammonia or glutamine; 2) those with cyclical vomiting and lethargy, episodic extreme irritability, ataxia, low BUN, or protein avoidance; 3) those with a family history of UCD or a family history of unexplained infant deaths (particularly males); 4) those with other signs or symptoms of UCD. Patients who develop symptoms of unexplained hyperammonemic encephalopathy while receiving valproate therapy should receive prompt treatment (including discontinuation of valproate therapy) and be evaluated for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **PRECAUTIONS**).

Somnolence in the Elderly

In a double-blind, multicenter trial of valproate in elderly patients with dementia (mean age = 83 years), doses were increased by 125 mg/day to a target dose of 20 mg/kg/day. A significantly higher proportion of valproate patients had somnolence compared to placebo, and although not statistically significant, there was a higher proportion of patients with dehydration. Discontinuations for somnolence were also significantly higher than with placebo. In some patients with somnolence (approximately one-half), there was associated reduced nutritional intake and weight loss. There was a trend for the patients who experienced these events to have a lower baseline albumin concentration, lower valproate clearance, and a higher BUN. In elderly patients, dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate

should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

Thrombocytopenia

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia [see **PRECAUTIONS**]) may be dose-related. In a clinical trial of DEPAKOTE (divalproex sodium) as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). The therapeutic benefit which may accompany the higher doses should therefore be weighed against the possibility of a greater incidence of adverse effects.

Usage in Pregnancy

VALPROATE CAN PRODUCE TERATOGENIC EFFECTS. DATA SUGGEST THAT THERE IS AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS ASSOCIATED WITH THE USE OF VALPROATE BY WOMEN WITH SEIZURE DISORDERS DURING PREGNANCY WHEN COMPARED TO THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO DO NOT USE ANTIEPILEPTIC DRUGS DURING PREGNANCY, THE INCIDENCE IN WOMEN WITH SEIZURE DISORDERS WHO USE OTHER ANTIEPILEPTIC DRUGS, AND THE BACKGROUND INCIDENCE FOR THE GENERAL POPULATION. THEREFORE, VALPROATE SHOULD BE CONSIDERED FOR WOMEN OF CHILDBEARING POTENTIAL ONLY AFTER THE RISKS HAVE BEEN THOROUGHLY DISCUSSED WITH THE PATIENT AND WEIGHED AGAINST THE POTENTIAL BENEFITS OF TREATMENT.

THERE ARE MULTIPLE REPORTS IN THE CLINICAL LITERATURE THAT INDICATE THE USE OF ANTIEPILEPTIC DRUGS DURING PREGNANCY RESULTS IN AN INCREASED INCIDENCE OF CONGENITAL MALFORMATIONS IN OFFSPRING. ANTIEPILEPTIC DRUGS, INCLUDING VALPROATE, SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING POTENTIAL ONLY IF THEY ARE CLEARLY SHOWN TO BE ESSENTIAL IN THE MANAGEMENT OF THEIR MEDICAL CONDITION.

Antiepileptic drugs should not be discontinued abruptly in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

HUMAN DATA

Congenital Malformations

The North American Antiepileptic Drug Pregnancy Registry reported 16 cases of congenital malformations among the offspring of 149 women with epilepsy who were exposed to valproic acid monotherapy during the first trimester of pregnancy at doses of

approximately 1,000 mg per day, for a prevalence rate of 10.7% (95% CI 6.3%-16.9%). Three of the 149 offspring (2%) had neural tube defects and 6 of the 149 (4%) had less severe malformations. Among epileptic women who were exposed to other antiepileptic drug monotherapies during pregnancy (1,048 patients) the malformation rate was 2.9% (95% CI 2.0% to 4.1%). There was a 4-fold increase in congenital malformations among infants with valproic acid-exposed mothers compared with those treated with other antiepileptic monotherapies as a group (Odds Ratio 4.0; 95% CI 2.1 to 7.4). This increased risk does not reflect a comparison versus any specific antiepileptic drug, but the risk versus the heterogeneous group of all other antiepileptic drug monotherapies combined. The increased teratogenic risk from valproic acid in women with epilepsy is expected to be reflected in an increased risk in other indications (e.g., migraine or bipolar disorder).

THE STRONGEST ASSOCIATION OF MATERNAL VALPROATE USAGE WITH CONGENITAL MALFORMATIONS IS WITH NEURAL TUBE DEFECTS (AS DISCUSSED UNDER THE NEXT SUBHEADING). HOWEVER, OTHER CONGENITAL ANOMALIES (E.G. CRANIOFACIAL DEFECTS, CARDIOVASCULAR MALFORMATIONS AND ANOMALIES INVOLVING VARIOUS BODY SYSTEMS), COMPATIBLE AND INCOMPATIBLE WITH LIFE, HAVE BEEN REPORTED. SUFFICIENT DATA TO DETERMINE THE INCIDENCE OF THESE CONGENITAL ANOMALIES IS NOT AVAILABLE.

Neural Tube Defects

THE INCIDENCE OF NEURAL TUBE DEFECTS IN THE FETUS IS INCREASED IN MOTHERS RECEIVING VALPROATE DURING THE FIRST TRIMESTER OF PREGNANCY. THE CENTERS FOR DISEASE CONTROL (CDC) HAS ESTIMATED THE RISK OF VALPROIC ACID EXPOSED WOMEN HAVING CHILDREN WITH SPINA BIFIDA TO BE APPROXIMATELY 1 TO 2%. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG) ESTIMATES THE GENERAL POPULATION RISK FOR CONGENITAL NEURAL TUBE DEFECTS AS 0.14% TO 0.2%.

