

NDA 20-272 / S-036, 20-588 / S-024, 21-444 / S-008: Final Agreed-Upon Labeling

**JANSSEN, L.P.**

**RISPERDAL<sup>®</sup>**  
**(risperidone)**  
**TABLETS/ORAL SOLUTION**

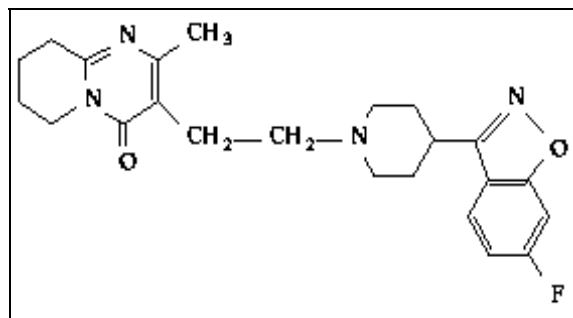
**RISPERDAL<sup>®</sup> M-TAB<sup>®</sup>**  
**(risperidone)**  
**ORALLY DISINTEGRATING TABLETS**

**Increased Mortality in Elderly Patients with Dementia –Related Psychosis**

Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10 week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. **RISPERDAL<sup>®</sup>** (risperidone) is not approved for the treatment of patients with Dementia-Related Psychosis.

**DESCRIPTION**

RISPERDAL<sup>®</sup> (risperidone) is a psychotropic agent belonging to the chemical class of benzisoxazole derivatives. The chemical designation is 3-[2-[4-(6-fluoro-1,2-benzisoxazol-3-yl)-1-piperidiny]ethyl]-6,7,8,9-tetrahydro-2-methyl-4H-pyrido[1,2-a]pyrimidin-4-one. Its molecular formula is C<sub>23</sub>H<sub>27</sub>FN<sub>4</sub>O<sub>2</sub> and its molecular weight is 410.49. The structural formula is:



Risperidone is a white to slightly beige powder. It is practically insoluble in water, freely soluble in methylene chloride, and soluble in methanol and 0.1 N HCl.

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RISPERDAL<sup>®</sup> tablets are available in 0.25 mg (dark yellow), 0.5 mg (red-brown), 1 mg (white), 2 mg (orange), 3 mg (yellow), and 4 mg (green) strengths. Inactive ingredients are colloidal silicon dioxide, hypromellose, lactose, magnesium stearate, microcrystalline cellulose, propylene glycol, sodium lauryl sulfate, and starch (corn). Tablets of 0.25, 0.5, 2, 3, and 4 mg also contain talc and titanium dioxide. The 0.25 mg tablets contain yellow iron oxide; the 0.5 mg tablets contain red iron oxide; the 2 mg tablets contain FD&C Yellow No. 6 Aluminum Lake; the 3 mg and 4 mg tablets contain D&C Yellow No. 10; the 4 mg tablets contain FD&C Blue No. 2 Aluminum Lake.

RISPERDAL<sup>®</sup> is also available as a 1 mg/mL oral solution. The inactive ingredients for this solution are tartaric acid, benzoic acid, sodium hydroxide, and purified water.

RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets are available in 0.5 mg (light coral), 1 mg (light coral), 2 mg (light coral), 3 mg (coral), and 4 mg (coral) strengths.

RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets contain the following inactive ingredients: Amberlite<sup>®</sup> resin, gelatin, mannitol, glycine, simethicone, carbomer, sodium hydroxide, aspartame, red ferric oxide, and peppermint oil. In addition, the 3 mg and 4 mg RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets contain xanthan gum.

## **CLINICAL PHARMACOLOGY**

### **Pharmacodynamics**

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

RISPERDAL<sup>®</sup> is a selective monoaminergic antagonist with high affinity (K<sub>i</sub> of 0.12 to 7.3 nM) for the serotonin Type 2 (5HT<sub>2</sub>), dopamine Type 2 (D<sub>2</sub>),  $\alpha_1$  and  $\alpha_2$  adrenergic, and H<sub>1</sub> histaminergic receptors. RISPERDAL<sup>®</sup> acts as an antagonist at other receptors, but with lower potency. RISPERDAL<sup>®</sup> has low to moderate affinity (K<sub>i</sub> of 47 to 253 nM) for the serotonin 5HT<sub>1C</sub>, 5HT<sub>1D</sub>, and 5HT<sub>1A</sub> receptors, weak affinity (K<sub>i</sub> of 620 to 800 nM) for the dopamine D<sub>1</sub> and haloperidol-sensitive sigma site, and no affinity (when tested at concentrations >10<sup>-5</sup> M) for cholinergic muscarinic or  $\beta_1$  and  $\beta_2$  adrenergic receptors.

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## Pharmacokinetics

### Absorption

Risperidone is well absorbed. The absolute oral bioavailability of risperidone is 70% (CV=25%). The relative oral bioavailability of risperidone from a tablet is 94% (CV=10%) when compared to a solution.

Pharmacokinetic studies showed that RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets and RISPERDAL<sup>®</sup> Oral Solution are bioequivalent to RISPERDAL<sup>®</sup> Tablets.

Plasma concentrations of risperidone, its major metabolite, 9-hydroxyrisperidone, and risperidone plus 9-hydroxyrisperidone are dose proportional over the dosing range of 1 to 16 mg daily (0.5 to 8 mg BID). Following oral administration of solution or tablet, mean peak plasma concentrations of risperidone occurred at about 1 hour. Peak concentrations of 9-hydroxyrisperidone occurred at about 3 hours in extensive metabolizers, and 17 hours in poor metabolizers. Steady-state concentrations of risperidone are reached in 1 day in extensive metabolizers and would be expected to reach steady-state in about 5 days in poor metabolizers. Steady-state concentrations of 9-hydroxyrisperidone are reached in 5-6 days (measured in extensive metabolizers).

### Food Effect

Food does not affect either the rate or extent of absorption of risperidone. Thus, risperidone can be given with or without meals.

### Distribution

Risperidone is rapidly distributed. The volume of distribution is 1-2 L/kg. In plasma, risperidone is bound to albumin and  $\alpha_1$ -acid glycoprotein. The plasma protein binding of risperidone is 90%, and that of its major metabolite, 9-hydroxyrisperidone, is 77%. Neither risperidone nor 9-hydroxyrisperidone displaces each other from plasma binding sites. High therapeutic concentrations of sulfamethazine (100 mcg/mL), warfarin (10 mcg/mL), and carbamazepine (10mcg/mL) caused only a slight increase in the free fraction of risperidone at 10 ng/mL and 9-hydroxyrisperidone at 50 ng/mL, changes of unknown clinical significance.