Tests to detect neural tube and other defects using current accepted procedures should be considered a part of routine prenatal care in pregnant women receiving valproate.

Evidence suggests that pregnant women who receive folic acid supplementation may be at decreased risk for congenital neural tube defects in their offspring compared to pregnant women not receiving folic acid. Whether the risk of neural tube defects in the offspring of women receiving valproate specifically is reduced by folic acid supplementation is unknown. DIETARY FOLIC ACID SUPPLEMENTATION BOTH PRIOR TO AND DURING PREGNANCY SHOULD BE ROUTINELY RECOMMENDED TO PATIENTS CONTEMPLATING PREGNANCY.

Other Adverse Pregnancy Effects

PATIENTS TAKING VALPROATE MAY DEVELOP CLOTTING ABNORMALITIES (SEE **PRECAUTIONS - GENERAL AND WARNINGS**). A PATIENT WHO HAD LOW FIBRINOGEN WHEN TAKING MULTIPLE ANTICONVULSANTS INCLUDING VALPROATE GAVE BIRTH TO AN INFANT WITH AFIBRINOGENEMIA WHO SUBSEQUENTLY DIED OF HEMORRHAGE. IF VALPROATE IS USED IN PREGNANCY, THE CLOTTING PARAMETERS SHOULD BE MONITORED CAREFULLY.

PATIENTS TAKING VALPROATE MAY DEVELOP HEPATIC FAILURE (SEE **WARNINGS - HEPATOTOXICITY AND BOX WARNING**). FATAL HEPATIC FAILURE, IN A NEWBORN AND IN AN INFANT, HAVE BEEN REPORTED FOLLOWING THE MATERNAL USE OF VALPROATE DURING PREGNANCY.

ANIMAL DATA

Animal studies have demonstrated valproate-induced teratogenicity. Increased frequencies of malformations, as well as intrauterine growth retardation and death, have been observed in mice, rats, rabbits, and monkeys following prenatal exposure to valproate. Malformations of the skeletal system are the most common structural abnormalities produced in experimental animals, but neural tube closure defects have been seen in mice exposed to maternal plasma valproate concentrations exceeding 230 µg/mL (2.3 times the upper limit of the human therapeutic range) during susceptible periods of embryonic development. Administration of an oral dose of 200 mg/kg/day or greater (50% of the maximum human daily dose or greater on a mg/m² basis) to pregnant rats during organogenesis produced malformations (skeletal, cardiac, and urogenital) and growth retardation in the offspring. These doses resulted in peak maternal plasma valproate levels of approximately 340 µg/mL or greater (3.4 times the upper limit of the human therapeutic range or greater). Behavioral deficits have been reported in the offspring of rats given a dose of 200 mg/kg/day throughout most of pregnancy. An oral dose of 350 mg/kg/day (approximately 2 times the maximum human daily dose on a mg/m² basis) produced skeletal and visceral malformations in rabbits exposed during organogenesis. Skeletal malformations, growth retardation, and death were observed in rhesus monkeys following administration of an oral dose of 200 mg/kg/day (equal to the maximum human daily dose on a mg/m² basis) during organogenesis. This dose resulted in peak maternal plasma valproate levels of approximately 280 µg/mL (2.8 times the upper limit of the human therapeutic range).

PRECAUTIONS

Hepatic Dysfunction

See **BOXED WARNING**, **CONTRAINDICATIONS**, and **WARNINGS** .

Pancreatitis

See **BOXED WARNING** and **WARNINGS**.

Hyperammonemia

Hyperammonemia has been reported in association with valproate therapy and may be present despite normal liver function tests. In patients who develop unexplained lethargy and vomiting or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. If ammonia is increased, valproate therapy should be discontinued. Appropriate interventions for treatment of hyperammonemia should be initiated, and such patients should undergo investigation for underlying urea cycle disorders (see **CONTRAINDICATIONS** and **WARNINGS - Urea**

Cycle Disorders and PRECAUTIONS - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use).

Asymptomatic elevations of ammonia are more common and when present, require close monitoring of plasma ammonia levels. If the elevation persists, discontinuation of valproate therapy should be considered.

Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use

Concomitant administration of topiramate and valproic acid has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. Clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level of consciousness and/or cognitive function with lethargy or vomiting. In most cases, symptoms and signs abated with discontinuation of either drug. This adverse event is not due to a pharmacokinetic interaction. It is not known if topiramate monotherapy is associated with hyperammonemia. Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, an interaction of topiramate and valproic acid may exacerbate existing defects or unmask deficiencies in susceptible persons. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders and PRECAUTIONS - Hyperammonemia**).

General

Because of reports of thrombocytopenia (see **WARNINGS**), inhibition of the secondary phase of platelet aggregation, and abnormal coagulation parameters, (e.g., low fibrinogen), platelet counts and coagulation tests are recommended before initiating therapy and at periodic intervals. It is recommended that patients receiving DEPAKENE (valproic acid) be monitored for platelet count and coagulation parameters prior to planned surgery. In a clinical trial of DEPAKOTE (divalproex sodium) as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9/L$. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \mu\text{g/mL}$ (females) or $\geq 135 \mu\text{g/mL}$ (males). Evidence of hemorrhage, bruising, or a disorder of hemostasis/coagulation is an indication for reduction of the dosage or withdrawal of therapy.

Since valproate may interact with concurrently administered drugs which are capable of enzyme induction, periodic plasma concentration determinations of valproate and concomitant drugs are recommended during the early course of therapy (see **PRECAUTIONS - Drug Interactions**).

Valproate is partially eliminated in the urine as a keto-metabolite which may lead to a false interpretation of the urine ketone test.