### Metabolism and Drug Interactions

Risperidone is extensively metabolized in the liver. The main metabolic pathway is through hydroxylation of risperidone to 9-hydroxyrisperidone by the enzyme, CYP 2D6. A minor metabolic pathway is through *N*-dealkylation. The main metabolite, 9-hydroxyrisperidone, has similar pharmacological activity as risperidone. Consequently, the clinical effect of the drug

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(e.g., the active moiety) results from the combined concentrations of risperidone plus 9-hydroxyrisperidone.

CYP 2D6, also called debrisoquin hydroxylase, is the enzyme responsible for metabolism of many neuroleptics, antidepressants, antiarrhythmics, and other drugs. CYP 2D6 is subject to genetic polymorphism (about 6%-8% of Caucasians, and a very low percentage of Asians, have little or no activity and are “poor metabolizers”) and to inhibition by a variety of substrates and some non-substrates, notably quinidine. Extensive CYP 2D6 metabolizers convert risperidone rapidly into 9-hydroxyrisperidone, whereas poor CYP 2D6 metabolizers convert it much more slowly. Although extensive metabolizers have lower risperidone and higher 9-hydroxyrisperidone concentrations than poor metabolizers, the pharmacokinetics of the active moiety, after single and multiple doses, are similar in extensive and poor metabolizers.

Risperidone could be subject to two kinds of drug-drug interactions (see [PRECAUTIONS – Drug Interactions](#)). First, inhibitors of CYP 2D6 interfere with conversion of risperidone to 9-hydroxyrisperidone. This occurs with quinidine, giving essentially all recipients a risperidone pharmacokinetic profile typical of poor metabolizers. The therapeutic benefits and adverse effects of risperidone in patients receiving quinidine have not been evaluated, but observations in a modest number ( $n \approx 70$ ) of poor metabolizers given risperidone do not suggest important differences between poor and extensive metabolizers. Second, co-administration of known enzyme inducers (e.g., phenytoin, rifampin, and phenobarbital) with risperidone may cause a decrease in the combined plasma concentrations of risperidone and 9-hydroxyrisperidone. It would also be possible for risperidone to interfere with metabolism of other drugs metabolized by CYP 2D6. Relatively weak binding of risperidone to the enzyme suggests this is unlikely.

In a drug interaction study in schizophrenic patients, 11 subjects received risperidone titrated to 6 mg/day for 3 weeks, followed by concurrent administration of carbamazepine for an additional 3 weeks. During co-administration, the plasma concentrations of risperidone and its pharmacologically active metabolite, 9-hydroxyrisperidone, were decreased by about 50%. Plasma concentrations of carbamazepine did not appear to be affected. Co-administration of other known enzyme inducers (e.g., phenytoin, rifampin, and phenobarbital) with risperidone may cause similar decreases in the combined plasma concentrations of risperidone and 9-hydroxyrisperidone, which could lead to decreased efficacy of risperidone treatment (see [PRECAUTIONS – Drug Interactions](#) and [DOSAGE AND ADMINISTRATION – Co-Administration of RISPERDAL<sup>®</sup> with Certain Other Medications](#)).

Fluoxetine (20 mg QD) and paroxetine (20 mg QD) have been shown to increase the plasma concentration of risperidone 2.5-2.8 fold and 3-9 fold respectively. Fluoxetine did not affect the

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plasma concentration of 9-hydroxyrisperidone. Paroxetine lowered the concentration of 9-hydroxyrisperidone by about 10% (see [PRECAUTIONS -Drug Interactions](#) and [DOSAGE AND ADMINISTRATION – Co-Administration of RISPERDAL<sup>®</sup> with Certain Other Medications](#)).

Repeated oral doses of risperidone (3 mg BID) did not affect the exposure (AUC) or peak plasma concentrations ( $C_{max}$ ) of lithium (n=13) (see [PRECAUTIONS – Drug Interactions](#)).

Repeated oral doses of risperidone (4 mg QD) did not affect the pre-dose or average plasma concentrations and exposure (AUC) of valproate (1000 mg/day in three divided doses) compared to placebo (n=21). However, there was a 20% increase in valproate peak plasma concentration ( $C_{max}$ ) after concomitant administration of risperidone (see [PRECAUTIONS – Drug Interactions](#)).

There were no significant interactions between risperidone (1 mg QD) and erythromycin (500 mg QID) (see [PRECAUTIONS – Drug Interactions](#)).

Cimetidine and ranitidine increased the bioavailability of risperidone by 64% and 26%, respectively. However, cimetidine did not affect the AUC of the active moiety, whereas ranitidine increased the AUC of the active moiety by 20%.

Amitriptyline did not affect the pharmacokinetics of risperidone or the active moiety.

In drug interaction studies, risperidone did not significantly affect the pharmacokinetics of donepezil and galantamine, which are metabolized by CYP 2D6.

RISPERDAL<sup>®</sup> (0.25 mg BID) did not show a clinically relevant effect on the pharmacokinetics of digoxin.

### Excretion

Risperidone and its metabolites are eliminated via the urine and, to a much lesser extent, via the feces. As illustrated by a mass balance study of a single 1 mg oral dose of <sup>14</sup>C-risperidone administered as solution to three healthy male volunteers, total recovery of radioactivity at 1 week was 84%, including 70% in the urine and 14% in the feces.

The apparent half-life of risperidone was 3 hours (CV=30%) in extensive metabolizers and 20 hours (CV=40%) in poor metabolizers. The apparent half-life of 9-hydroxyrisperidone was about 21 hours (CV=20%) in extensive metabolizers and 30 hours (CV=25%) in poor metabolizers. The pharmacokinetics of the active moiety, after single and multiple doses, were similar in extensive and poor metabolizers, with an overall mean elimination half-life of about 20 hours.

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## Special Populations

### Renal Impairment

In patients with moderate to severe renal disease, clearance of the sum of risperidone and its active metabolite decreased by 60% compared to young healthy subjects. RISPERDAL<sup>®</sup> doses should be reduced in patients with renal disease (see [PRECAUTIONS](#) and [DOSAGE AND ADMINISTRATION](#)).

### Hepatic Impairment

While the pharmacokinetics of risperidone in subjects with liver disease were comparable to those in young healthy subjects, the mean free fraction of risperidone in plasma was increased by about 35% because of the diminished concentration of both albumin and  $\alpha_1$ -acid glycoprotein. RISPERDAL<sup>®</sup> doses should be reduced in patients with liver disease (see [PRECAUTIONS](#) and [DOSAGE AND ADMINISTRATION](#)).

### Elderly

In healthy elderly subjects, renal clearance of both risperidone and 9-hydroxyrisperidone was decreased, and elimination half-lives were prolonged compared to young healthy subjects. Dosing should be modified accordingly in the elderly patients (see [DOSAGE AND ADMINISTRATION](#)).

### Pediatric

The pharmacokinetics of risperidone and 9-hydroxyrisperidone in children were similar to those in adults after correcting for the difference in body weight.

### Race and Gender Effects

No specific pharmacokinetic study was conducted to investigate race and gender effects, but a population pharmacokinetic analysis did not identify important differences in the disposition of risperidone due to gender (whether corrected for body weight or not) or race.

## CLINICAL TRIALS SCHIZOPHRENIA

### Short-Term Efficacy

The efficacy of RISPERDAL<sup>®</sup> in the treatment of schizophrenia was established in four short-term (4- to 8-week) controlled trials of psychotic inpatients who met DSM-III-R criteria for schizophrenia.

Several instruments were used for assessing psychiatric signs and symptoms in these studies, among them the Brief Psychiatric Rating Scale (BPRS), a multi-item inventory of general psychopathology traditionally used to evaluate the effects of drug treatment in schizophrenia. The BPRS psychosis cluster (conceptual disorganization, hallucinatory behavior, suspiciousness,

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and unusual thought content) is considered a particularly useful subset for assessing actively psychotic schizophrenic patients. A second traditional assessment, the Clinical Global Impression (CGI), reflects the impression of a skilled observer, fully familiar with the manifestations of schizophrenia, about the overall clinical state of the patient. In addition, the Positive and Negative Syndrome Scale (PANSS) and the Scale for Assessing Negative Symptoms (SANS) were employed.

The results of the trials follow:

- (1) In a 6-week, placebo-controlled trial (n=160) involving titration of RISPERDAL<sup>®</sup> in doses up to 10 mg/day (BID schedule), RISPERDAL<sup>®</sup> was generally superior to placebo on the BPRS total score, on the BPRS psychosis cluster, and marginally superior to placebo on the SANS.
- (2) In an 8-week, placebo-controlled trial (n=513) involving 4 fixed doses of RISPERDAL<sup>®</sup> (2, 6, 10, and 16 mg/day, on a BID schedule), all 4 RISPERDAL<sup>®</sup> groups were generally superior to placebo on the BPRS total score, BPRS psychosis cluster, and CGI severity score; the 3 highest RISPERDAL<sup>®</sup> dose groups were generally superior to placebo on the PANSS negative subscale. The most consistently positive responses on all measures were seen for the 6 mg dose group, and there was no suggestion of increased benefit from larger doses.
- (3) In an 8-week, dose comparison trial (n=1356) involving 5 fixed doses of RISPERDAL<sup>®</sup> (1, 4, 8, 12, and 16 mg/day, on a BID schedule), the four highest RISPERDAL<sup>®</sup> dose groups were generally superior to the 1 mg RISPERDAL<sup>®</sup> dose group on BPRS total score, BPRS psychosis cluster, and CGI severity score. None of the dose groups were superior to the 1 mg group on the PANSS negative subscale. The most consistently positive responses were seen for the 4 mg dose group.
- (4) In a 4-week, placebo-controlled dose comparison trial (n=246) involving 2 fixed doses of RISPERDAL<sup>®</sup> (4 and 8 mg/day on a QD schedule), both RISPERDAL<sup>®</sup> dose groups were generally superior to placebo on several PANSS measures, including a response measure (>20% reduction in PANSS total score), PANSS total score, and the BPRS psychosis cluster (derived from PANSS). The results were generally stronger for the 8 mg than for the 4 mg dose group.

### Long-Term Efficacy

In a longer-term trial, 365 adult outpatients predominantly meeting DSM-IV criteria for schizophrenia and who had been clinically stable for at least 4 weeks on an antipsychotic

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medication were randomized to RISPERDAL<sup>®</sup> (2-8 mg/day) or to an active comparator, for 1 to 2 years of observation for relapse. Patients receiving RISPERDAL<sup>®</sup> experienced a significantly longer time to relapse over this time period compared to those receiving the active comparator.

## **Bipolar Mania**

### **Monotherapy**

The efficacy of RISPERDAL<sup>®</sup> in the treatment of acute manic or mixed episodes was established in 2 short-term (3-week) placebo-controlled trials in patients who met the DSM-IV criteria for Bipolar I Disorder with manic or mixed episodes. These trials included patients with or without psychotic features.

The primary rating instrument used for assessing manic symptoms in these trials was the Young Mania Rating Scale (Y-MRS), an 11-item clinician-rated scale traditionally used to assess the degree of manic symptomatology (irritability, disruptive/aggressive behavior, sleep, elevated mood, speech, increased activity, sexual interest, language/thought disorder, thought content, appearance, and insight) in a range from 0 (no manic features) to 60 (maximum score). The primary outcome in these trials was change from baseline in the Y-MRS total score. The results of the trials follow:

- (1) In one 3-week placebo-controlled trial (n=246), limited to patients with manic episodes, which involved a dose range of RISPERDAL<sup>®</sup> 1-6 mg/day, once daily, starting at 3 mg/day (mean modal dose was 4.1 mg/day), RISPERDAL<sup>®</sup> was superior to placebo in the reduction of Y-MRS total score.
- (2) In another 3-week placebo-controlled trial (n=286), which involved a dose range of 1-6 mg/day, once daily, starting at 3 mg/day (mean modal dose was 5.6 mg/day), RISPERDAL<sup>®</sup> was superior to placebo in the reduction of Y-MRS total score.

### **Combination Therapy**

The efficacy of risperidone with concomitant lithium or valproate in the treatment of acute manic or mixed episodes was established in one controlled trial in patients who met the DSM-IV criteria for Bipolar I Disorder. This trial included patients with or without psychotic features and with or without a rapid-cycling course.

- (1) In this 3-week placebo-controlled combination trial, 148 in- or outpatients on lithium or valproate therapy with inadequately controlled manic or mixed symptoms were randomized to receive RISPERDAL<sup>®</sup>, placebo, or an active comparator, in combination with their original therapy. RISPERDAL<sup>®</sup>, in a dose range of 1-6 mg/day, once daily, starting at 2

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mg/day (mean modal dose of 3.8 mg/day), combined with lithium or valproate (in a therapeutic range of 0.6 mEq/L to 1.4 mEq/L or 50 mcg/mL to 120 mcg/mL, respectively) was superior to lithium or valproate alone in the reduction of Y-MRS total score.

- (2) In a second 3-week placebo-controlled combination trial, 142 in- or outpatients on lithium, valproate, or carbamazepine therapy with inadequately controlled manic or mixed symptoms were randomized to receive RISPERDAL<sup>®</sup> or placebo, in combination with their original therapy. RISPERDAL<sup>®</sup>, in a dose range of 1-6 mg/day, once daily, starting at 2 mg/day (mean modal dose of 3.7 mg/day), combined with lithium, valproate, or carbamazepine (in therapeutic ranges of 0.6 mEq/L to 1.4 mEq/L for lithium, 50 mcg/mL to 125 mcg/mL for valproate, or 4-12 mcg/mL for carbamazepine, respectively) was not superior to lithium, valproate, or carbamazepine alone in the reduction of Y-MRS total score. A possible explanation for the failure of this trial was induction of risperidone and 9-hydroxyrisperidone clearance by carbamazepine, leading to subtherapeutic levels of risperidone and 9-hydroxyrisperidone.