There have been reports of altered thyroid function tests associated with valproate. The clinical significance of these is unknown.

There are *in vitro* studies that suggest valproate stimulates the replication of the HIV and CMV viruses under certain experimental conditions. The clinical consequence, if any, is not known. Additionally, the relevance of these *in vitro* findings is uncertain for patients receiving maximally suppressive antiretroviral therapy. Nevertheless, these data should be borne in mind when interpreting the results from regular monitoring of the viral load in HIV infected patients receiving valproate or when following CMV infected patients clinically.

Multi-organ Hypersensitivity Reaction

Multi-organ hypersensitivity reactions have been rarely reported in close temporal association to the initiation of valproate therapy in adult and pediatric patients (median time to detection 21 days: range 1 to 40 days). Although there have been a limited number of reports, many of these cases resulted in hospitalization and at least one death has been reported. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement. Other associated manifestations may include lymphadenopathy, hepatitis, liver function test abnormalities, hematological abnormalities (e.g., eosinophilia, thrombocytopenia, neutropenia), pruritis, nephritis, oliguria, hepatorenal syndrome, arthralgia, and asthenia. Because the disorder is variable in its expression, other organ system symptoms and signs, not noted here, may occur. If this reaction is suspected, valproate should be discontinued and an alternative treatment started. Although the existence of cross sensitivity with other drugs that produce this syndrome is unclear, the experience amongst drugs associated with multi-organ hypersensitivity would indicate this to be a possibility.

Information for Patients

Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis and, therefore, require further medical evaluation promptly.

Patients should be informed of the signs and symptoms associated with hyperammonemic encephalopathy (see **PRECAUTIONS - Hyperammonemia**) and be told to inform the prescriber if any of these symptoms occur.

Since DEPAKENE products may produce CNS depression, especially when combined with another CNS depressant (e.g., alcohol), patients should be advised not to engage in hazardous activities, such as driving an automobile or operating dangerous machinery, until it is known that they do not become drowsy from the drug.

Since DEPAKENE has been associated with certain types of birth defects, female patients of child-bearing age considering the use of DEPAKENE should be advised of the risk and of alternative therapeutic options and to read the **Patient Information Leaflet**, which appears as the last section of the labeling. This is especially important when the treatment of a spontaneously reversible condition not ordinarily associated with permanent injury or risk of death (e.g., migraine) is considered.

Patients should be instructed that a fever associated with other organ system involvement (rash, lymphadenopathy, etc.) may be drug-related and should be reported to the physician immediately (see **PRECAUTIONS - Multi-organ Hypersensitivity Reaction**).

Drug Interactions

Effects of Co-Administered Drugs on Valproate Clearance

Drugs that affect the level of expression of hepatic enzymes, particularly those that elevate levels of glucuronosyltransferases, may increase the clearance of valproate. For example, phenytoin, carbamazepine, and phenobarbital (or primidone) can double the clearance of valproate. Thus, patients on monotherapy will generally have longer half-lives and higher concentrations than patients receiving polytherapy with antiepilepsy drugs.

In contrast, drugs that are inhibitors of cytochrome P450 isozymes, e.g., antidepressants, may be expected to have little effect on valproate clearance because cytochrome P450 microsomal mediated oxidation is a relatively minor secondary metabolic pathway compared to glucuronidation and beta-oxidation.

Because of these changes in valproate clearance, monitoring of valproate and concomitant drug concentrations should be increased whenever enzyme inducing drugs are introduced or withdrawn.

The following list provides information about the potential for an influence of several commonly prescribed medications on valproate pharmacokinetics. The list is not exhaustive nor could it be, since new interactions are continuously being reported.

Drugs for Which a Potentially Important Interaction Has Been Observed

Aspirin

A study involving the co-administration of aspirin at antipyretic doses (11 to 16 mg/kg) with valproate to pediatric patients (n = 6) revealed a decrease in protein binding and an inhibition of metabolism of valproate. Valproate free fraction was increased 4-fold in the presence of aspirin compared to valproate alone. The β -oxidation pathway consisting of 2-E-valproic acid, 3-OH-valproic acid, and 3-keto valproic acid was decreased from 25% of total metabolites excreted on valproate alone to 8.3% in the presence of aspirin. Caution should be observed if valproate and aspirin are to be co-administered.

Felbamate

A study involving the co-administration of 1200 mg/day of felbamate with valproate to patients with epilepsy (n = 10) revealed an increase in mean valproate peak concentration by 35% (from 86 to 115 μ g/mL) compared to valproate alone. Increasing the felbamate dose to 2400 mg/day increased the mean valproate peak concentration to 133 μ g/mL (another 16% increase). A decrease in valproate dosage may be necessary when felbamate therapy is initiated.

Meropenem

Subtherapeutic valproic acid levels have been reported when meropenem was co-administered.

Rifampin

A study involving the administration of a single dose of valproate (7 mg/kg) 36 hours after 5 nights of daily dosing with rifampin (600 mg) revealed a 40% increase in the oral clearance of valproate. Valproate dosage adjustment may be necessary when it is co-administered with rifampin.

Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

Antacids

A study involving the co-administration of valproate 500 mg with commonly administered antacids (Maalox, Trisogel, and Titalac - 160 mEq doses) did not reveal any effect on the extent of absorption of valproate.

Chlorpromazine

A study involving the administration of 100 to 300 mg/day of chlorpromazine to schizophrenic patients already receiving valproate (200 mg BID) revealed a 15% increase in trough plasma levels of valproate.

Haloperidol

A study involving the administration of 6 to 10 mg/day of haloperidol to schizophrenic patients already receiving valproate (200 mg BID) revealed no significant changes in valproate trough plasma levels.