## **Irritability Associated with Autistic Disorder**

### **Short-Term Efficacy**

The efficacy of RISPERDAL<sup>®</sup> in the treatment of irritability associated with autistic disorder was established in two 8-week, placebo-controlled trials in children and adolescents (aged 5 to 16 years) who met the DSM-IV criteria for autistic disorder. Over 90% of these subjects were under 12 years of age and most weighed over 20 kg (16-104.3 kg).

Efficacy was evaluated using two assessment scales: the Aberrant Behavior Checklist (ABC) and the Clinical Global Impression - Change (CGI-C) scale. The primary outcome measure in both trials was the change from baseline to endpoint in the Irritability subscale of the ABC (ABC-I). The ABC-I subscale measured the emotional and behavioral symptoms of autism, including aggression towards others, deliberate self-injuriousness, temper tantrums, and quickly changing moods. The CGI-C rating at endpoint was a co-primary outcome measure in one of the studies.

The results of these trials are as follows:

- (1) In one of the 8-week, placebo-controlled trials, children and adolescents with autistic disorder (n=101), aged 5 to 16 years, received twice daily doses of placebo or RISPERDAL<sup>®</sup> 0.5-3.5 mg/day on a weight-adjusted basis. RISPERDAL<sup>®</sup>, starting at 0.25 mg/day or 0.5 mg/day depending on baseline weight (< 20 kg and ≥ 20 kg, respectively) and titrated to clinical response (mean modal dose of 1.9 mg/day, equivalent to 0.06 mg/kg/day),

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significantly improved scores on the ABC-I subscale and on the CGI-C scale compared with placebo.

- (2) In the other 8-week, placebo-controlled trial in children with autistic disorder (n=55), aged 5 to 12 years, RISPERDAL<sup>®</sup> 0.02 to 0.06 mg/kg/day given once or twice daily, starting at 0.01 mg/kg/day and titrated to clinical response (mean modal dose of 0.05 mg/kg/day, equivalent to 1.4 mg/day), significantly improved scores on the ABC-I subscale compared with placebo.

### Long-Term Efficacy

Following completion of the first 8-week double-blind study, 63 patients entered an open-label study extension where they were treated with RISPERDAL<sup>®</sup> for 4 or 6 months (depending on whether they received RISPERDAL<sup>®</sup> or placebo in the double-blind study). During this open-label treatment period, patients were maintained on a mean modal dose of RISPERDAL<sup>®</sup> of 1.8-2.1 mg/day (equivalent to 0.05 - 0.07 mg/kg/day).

Patients who maintained their positive response to RISPERDAL<sup>®</sup> (response was defined as  $\geq 25\%$  improvement on the ABC-I subscale and a CGI-C rating of ‘much improved’ or ‘very much improved’) during the 4-6 month open-label treatment phase for about 140 days, on average, were randomized to receive RISPERDAL<sup>®</sup> or placebo during an 8-week, double-blind withdrawal study (n=39 of the 63 patients). A pre-planned interim analysis of data from patients who completed the withdrawal study (n=32), undertaken by an independent Data Safety Monitoring Board, demonstrated a significantly lower relapse rate in the RISPERDAL<sup>®</sup> group compared with the placebo group. Based on the interim analysis results, the study was terminated due to demonstration of a statistically significant effect on relapse prevention. Relapse was defined as  $\geq 25\%$  worsening on the most recent assessment of the ABC-I subscale (in relation to baseline of the randomized withdrawal phase).

## INDICATIONS AND USAGE

### Schizophrenia

RISPERDAL<sup>®</sup> (risperidone) is indicated for the treatment of schizophrenia.

The efficacy of RISPERDAL<sup>®</sup> in schizophrenia was established in short-term (6- to 8-weeks) controlled trials of schizophrenic inpatients (see [CLINICAL PHARMACOLOGY](#)).

The efficacy of RISPERDAL<sup>®</sup> in delaying relapse was demonstrated in schizophrenic patients who had been clinically stable for at least 4 weeks before initiation of treatment with RISPERDAL<sup>®</sup> or an active comparator and who were then observed for relapse during a period of 1 to 2 years (see [CLINICAL PHARMACOLOGY -Clinical Trials](#)). Nevertheless, the

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physician who elects to use RISPERDAL<sup>®</sup> for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see [DOSAGE AND ADMINISTRATION](#)).

### **Bipolar Mania**

#### **Monotherapy**

RISPERDAL<sup>®</sup> is indicated for the short-term treatment of acute manic or mixed episodes associated with Bipolar I Disorder.

The efficacy of RISPERDAL<sup>®</sup> was established in two placebo-controlled trials (3-week) with patients meeting DSM-IV criteria for Bipolar I Disorder who currently displayed an acute manic or mixed episode with or without psychotic features (see [CLINICAL PHARMACOLOGY](#)).

#### **Combination Therapy**

The combination of RISPERDAL<sup>®</sup> with lithium or valproate is indicated for the short-term treatment of acute manic or mixed episodes associated with Bipolar I Disorder.

The efficacy of RISPERDAL<sup>®</sup> in combination with lithium or valproate was established in one placebo-controlled (3-week) trial with patients meeting DSM-IV criteria for Bipolar I Disorder who currently displayed an acute manic or mixed episode with or without psychotic features (see [CLINICAL PHARMACOLOGY](#)).

The effectiveness of RISPERDAL<sup>®</sup> for longer-term use, that is, for more than 3 weeks of treatment of an acute episode, and for prophylactic use in mania, has not been systematically evaluated in controlled clinical trials. Therefore, physicians who elect to use RISPERDAL<sup>®</sup> for extended periods should periodically re-evaluate the long-term risks and benefits of the drug for the individual patient (see [DOSAGE AND ADMINISTRATION](#)).

### **Irritability Associated with Autistic Disorder**

RISPERDAL<sup>®</sup> is indicated for the treatment of irritability associated with autistic disorder in children and adolescents, including symptoms of aggression towards others, deliberate self-injuriousness, temper tantrums, and quickly changing moods.

The efficacy of RISPERDAL<sup>®</sup> was established in two 8-week, placebo-controlled trials in children and adolescents (aged 5 to 16 years) who met the DSM-IV criteria for autistic disorder. The benefit of maintaining patients with irritability associated with autistic disorder on therapy with RISPERDAL<sup>®</sup> after achieving a responder status for an average duration of about 140 days was demonstrated in a controlled trial (see [CLINICAL PHARMACOLOGY](#) - [Clinical Trials](#).)