Cimetidine and Ranitidine

Cimetidine and ranitidine do not affect the clearance of valproate.

Effects of Valproate on Other Drugs

Valproate has been found to be a weak inhibitor of some P450 isozymes, epoxide hydrase, and glucuronyltransferases.

The following list provides information about the potential for an influence of valproate co-administration on the pharmacokinetics or pharmacodynamics of several commonly prescribed medications. The list is not exhaustive, since new interactions are continuously being reported.

Drugs for Which a Potentially Important Valproate Interaction Has Been Observed

Amitriptyline/Nortriptyline

Administration of a single oral 50 mg dose of amitriptyline to 15 normal volunteers (10 males and 5 females) who received valproate (500 mg BID) resulted in a 21% decrease in plasma clearance of amitriptyline and a 34% decrease in the net clearance of nortriptyline. Rare postmarketing reports of concurrent use of valproate and amitriptyline resulting in an increased amitriptyline level have been received. Concurrent use of valproate and amitriptyline has rarely been associated with toxicity. Monitoring of amitriptyline levels should be considered for patients taking valproate concomitantly with amitriptyline. Consideration should be given to lowering the dose of amitriptyline/nortriptyline in the presence of valproate.

Carbamazepine/carbamazepine-10,11-Epoxide

Serum levels of carbamazepine (CBZ) decreased 17% while that of carbamazepine-10,11-epoxide (CBZ-E) increased by 45% upon co-administration of valproate and CBZ to epileptic patients.

Clonazepam

The concomitant use of valproic acid and clonazepam may induce absence status in patients with a history of absence type seizures.

Diazepam

Valproate displaces diazepam from its plasma albumin binding sites and inhibits its metabolism. Co-administration of valproate (1500 mg daily) increased the free fraction of diazepam (10 mg) by 90% in healthy volunteers (n = 6). Plasma clearance and volume of distribution for free diazepam were reduced by 25% and 20%, respectively, in the presence of valproate. The elimination half-life of diazepam remained unchanged upon addition of valproate.

Ethosuximide

Valproate inhibits the metabolism of ethosuximide. Administration of a single ethosuximide dose of 500 mg with valproate (800 to 1600 mg/day) to healthy volunteers (n = 6) was accompanied by a 25% increase in elimination half-life of ethosuximide and a 15% decrease in its total clearance as compared to ethosuximide alone. Patients receiving valproate and ethosuximide, especially along with other anticonvulsants, should be monitored for alterations in serum concentrations of both drugs.

Lamotrigine

In a steady-state study involving 10 healthy volunteers, the elimination half-life of lamotrigine increased from 26 to 70 hours with valproate co-administration (a 165% increase). The dose of lamotrigine should be reduced when co-administered with valproate. Serious skin reactions (such as Stevens-Johnson Syndrome and toxic epidermal necrolysis) have been reported with concomitant lamotrigine and valproate administration. See lamotrigine package insert for details on lamotrigine dosing with concomitant valproate administration.

Phenobarbital

Valproate was found to inhibit the metabolism of phenobarbital. Co-administration of valproate (250 mg BID for 14 days) with phenobarbital to normal subjects (n = 6) resulted in a 50% increase in half-life and a 30% decrease in plasma clearance of phenobarbital (60 mg single-dose). The fraction of phenobarbital dose excreted unchanged increased by 50% in presence of valproate.

There is evidence for severe CNS depression, with or without significant elevations of barbiturate or valproate serum concentrations. All patients receiving concomitant barbiturate therapy should be closely monitored for neurological toxicity. Serum barbiturate concentrations should be obtained, if possible, and the barbiturate dosage decreased, if appropriate.

Primidone, which is metabolized to a barbiturate, may be involved in a similar interaction with valproate.

Phenytoin

Valproate displaces phenytoin from its plasma albumin binding sites and inhibits its hepatic metabolism. Co-administration of valproate (400 mg TID) with phenytoin (250 mg)

in normal volunteers (n = 7) was associated with a 60% increase in the free fraction of phenytoin. Total plasma clearance and apparent volume of distribution of phenytoin increased 30% in the presence of valproate. Both the clearance and apparent volume of distribution of free phenytoin were reduced by 25%.

In patients with epilepsy, there have been reports of breakthrough seizures occurring with the combination of valproate and phenytoin. The dosage of phenytoin should be adjusted as required by the clinical situation.

Tolbutamide

From *in vitro* experiments, the unbound fraction of tolbutamide was increased from 20% to 50% when added to plasma samples taken from patients treated with valproate. The clinical relevance of this displacement is unknown.

Topiramate

Concomitant administration of valproic acid and topiramate has been associated with hyperammonemia with and without encephalopathy (see **CONTRAINDICATIONS** and **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS - Hyperammonemia and - Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use**).

Warfarin

In an *in vitro* study, valproate increased the unbound fraction of warfarin by up to 32.6%. The therapeutic relevance of this is unknown; however, coagulation tests should be monitored if DEPAKENE therapy is instituted in patients taking anticoagulants.

Zidovudine

In six patients who were seropositive for HIV, the clearance of zidovudine (100 mg q8h) was decreased by 38% after administration of valproate (250 or 500 mg q8h); the half-life of zidovudine was unaffected.

Drugs for Which Either No Interaction or a Likely Clinically Unimportant Interaction Has Been Observed

Acetaminophen

Valproate had no effect on any of the pharmacokinetic parameters of acetaminophen when it was concurrently administered to three epileptic patients.

Clozapine

In psychotic patients (n = 11), no interaction was observed when valproate was co-administered with clozapine.

Lithium

Co-administration of valproate (500 mg BID) and lithium carbonate (300 mg TID) to normal male volunteers (n = 16) had no effect on the steady-state kinetics of lithium.

Lorazepam

Concomitant administration of valproate (500 mg BID) and lorazepam (1 mg BID) in normal male volunteers (n = 9) was accompanied by a 17% decrease in the plasma clearance of lorazepam.

Oral Contraceptive Steroids

Administration of a single-dose of ethinylloestradiol (50 µg)/levonorgestrel (250 µg) to 6 women on valproate (200 mg BID) therapy for 2 months did not reveal any pharmacokinetic interaction.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Valproic acid was administered orally to Sprague Dawley rats and ICR (HA/ICR) mice at doses of 80 and 170 mg/kg/day (approximately 10 to 50% of the maximum human daily dose on a mg/m² basis) for two years. A variety of neoplasms were observed in both species. The chief findings were a statistically significant increase in the incidence of subcutaneous fibrosarcomas in high dose male rats receiving valproic acid and a statistically significant dose-related trend for benign pulmonary adenomas in male mice receiving valproic acid. The significance of these findings for humans is unknown.

Mutagenesis

Valproate was not mutagenic in an *in vitro* bacterial assay (Ames test), did not produce dominant lethal effects in mice, and did not increase chromosome aberration frequency in an *in vivo* cytogenetic study in rats. Increased frequencies of sister chromatid exchange (SCE) have been reported in a study of epileptic children taking valproate, but this association was not observed in another study conducted in adults. There is some evidence that increased SCE frequencies may be associated with epilepsy. The biological significance of an increase in SCE frequency is not known.

Fertility

Chronic toxicity studies in juvenile and adult rats and dogs demonstrated reduced spermatogenesis and testicular atrophy at oral doses of 400 mg/kg/day or greater in rats (approximately equivalent to or greater than the maximum human daily dose on a mg/m² basis) and 150 mg/kg/day or greater in dogs (approximately 1.4 times the maximum human daily dose or greater on a mg/m² basis). Segment I fertility studies in rats have shown oral doses up to 350 mg/kg/day (approximately equal to the maximum human daily dose on a mg/m² basis) for 60 days to have no effect on fertility. THE EFFECT OF VALPROATE ON TESTICULAR DEVELOPMENT AND ON SPERM PRODUCTION AND FERTILITY IN HUMANS IS UNKNOWN.

Pregnancy

Pregnancy Category D: See **WARNINGS** .

Nursing Mothers

Valproate is excreted in breast milk. Concentrations in breast milk have been reported to be 1 - 10% of serum concentrations. It is not known what effect this would have on a

nursing infant. Consideration should be given to discontinuing nursing when valproic acid is administered to a nursing woman.

Pediatric Use

Experience has indicated that pediatric patients under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions (see **BOXED WARNING**). When DEPAKENE is used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above the age of 2 years, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups.

Younger children, especially those receiving enzyme-inducing drugs, will require larger maintenance doses to attain targeted total and unbound valproic acid concentrations.

The variability in free fraction limits the clinical usefulness of monitoring total serum valproic acid concentrations. Interpretation of valproic acid concentrations in children should include consideration of factors that affect hepatic metabolism and protein binding.

The basic toxicology and pathologic manifestations of valproate sodium in neonatal (4-day old) and juvenile (14-day old) rats are similar to those seen in young adult rats. However, additional findings, including renal alterations in juvenile rats and renal alterations and retinal dysplasia in neonatal rats, have been reported. These findings occurred at 240 mg/kg/day, a dosage approximately equivalent to the human maximum recommended daily dose on a mg/m² basis. They were not seen at 90 mg/kg, or 40% of the maximum human daily dose on a mg/m² basis.

Geriatric Use

No patients above the age of 65 years were enrolled in double-blind prospective clinical trials of mania associated with bipolar illness. In a case review study of 583 patients, 72 patients (12%) were greater than 65 years of age. A higher percentage of patients above 65 years of age reported accidental injury, infection, pain, somnolence, and tremor. Discontinuation of valproate was occasionally associated with the latter two events. It is not clear whether these events indicate additional risk or whether they result from preexisting medical illness and concomitant medication use among these patients.

A study of elderly patients with dementia revealed drug related somnolence and discontinuation for somnolence (see **WARNINGS - Somnolence in the Elderly**). The starting dose should be reduced in these patients, and dosage reductions or discontinuation should be considered in patients with excessive somnolence (see **DOSAGE AND ADMINISTRATION**).

ADVERSE REACTIONS

Epilepsy

The data described in the following section were obtained using DEPAKOTE (divalproex sodium) tablets.

Based on a placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures, DEPAKOTE was generally well tolerated with most adverse events rated as mild

to moderate in severity. Intolerance was the primary reason for discontinuation in the DEPAKOTE-treated patients (6%), compared to 1% of placebo-treated patients.