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Physicians who elect to use RISPERDAL<sup>®</sup> for extended periods should periodically re-evaluate the long-term risks and benefits of the drug for the individual patient.

## **CONTRAINDICATIONS**

RISPERDAL<sup>®</sup> (risperidone) is contraindicated in patients with a known hypersensitivity to the product.

## **WARNINGS**

### **Increased Mortality in Elderly Patients with Dementia-Related Psychosis**

**Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. RISPERDAL<sup>®</sup>(risperidone) is not approved for the treatment of dementia-related psychosis (see [Boxed Warning](#)).**

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

A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatinine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure.

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

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

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

### **Tardive Dyskinesia**

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A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

The risk of developing tardive dyskinesia and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses.

There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown.

Given these considerations, RISPERDAL<sup>®</sup> (risperidone) should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who suffer from a chronic illness that: (1) is known to respond to antipsychotic drugs, and (2) for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically.

If signs and symptoms of tardive dyskinesia appear in a patient treated with RISPERDAL<sup>®</sup>, drug discontinuation should be considered. However, some patients may require treatment with RISPERDAL<sup>®</sup> despite the presence of the syndrome.

### **Cerebrovascular Adverse Events, Including Stroke, in Elderly Patients With Dementia-Related Psychosis**

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Cerebrovascular adverse events (e.g., stroke, transient ischemic attack), including fatalities, were reported in patients (mean age 85 years; range 73-97) in trials of risperidone in elderly patients with dementia-related psychosis. In placebo-controlled trials, there was a significantly higher incidence of cerebrovascular adverse events in patients treated with risperidone compared to patients treated with placebo. RISPERDAL<sup>®</sup> is not approved for the treatment of patients with dementia-related psychosis (See also [Boxed WARNING](#), [WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis](#).)

### **Hyperglycemia and Diabetes Mellitus**

Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics including RISPERDAL<sup>®</sup>. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available.

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

## **PRECAUTIONS**

### **General**

#### **Orthostatic Hypotension**

RISPERDAL<sup>®</sup> (risperidone) may induce orthostatic hypotension associated with dizziness, tachycardia, and in some patients, syncope, especially during the initial dose-titration period,

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probably reflecting its alpha-adrenergic antagonistic properties. Syncope was reported in 0.2% (6/2607) of RISPERDAL<sup>®</sup>-treated patients in Phase 2 and 3 studies. The risk of orthostatic hypotension and syncope may be minimized by limiting the initial dose to 2 mg total (either QD or 1 mg BID) in normal adults and 0.5 mg BID in the elderly and patients with renal or hepatic impairment (see [DOSAGE AND ADMINISTRATION](#)). Monitoring of orthostatic vital signs should be considered in patients for whom this is of concern. A dose reduction should be considered if hypotension occurs. RISPERDAL<sup>®</sup> should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemia, heart failure, or conduction abnormalities), cerebrovascular disease, and conditions which would predispose patients to hypotension, e.g., dehydration and hypovolemia. Clinically significant hypotension has been observed with concomitant use of RISPERDAL<sup>®</sup> and antihypertensive medication.

### Seizures

During premarketing testing, seizures occurred in 0.3% (9/2607) of RISPERDAL<sup>®</sup>-treated patients, two in association with hyponatremia. RISPERDAL<sup>®</sup> should be used cautiously in patients with a history of seizures.

### Dysphagia

Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in patients with advanced Alzheimer's dementia. RISPERDAL<sup>®</sup> and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia. (See also [Boxed WARNING](#), [WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis](#).)

### Hyperprolactinemia

As with other drugs that antagonize dopamine D<sub>2</sub> receptors, risperidone elevates prolactin levels and the elevation persists during chronic administration. Risperidone is associated with higher levels of prolactin elevation than other antipsychotic agents.

Hyperprolactinemia may suppress hypothalamic GnRH, resulting in reduced pituitary gonadotropin secretion. This, in turn, may inhibit reproductive function by impairing gonadal steroidogenesis in both female and male patients. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported in patients receiving prolactin-elevating compounds. Long-standing hyperprolactinemia when associated with hypogonadism may lead to decreased bone density in both female and male subjects.

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Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with previously detected breast cancer. An increase in pituitary gland, mammary gland, and pancreatic islet cell neoplasia (mammary adenocarcinomas, pituitary and pancreatic adenomas) was observed in the risperidone carcinogenicity studies conducted in mice and rats (see [PRECAUTIONS – Carcinogenesis, Mutagenesis, Impairment of Fertility](#)). Neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive at this time.

#### Potential for Cognitive and Motor Impairment

Somnolence was a commonly reported adverse event associated with RISPERDAL<sup>®</sup> treatment, especially when ascertained by direct questioning of patients. This adverse event is dose-related, and in a study utilizing a checklist to detect adverse events, 41% of the high-dose patients (RISPERDAL<sup>®</sup> 16 mg/day) reported somnolence compared to 16% of placebo patients. Direct questioning is more sensitive for detecting adverse events than spontaneous reporting, by which 8% of RISPERDAL<sup>®</sup> 16 mg/day patients and 1% of placebo patients reported somnolence as an adverse event. Since RISPERDAL<sup>®</sup> has the potential to impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that RISPERDAL<sup>®</sup> therapy does not affect them adversely.

#### Priapism

Rare cases of priapism have been reported. While the relationship of the events to RISPERDAL<sup>®</sup> use has not been established, other drugs with alpha-adrenergic blocking effects have been reported to induce priapism, and it is possible that RISPERDAL<sup>®</sup> may share this capacity. Severe priapism may require surgical intervention.

#### Thrombotic Thrombocytopenic Purpura (TTP)

A single case of TTP was reported in a 28 year-old female patient receiving RISPERDAL<sup>®</sup> in a large, open premarketing experience (approximately 1300 patients). She experienced jaundice, fever, and bruising, but eventually recovered after receiving plasmapheresis. The relationship to RISPERDAL<sup>®</sup> therapy is unknown.

#### Antiemetic Effect

Risperidone has an antiemetic effect in animals; this effect may also occur in humans, and may mask signs and symptoms of overdose with certain drugs or of conditions such as intestinal obstruction, Reye's syndrome, and brain tumor.

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### Body Temperature Regulation

Disruption of body temperature regulation has been attributed to antipsychotic agents. Both hyperthermia and hypothermia have been reported in association with oral RISPERDAL<sup>®</sup> use. Caution is advised when prescribing for patients who will be exposed to temperature extremes.

### Suicide

The possibility of a suicide attempt is inherent in patients with schizophrenia and bipolar mania, including children and adolescent patients, and close supervision of high-risk patients should accompany drug therapy. Prescriptions for RISPERDAL<sup>®</sup> should be written for the smallest quantity of tablets, consistent with good patient management, in order to reduce the risk of overdose.

### Use in Patients With Concomitant Illness

Clinical experience with RISPERDAL<sup>®</sup> in patients with certain concomitant systemic illnesses is limited. Patients with Parkinson's Disease or Dementia with Lewy Bodies who receive antipsychotics, including RISPERDAL<sup>®</sup>, are reported to have an increased sensitivity to antipsychotic medications. Manifestations of this increased sensitivity have been reported to include confusion, obtundation, postural instability with frequent falls, extrapyramidal symptoms, and clinical features consistent with the neuroleptic malignant syndrome.

Caution is advisable in using RISPERDAL<sup>®</sup> in patients with diseases or conditions that could affect metabolism or hemodynamic responses. RISPERDAL<sup>®</sup> has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from clinical studies during the product's premarket testing.

Increased plasma concentrations of risperidone and 9-hydroxyrisperidone occur in patients with severe renal impairment (creatinine clearance <30 mL/min/1.73 m<sup>2</sup>), and an increase in the free fraction of risperidone is seen in patients with severe hepatic impairment. A lower starting dose should be used in such patients (see [DOSAGE AND ADMINISTRATION](#)).

### Information for Patients

Physicians are advised to discuss the following issues with patients for whom they prescribe RISPERDAL<sup>®</sup>:

#### Orthostatic Hypotension

Patients should be advised of the risk of orthostatic hypotension, especially during the period of initial dose titration.

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### **Interference With Cognitive and Motor Performance**

Since RISPERDAL<sup>®</sup> has the potential to impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that RISPERDAL<sup>®</sup> therapy does not affect them adversely.

### **Pregnancy**

Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy.

### **Nursing**

Patients should be advised not to breast-feed an infant if they are taking RISPERDAL<sup>®</sup>.

### **Concomitant Medication**

Patients should be advised to inform their physicians if they are taking, or plan to take, any prescription or over-the-counter drugs, since there is a potential for interactions.

### **Alcohol**

Patients should be advised to avoid alcohol while taking RISPERDAL<sup>®</sup>.

### **Phenylketonurics**

Phenylalanine is a component of aspartame. Each 4 mg RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablet contains 0.84 mg phenylalanine; each 3 mg RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablet contains 0.63 mg phenylalanine; each 2 mg RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablet contains 0.42 mg phenylalanine; each 1 mg RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablet contains 0.28 mg phenylalanine; and each 0.5 mg RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablet contains 0.14 mg phenylalanine.

### **Laboratory Tests**

No specific laboratory tests are recommended.

### **Drug Interactions**

The interactions of RISPERDAL<sup>®</sup> and other drugs have not been systematically evaluated. Given the primary CNS effects of risperidone, caution should be used when RISPERDAL<sup>®</sup> is taken in combination with other centrally acting drugs and alcohol.

Because of its potential for inducing hypotension, RISPERDAL<sup>®</sup> may enhance the hypotensive effects of other therapeutic agents with this potential.

RISPERDAL<sup>®</sup> may antagonize the effects of levodopa and dopamine agonists.

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Amitriptyline did not affect the pharmacokinetics of risperidone or the active moiety. Cimetidine and ranitidine increased the bioavailability of risperidone by 64% and 26%, respectively. However, cimetidine did not affect the AUC of the active moiety, whereas ranitidine increased the AUC of the active moiety by 20%.

Chronic administration of clozapine with risperidone may decrease the clearance of risperidone.

#### Carbamazepine and Other Enzyme Inducers

In a drug interaction study in schizophrenic patients, 11 subjects received risperidone titrated to 6 mg/day for 3 weeks, followed by concurrent administration of carbamazepine for an additional 3 weeks. During co-administration, the plasma concentrations of risperidone and its pharmacologically active metabolite, 9-hydroxyrisperidone, were decreased by about 50%. Plasma concentrations of carbamazepine did not appear to be affected. The dose of risperidone may need to be titrated accordingly for patients receiving carbamazepine, particularly during initiation or discontinuation of carbamazepine therapy. Co-administration of other known enzyme inducers (e.g., phenytoin, rifampin, and phenobarbital) with risperidone may cause similar decreases in the combined plasma concentrations of risperidone and 9-hydroxyrisperidone, which could lead to decreased efficacy of risperidone treatment.

#### Fluoxetine and Paroxetine

Fluoxetine (20 mg QD) and paroxetine (20 mg QD) have been shown to increase the plasma concentration of risperidone 2.5-2.8 fold and 3-9 fold respectively. Fluoxetine did not affect the plasma concentration of 9-hydroxyrisperidone. Paroxetine lowered the concentration of 9-hydroxyrisperidone by about 10%. When either concomitant fluoxetine or paroxetine is initiated or discontinued, the physician should re-evaluate the dosing of RISPERDAL<sup>®</sup>. The effects of discontinuation of concomitant fluoxetine or paroxetine therapy on the pharmacokinetics of risperidone and 9-hydroxyrisperidone have not been studied.

#### Lithium

Repeated oral doses of risperidone (3 mg BID) did not affect the exposure (AUC) or peak plasma concentrations ( $C_{max}$ ) of lithium (n=13).

#### Valproate

Repeated oral doses of risperidone (4 mg QD) did not affect the pre-dose or average plasma concentrations and exposure (AUC) of valproate (1000 mg/day in three divided doses) compared to placebo (n=21). However, there was a 20% increase in valproate peak plasma concentration ( $C_{max}$ ) after concomitant administration of risperidone.

#### Digoxin

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RISPERDAL<sup>®</sup> (0.25 mg BID) did not show a clinically relevant effect on the pharmacokinetics of digoxin.

#### Drugs That Inhibit CYP 2D6 and Other CYP Isozymes

Risperidone is metabolized to 9-hydroxyrisperidone by CYP 2D6, an enzyme that is polymorphic in the population and that can be inhibited by a variety of psychotropic and other drugs (see [CLINICAL PHARMACOLOGY](#)). Drug interactions that reduce the metabolism of risperidone to 9-hydroxyrisperidone would increase the plasma concentrations of risperidone and lower the concentrations of 9-hydroxyrisperidone. Analysis of clinical studies involving a modest number of poor metabolizers (n≈70) does not suggest that poor and extensive metabolizers have different rates of adverse effects. No comparison of effectiveness in the two groups has been made.

*In vitro* studies showed that drugs metabolized by other CYP isozymes, including 1A1, 1A2, 2C9, 2C19, and 3A4, are only weak inhibitors of risperidone metabolism.

There were no significant interactions between risperidone and erythromycin (see [CLINICAL PHARMACOLOGY](#)).