Table 1 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of DEPAKOTE-treated patients and for which the incidence was greater than in the placebo group, in a placebo-controlled trial of adjunctive therapy for the treatment of complex partial seizures. Since patients were also treated with other antiepilepsy drugs, it is not possible, in most cases, to determine whether the following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 1. Adverse Events Reported by $\geq 5\%$ of Patients Treated with DEPAKOTE During Placebo-Controlled Trial of Adjunctive Therapy for Complex Partial Seizures

Body System/Event	Depakote (%) (n = 77)	Placebo (%) (n = 70)
Body as a Whole		
Headache	31	21
Asthenia	27	7
Fever	6	4
Gastrointestinal System		
Nausea	48	14
Vomiting	27	7
Abdominal Pain	23	6
Diarrhea	13	6
Anorexia	12	0
Dyspepsia	8	4
Constipation	5	1
Nervous System		
Somnolence	27	11
Tremor	25	6
Dizziness	25	13
Diplopia	16	9
Amblyopia/Blurred Vision	12	9
Ataxia	8	1
Nystagmus	8	1
Emotional Lability	6	4
Thinking Abnormal	6	0
Amnesia	5	1
Respiratory System		
Flu Syndrome	12	9
Infection	12	6
Bronchitis	5	1
Rhinitis	5	4
Other		
Alopecia	6	1
Weight Loss	6	0

Table 2 lists treatment-emergent adverse events which were reported by $\geq 5\%$ of patients in the high dose DEPAKOTE group, and for which the incidence was greater than in the low dose group, in a controlled trial of DEPAKOTE monotherapy treatment of complex partial seizures. Since patients were being titrated off another antiepilepsy drug during the first portion of the trial, it is not possible, in many cases, to determine whether the

following adverse events can be ascribed to DEPAKOTE alone, or the combination of DEPAKOTE and other antiepilepsy drugs.

Table 2. Adverse Events Reported by \geq 5% of Patients in the High Dose Group in the Controlled Trial of DEPAKOTE Monotherapy for Complex Partial Seizures¹

Body System/Event	High Dose (%) (n = 131)	Low Dose (%) (n = 134)
Body as a Whole		
Asthenia	21	10
Digestive System		
Nausea	34	26
Diarrhea	23	19
Vomiting	23	15
Abdominal Pain	12	9
Anorexia	11	4
Dyspepsia	11	10
Hemic/Lymphatic System		
Thrombocytopenia	24	1
Ecchymosis	5	4
Metabolic/Nutritional		
Weight Gain	9	4
Peripheral Edema	8	3
Nervous System		
Tremor	57	19
Somnolence	30	18
Dizziness	18	13
Insomnia	15	9
Nervousness	11	7
Amnesia	7	4
Nystagmus	7	1
Depression	5	4
Respiratory System		
Infection	20	13
Pharyngitis	8	2
Dyspnea	5	1
Skin and Appendages		
Alopecia	24	13
Special Senses		
Amblyopia/Blurred Vision	8	4
Tinnitus	7	1

¹ Headache was the only adverse event that occurred in \geq 5% of patients in the high dose group and at an equal or greater incidence in the low dose group.

The following additional adverse events were reported by greater than 1% but less than 5% of the 358 patients treated with DEPAKOTE in the controlled trials of complex partial seizures:

Body as a Whole

Back pain, chest pain, malaise.

Cardiovascular System

Tachycardia, hypertension, palpitation.

Digestive System

Increased appetite, flatulence, hematemesis, eructation, pancreatitis, periodontal abscess.

Hemic and Lymphatic System

Petechia.

Metabolic and Nutritional Disorders

SGOT increased, SGPT increased.

Musculoskeletal System

Myalgia, twitching, arthralgia, leg cramps, myasthenia.

Nervous System

Anxiety, confusion, abnormal gait, paresthesia, hypertonia, incoordination, abnormal dreams, personality disorder.

Respiratory System

Sinusitis, cough increased, pneumonia, epistaxis.

Skin and Appendages

Rash, pruritus, dry skin.

Special Senses

Taste perversion, abnormal vision, deafness, otitis media.

Urogenital System

Urinary incontinence, vaginitis, dysmenorrhea, amenorrhea, urinary frequency.

Other Patient Populations

Adverse events that have been reported with all dosage forms of valproate from epilepsy trials, spontaneous reports, and other sources are listed below by body system.

Gastrointestinal

The most commonly reported side effects at the initiation of therapy are nausea, vomiting, and indigestion. These effects are usually transient and rarely require discontinuation of therapy. Diarrhea, abdominal cramps, and constipation have been reported. Both anorexia with some weight loss and increased appetite with weight gain have also been reported. The administration of delayed-release divalproex sodium may result in reduction of gastrointestinal side effects in some patients.

CNS Effects

Sedative effects have occurred in patients receiving valproate alone but occur most often in patients receiving combination therapy. Sedation usually abates upon reduction of other antiepileptic medication. Tremor (may be dose-related), hallucinations, ataxia, headache, nystagmus, diplopia, asterixis, "spots before eyes", dysarthria, dizziness, confusion, hypesthesia, vertigo, incoordination, and Parkinsonism have been reported with the use of valproate. Rare cases of coma have occurred in patients receiving valproate alone or in conjunction with phenobarbital. In rare instances encephalopathy with or without fever has developed shortly after the introduction of valproate monotherapy without evidence of hepatic dysfunction or inappropriately high plasma valproate levels. Although recovery has been described following drug withdrawal, there have been fatalities in patients with hyperammonemic encephalopathy, particularly in patients with underlying urea cycle disorders (see **WARNINGS - Urea Cycle Disorders** and **PRECAUTIONS**).

Several reports have noted reversible cerebral atrophy and dementia in association with valproate therapy.

Dermatologic

Transient hair loss, skin rash, photosensitivity, generalized pruritus, erythema multiforme, and Stevens-Johnson syndrome. Rare cases of toxic epidermal necrolysis have been reported including a fatal case in a 6 month old infant taking valproate and several other concomitant medications. An additional case of toxic epidermal necrosis resulting in death was reported in a 35 year old patient with AIDS taking several concomitant medications and with a history of multiple cutaneous drug reactions. Serious skin reactions have been reported with concomitant administration of lamotrigine and valproate (see **PRECAUTIONS - Drug Interactions**).

Psychiatric

Emotional upset, depression, psychosis, aggression, hyperactivity, hostility, and behavioral deterioration.