#### Drugs Metabolized by CYP 2D6

*In vitro* studies indicate that risperidone is a relatively weak inhibitor of CYP 2D6. Therefore, RISPERDAL<sup>®</sup> is not expected to substantially inhibit the clearance of drugs that are metabolized by this enzymatic pathway. In drug interaction studies, risperidone did not significantly affect the pharmacokinetics of donepezil and galantamine, which are metabolized by CYP 2D6.

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

#### **Carcinogenesis**

Carcinogenicity studies were conducted in Swiss albino mice and Wistar rats. Risperidone was administered in the diet at doses of 0.63, 2.5, and 10 mg/kg for 18 months to mice and for 25 months to rats. These doses are equivalent to 2.4, 9.4, and 37.5 times the maximum recommended human dose (MRHD) for schizophrenia (16 mg/day) on a mg/kg basis or 0.2, 0.75, and 3 times the MRHD (mice) or 0.4, 1.5, and 6 times the MRHD (rats) on a mg/m<sup>2</sup> basis. A maximum tolerated dose was not achieved in male mice. There were statistically significant increases in pituitary gland adenomas, endocrine pancreas adenomas, and mammary gland adenocarcinomas. The following table summarizes the multiples of the human dose on a mg/m<sup>2</sup> (mg/kg) basis at which these tumors occurred.

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Tumor Type	Species	Sex	Multiples of Maximum Human Dose in mg/m <sup>2</sup> (mg/kg)	
			Lowest Effect Level	Highest No-Effect Level
Pituitary adenomas	mouse	female	0.75 (9.4)	0.2 (2.4)
Endocrine pancreas adenomas	rat	male	1.5 (9.4)	0.4 (2.4)
Mammary gland adenocarcinomas	mouse	female	0.2 (2.4)	none
	rat	female	0.4 (2.4)	none
	rat	male	6.0 (37.5)	1.5 (9.4)
Mammary gland neoplasm, Total	rat	male	1.5 (9.4)	0.4 (2.4)

Antipsychotic drugs have been shown to chronically elevate prolactin levels in rodents. Serum prolactin levels were not measured during the risperidone carcinogenicity studies; however, measurements during subchronic toxicity studies showed that risperidone elevated serum prolactin levels 5-6 fold in mice and rats at the same doses used in the carcinogenicity studies. An increase in mammary, pituitary, and endocrine pancreas neoplasms has been found in rodents after chronic administration of other antipsychotic drugs and is considered to be prolactin-mediated. The relevance for human risk of the findings of prolactin-mediated endocrine tumors in rodents is unknown (see [PRECAUTIONS, General -Hyperprolactinemia](#)).

### Mutagenesis

No evidence of mutagenic potential for risperidone was found in the Ames reverse mutation test, mouse lymphoma assay, in vitro rat hepatocyte DNA-repair assay, in vivo micronucleus test in mice, the sex-linked recessive lethal test in *Drosophila*, or the chromosomal aberration test in human lymphocytes or Chinese hamster cells.

### Impairment of Fertility

Risperidone (0.16 to 5 mg/kg) was shown to impair mating, but not fertility, in Wistar rats in three reproductive studies (two Segment I and a multigenerational study) at doses 0.1 to 3 times the maximum recommended human dose (MRHD) on a mg/m<sup>2</sup> basis. The effect appeared to be in females, since impaired mating behavior was not noted in the Segment I study in which males only were treated. In a subchronic study in Beagle dogs in which risperidone was administered at doses of 0.31 to 5 mg/kg, sperm motility and concentration were decreased at doses 0.6 to 10 times the MRHD on a mg/m<sup>2</sup> basis. Dose-related decreases were also noted in serum testosterone at the same doses. Serum testosterone and sperm parameters partially recovered, but remained decreased after treatment was discontinued. No no-effect doses were noted in either rat or dog.

### Pregnancy

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### Pregnancy Category C

The teratogenic potential of risperidone was studied in three Segment II studies in Sprague-Dawley and Wistar rats (0.63-10 mg/kg or 0.4 to 6 times the maximum recommended human dose [MRHD] on a mg/m<sup>2</sup> basis) and in one Segment II study in New Zealand rabbits (0.31-5 mg/kg or 0.4 to 6 times the MRHD on a mg/m<sup>2</sup> basis). The incidence of malformations was not increased compared to control in offspring of rats or rabbits given 0.4 to 6 times the MRHD on a mg/m<sup>2</sup> basis. In three reproductive studies in rats (two Segment III and a multigenerational study), there was an increase in pup deaths during the first 4 days of lactation at doses of 0.16-5 mg/kg or 0.1 to 3 times the MRHD on a mg/m<sup>2</sup> basis. It is not known whether these deaths were due to a direct effect on the fetuses or pups or to effects on the dams.

There was no no-effect dose for increased rat pup mortality. In one Segment III study, there was an increase in stillborn rat pups at a dose of 2.5 mg/kg or 1.5 times the MRHD on a mg/m<sup>2</sup> basis. In a cross-fostering study in Wistar rats, toxic effects on the fetus or pups, as evidenced by a decrease in the number of live pups and an increase in the number of dead pups at birth (Day 0), and a decrease in birth weight in pups of drug-treated dams were observed. In addition, there was an increase in deaths by Day 1 among pups of drug-treated dams, regardless of whether or not the pups were cross-fostered. Risperidone also appeared to impair maternal behavior in that pup body weight gain and survival (from Day 1 to 4 of lactation) were reduced in pups born to control but reared by drug-treated dams. These effects were all noted at the one dose of risperidone tested, i.e., 5 mg/kg or 3 times the MRHD on a mg/m<sup>2</sup> basis.

Placental transfer of risperidone occurs in rat pups. There are no adequate and well-controlled studies in pregnant women. However, there was one report of a case of agenesis of the corpus callosum in an infant exposed to risperidone *in utero*. The causal relationship to RISPERDAL<sup>®</sup> therapy is unknown. Reversible extrapyramidal symptoms in the neonate were observed following postmarketing use of risperidone during the last trimester of pregnancy.

RISPERDAL<sup>®</sup> should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

### Labor and Delivery

The effect of RISPERDAL<sup>®</sup> on labor and delivery in humans is unknown.

### Nursing Mothers

In animal studies, risperidone and 9-hydroxyrisperidone are excreted in milk. Risperidone and 9-hydroxyrisperidone are also excreted in human breast milk. Therefore, women receiving risperidone should not breast-feed.

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### **Pediatric Use**

The safety and effectiveness of RISPERDAL<sup>®</sup> in pediatric patients with schizophrenia or bipolar mania have not been established.

The efficacy and safety of RISPERDAL<sup>®</sup> in the treatment of irritability associated with autistic disorder were established in two 8-week, placebo-controlled trials in 156 children and adolescent patients, aged 5 to 16 years (see [CLINICAL PHARMACOLOGY](#) - [Clinical Trials](#), [INDICATIONS AND USAGE](#), and [ADVERSE REACTIONS](#)). Additional safety information was also assessed in a long-term study in patients with autistic disorder, or in short- and long-term studies in more than 1200 pediatric patients with other psychiatric disorders who were of similar age and weight, and who received similar dosages of RISPERDAL<sup>®</sup> as patients who were treated for irritability associated with autistic disorder.