Musculoskeletal

Weakness.

Hematologic

Thrombocytopenia and inhibition of the secondary phase of platelet aggregation may be reflected in altered bleeding time, petechiae, bruising, hematoma formation, epistaxis, and frank hemorrhage (see **PRECAUTIONS - General** and **Drug Interactions**). Relative lymphocytosis, macrocytosis, hypofibrinogenemia, leukopenia, eosinophilia, anemia including macrocytic with or without folate deficiency, bone marrow suppression, pancytopenia, aplastic anemia, agranulocytosis, and acute intermittent porphyria.

Hepatic

Minor elevations of transaminases (e.g., SGOT and SGPT) and LDH are frequent and appear to be dose-related. Occasionally, laboratory test results include increases in serum bilirubin and abnormal changes in other liver function tests. These results may reflect potentially serious hepatotoxicity (see **WARNINGS**).

Endocrine

Irregular menses, secondary amenorrhea, breast enlargement, galactorrhea, and parotid gland swelling. Abnormal thyroid function tests (see **PRECAUTIONS**).

There have been rare spontaneous reports of polycystic ovary disease. A cause and effect relationship has not been established.

Pancreatic

Acute pancreatitis, including fatalities (see **WARNINGS**).

Metabolic

Hyperammonemia (see **PRECAUTIONS**), hyponatremia, and inappropriate ADH secretion.

There have been rare reports of Fanconi's syndrome occurring chiefly in children.

Decreased carnitine concentrations have been reported although the clinical relevance is undetermined.

Hyperglycinemia has occurred and was associated with a fatal outcome in a patient with preexistent nonketotic hyperglycinemia.

Genitourinary

Enuresis and urinary tract infection.

Special Senses

Hearing loss, either reversible or irreversible, has been reported; however, a cause and effect relationship has not been established. Ear pain has also been reported.

Other

Allergic reaction, anaphylaxis, edema of the extremities, lupus erythematosus, bone pain, cough increased, pneumonia, otitis media, bradycardia, cutaneous vasculitis, fever, and hypothermia.

Mania

Although DEPAKENE has not been evaluated for safety and efficacy in the treatment of manic episodes associated with bipolar disorder, the following adverse events not listed above were reported by 1% or more of patients from two placebo-controlled clinical trials of DEPAKOTE tablets.

Body as a Whole

Chills, neck pain, neck rigidity.

Cardiovascular System

Hypotension, postural hypotension, vasodilation.

Digestive System

Fecal incontinence, gastroenteritis, glossitis.

Musculoskeletal System

Arthrosis.

Nervous System

Agitation, catatonic reaction, hypokinesia, reflexes increased, tardive dyskinesia, vertigo.

Skin and Appendages

Furunculosis, maculopapular rash, seborrhea.

Special Senses

Conjunctivitis, dry eyes, eye pain.

Urogenital System

Dysuria.

Migraine

Although DEPAKENE has not been evaluated for safety and efficacy in the treatment of prophylaxis of migraine headaches, the following adverse events not listed above were reported by 1% or more of patients from two placebo-controlled clinical trials of DEPAKOTE tablets.

Body as a Whole

Face edema.

Digestive System

Dry mouth, stomatitis.

Urogenital System

Cystitis, metrorrhagia, and vaginal hemorrhage.

OVERDOSAGE

Overdosage with valproate may result in somnolence, heart block, and deep coma. Fatalities have been reported; however, patients have recovered from valproate levels as high as 2120 µg/mL.

In overdose situations, the fraction of drug not bound to protein is high and hemodialysis or tandem hemodialysis plus hemoperfusion may result in significant removal of drug. The benefit of gastric lavage or emesis will vary with the time since ingestion. General supportive measures should be applied with particular attention to the maintenance of adequate urinary output.

Naloxone has been reported to reverse the CNS depressant effects of valproate overdose. Because naloxone could theoretically also reverse the antiepileptic effects of valproate, it should be used with caution in patients with epilepsy.

DOSAGE AND ADMINISTRATION

THE CAPSULES SHOULD BE SWALLOWED WITHOUT CHEWING TO AVOID LOCAL IRRITATION OF THE MOUTH AND THROAT.

DEPAKENE (valproic acid) is administered orally. DEPAKENE is indicated as monotherapy and adjunctive therapy in complex partial seizures in adults and pediatric patients down to the age of 10 years, and in simple and complex absence seizures. As the DEPAKENE dosage is titrated upward, concentrations of phenobarbital, carbamazepine, and/or phenytoin may be affected (see **PRECAUTIONS - Drug Interactions**).

Complex Partial Seizures

For adults and children 10 years of age or older.

Monotherapy (Initial Therapy)

DEPAKENE has not been systematically studied as initial therapy. Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made.

The probability of thrombocytopenia increases significantly at total trough valproate plasma concentrations above 110 µg/mL in females and 135 µg/mL in males. The benefit of improved seizure control with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

Conversion to Monotherapy

Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50-100 µg/mL). No recommendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. Concomitant antiepilepsy drug (AED) dosage can ordinarily be reduced by approximately 25% every 2 weeks. This reduction may be started at initiation of DEPAKENE therapy, or delayed by 1 to 2 weeks if there is a concern that seizures are likely to occur with a reduction. The speed and duration of withdrawal of the concomitant AED can be highly variable, and patients should be monitored closely during this period for increased seizure frequency.

Adjunctive Therapy

DEPAKENE may be added to the patient's regimen at a dosage of 10 to 15 mg/kg/day. The dosage may be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 µg/mL). No recommendation regarding the safety of

valproate for use at doses above 60 mg/kg/day can be made. If the total daily dose exceeds 250 mg, it should be given in divided doses.

In a study of adjunctive therapy for complex partial seizures in which patients were receiving either carbamazepine or phenytoin in addition to DEPAKOTE tablets, no adjustment of carbamazepine or phenytoin dosage was needed (see **CLINICAL STUDIES**). However, since valproate may interact with these or other concurrently administered AEDs as well as other drugs (see **Drug Interactions**), periodic plasma concentration determinations of concomitant AEDs are recommended during the early course of therapy (see **PRECAUTIONS - Drug Interactions**).

Simple and Complex Absence Seizures

The recommended initial dose is 15 mg/kg/day, increasing at one week intervals by 5 to 10 mg/kg/day until seizures are controlled or side effects preclude further increases. The maximum recommended dosage is 60 mg/kg/day. If the total daily dose exceeds 250 mg, it should be given in divided doses.

A good correlation has not been established between daily dose, serum concentrations, and therapeutic effect. However, therapeutic valproate serum concentrations for most patients with absence seizures is considered to range from 50 to 100 µg/mL. Some patients may be controlled with lower or higher serum concentrations (see **CLINICAL PHARMACOLOGY**).

As the DEPAKENE dosage is titrated upward, blood concentrations of phenobarbital and/or phenytoin may be affected (see **PRECAUTIONS**).

Antiepilepsy drugs should not be abruptly discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life.

The following table is a guide for the initial daily dose of DEPAKENE (valproic acid) (15 mg/kg/day):

Weight		Total Daily Dose (mg)	Number of Capsules or Teaspoonfuls of Syrup		
(Kg)	(Lb)		Dose 1	Dose 2	Dose 3
10 - 24.9	22 - 54.9	250	0	0	1
25 - 39.9	55 - 87.9	500	1	0	1
40 - 59.9	88 - 131.9	750	1	1	1
60 - 74.9	132 - 164.9	1,000	1	1	2
75 - 89.9	165 - 197.9	1,250	2	1	2

General Dosing Advice

Dosing in Elderly Patients

Due to a decrease in unbound clearance of valproate and possibly a greater sensitivity to somnolence in the elderly, the starting dose should be reduced in these patients. Dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse events. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid

intake and in patients with excessive somnolence. The ultimate therapeutic dose should be achieved on the basis of both tolerability and clinical response (see **WARNINGS**).

Dose-Related Adverse Events

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia) may be dose-related. The probability of thrombocytopenia appears to increase significantly at total valproate concentrations of ≥ 110 $\mu\text{g/mL}$ (females) or ≥ 135 $\mu\text{g/mL}$ (males) (see **PRECAUTIONS**). The benefit of improved therapeutic effect with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

G.I. Irritation

Patients who experience G.I. irritation may benefit from administration of the drug with food or by slowly building up the dose from an initial low level.

HOW SUPPLIED

DEPAKENE (valproic acid) is available as orange-colored soft gelatin capsules of 250 mg valproic acid, bearing the trademark DEPAKENE for product identification, in bottles of 100 capsules (**NDC 0074-5681-13**), and as a red Oral Solution containing the equivalent of 250 mg valproic acid per 5 mL as the sodium salt in bottles of 16 ounces (**NDC 0074-5682-16**).

Store capsules at 59-77°F (15-25°C). Store Oral Solution below 86°F (30°C).

Patient Information Leaflet

Important Information for Women Who Could Become Pregnant About the Use of DEPAKOTE[®], DEPAKOTE[®] ER, DEPAKOTE[®] Sprinkle Capsules, and DEPAKENE[®].

Please read this leaflet carefully before you take any of these medications. This leaflet provides a summary of important information about taking these medications to women who could become pregnant. If you have any questions or concerns, or want more information about these medications, contact your doctor or pharmacist.

Information for Women Who Could Become Pregnant

These medications can be obtained only by prescription from your doctor. The decision to use any of these medications is one that you and your doctor should make together, taking into account your individual needs and medical condition.

Before using any of these medications, women who can become pregnant should consider the fact that these medications have been associated with birth defects, in particular, with spina bifida and other defects related to failure of the spinal canal to close normally. Approximately 1 to 2% of children born to women with epilepsy taking DEPAKOTE in the first 12 weeks of pregnancy had these defects (based on data from the Centers for Disease Control, a U.S. agency based in Atlanta). The incidence in the general population is 0.1 to 0.2%.

These medications have also been associated with other birth defects such as defects of the heart, the bones, and other parts of the body. Information suggests that birth defects

may be more likely to occur with these medications than some other drugs that treat your medical condition.

Information for Women Who Are Planning to Get Pregnant

- Women taking any of these medications who are planning to get pregnant should discuss the treatment options with their doctor.

Information for Women Who Become Pregnant

- If you become pregnant while taking any of these medications you should contact your doctor immediately.

Other Important Information

- Your medication should be taken exactly as prescribed by your doctor to get the most benefit from your medication and reduce the risk of side effects.
- If you have taken more than the prescribed dose of your medication, contact your hospital emergency room or local poison center immediately.
- Your medication was prescribed for your particular condition. Do not use it for another condition or give the drug to others.

Facts About Birth Defects

It is important to know that birth defects may occur even in children of individuals not taking any medications or without any additional risk factors.

This summary provides important information about the use of DEPAKOTE®, DEPAKOTE® ER, DEPAKOTE® Sprinkle Capsules, and DEPAKENE® to women who could become pregnant. If you would like more information about the other potential risks and benefits of these medications, ask your doctor or pharmacist to let you read the professional labeling and then discuss it with them. If you have any questions or concerns about taking these medications, you should discuss them with your doctor.

Manufactured by:

Abbott Laboratories

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