The safety and effectiveness of RISPERDAL<sup>®</sup> in pediatric patients with autistic disorder less than 5 years of age have not been established.

### **Tardive Dyskinesia**

In clinical trials in 1885 children and adolescents with autistic disorder or other psychiatric disorders treated with risperidone, 2 (0.1%) patients were reported to have tardive dyskinesia, which resolved on discontinuation of risperidone treatment (see WARNINGS – Tardive Dyskinesia).

### **Weight Gain**

In long-term, open-label trials (studies in patients with autistic disorder or other psychiatric disorders), a mean increase of 7.5 kg after 12 months of RISPERDAL<sup>®</sup> treatment was observed, which was higher than the expected normal weight gain (approximately 3 to 3.5 kg per year adjusted for age, based on Centers for Disease Control and Prevention normative data). The majority of that increase occurred within the first 6 months of exposure to RISPERDAL<sup>®</sup>. The average percentiles at baseline and 12 months, respectively, were 49 and 60 for weight, 48 and 53 for height, and 50 and 62 for body mass index. When treating patients with RISPERDAL<sup>®</sup>, weight gain should be assessed against that expected with normal growth. (See also [ADVERSE REACTIONS](#).)

### **Somnolence**

Somnolence was frequently observed in placebo-controlled clinical trials of pediatric patients with autistic disorder. Most cases were mild or moderate in severity. These events were most often of early onset with peak incidence occurring during the first two weeks of treatment, and transient with a median duration of 16 days. (See also [ADVERSE REACTIONS](#).) Patients

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experiencing persistent somnolence may benefit from a change in dosing regimen (see DOSAGE AND ADMINISTRATION – Irritability Associated with Autistic Disorder).

#### Hyperprolactinemia, Growth, and Sexual Maturation

Risperidone has been shown to elevate prolactin levels in children and adolescents as well as in adults (see [PRECAUTIONS - Hyperprolactinemia](#)). In double-blind, placebo-controlled studies of up to 8 weeks duration in children and adolescents (aged 5 to 17 years) 49% of patients who received risperidone had elevated prolactin levels compared to 2% of patients who received placebo.

In clinical trials in 1885 children and adolescents with autistic disorder or other psychiatric disorders treated with risperidone, galactorrhea was reported in 0.8% of risperidone-treated patients and gynecomastia was reported in 2.3% of risperidone-treated patients.

The long-term effects of risperidone on growth and sexual maturation have not been fully evaluated.

#### Geriatric Use

Clinical studies of RISPERDAL<sup>®</sup> in the treatment of schizophrenia did not include sufficient numbers of patients aged 65 and over to determine whether or not they respond differently than younger patients. Other reported clinical experience has not identified differences in responses between elderly and younger patients. In general, a lower starting dose is recommended for an elderly patient, reflecting a decreased pharmacokinetic clearance in the elderly, as well as a greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy (see [CLINICAL PHARMACOLOGY](#) and [DOSAGE AND ADMINISTRATION](#)). While elderly patients exhibit a greater tendency to orthostatic hypotension, its risk in the elderly may be minimized by limiting the initial dose to 0.5 mg BID followed by careful titration (see [PRECAUTIONS](#)). Monitoring of orthostatic vital signs should be considered in patients for whom this is of concern.

This drug is substantially excreted by the kidneys, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function (see [DOSAGE AND ADMINISTRATION](#)).

#### Concomitant use with Furosemide in Elderly Patients with Dementia-Related Psychosis

In two of four placebo-controlled trials in elderly patients with dementia-related psychosis, a higher incidence of mortality was observed in patients treated with furosemide plus risperidone

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when compared to patients treated with risperidone alone or with placebo plus furosemide. No pathological mechanism has been identified to explain this finding, and no consistent pattern for cause of death was observed. An increase of mortality in elderly patients with dementia-related psychosis was seen with the use of RISPERDAL<sup>®</sup> regardless of concomitant use with furosemide. RISPERDAL<sup>®</sup> is not approved for the treatment of patients with dementia-related psychosis. (See [Boxed WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis.](#))

## ADVERSE REACTIONS

The following findings are based on the short-term, placebo-controlled, North American, premarketing trials for schizophrenia and acute bipolar mania, and are followed by a description of adverse events and other safety measures in short-term, placebo-controlled trials in pediatric patients treated for irritability associated with autistic disorder. In patients with Bipolar I Disorder, treatment-emergent adverse events are presented separately for risperidone as monotherapy and as adjunctive therapy to mood stabilizers.

Certain portions of the discussion below relating to objective or numeric safety parameters, namely dose-dependent adverse events, vital sign changes, weight gain, laboratory changes, and ECG changes are derived from studies in patients with schizophrenia. However, this information is also generally applicable to bipolar mania and pediatric patients with autistic disorder.

### Associated With Discontinuation of Treatment

#### Schizophrenia

Approximately 9% (244/2607) of RISPERDAL<sup>®</sup> (risperidone)-treated patients in Phase 2 and 3 studies discontinued treatment due to an adverse event, compared with about 7% on placebo and 10% on active control drugs. The more common events ( $\geq 0.3\%$ ) associated with discontinuation and considered to be possibly or probably drug-related included:

Adverse Event	RISPERDAL <sup>®</sup>	Placebo
Extrapyramidal symptoms	2.1%	0%
Dizziness	0.7%	0%
Hyperkinesia	0.6%	0%
Somnolence	0.5%	0%
Nausea	0.3%	0%

Suicide attempt was associated with discontinuation in 1.2% of RISPERDAL<sup>®</sup>-treated patients compared to 0.6% of placebo patients, but, given the almost 40-fold greater exposure time in RISPERDAL<sup>®</sup> compared to placebo patients, it is unlikely that suicide attempt is a RISPERDAL<sup>®</sup>-related adverse event (see [PRECAUTIONS](#)). Discontinuation for extrapyramidal

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symptoms was 0% in placebo patients, but 3.8% in active-control patients in the Phase 2 and 3 trials.

### **Bipolar Mania**

In the US placebo-controlled trial with risperidone as monotherapy, approximately 8% (10/134) of RISPERDAL<sup>®</sup>-treated patients discontinued treatment due to an adverse event, compared with approximately 6% (7/125) of placebo-treated patients. The adverse events associated with discontinuation and considered to be possibly, probably, or very likely drug-related included paroniria, somnolence, dizziness, extrapyramidal disorder, and muscle contractions involuntary. Each of these events occurred in one RISPERDAL<sup>®</sup>-treated patient (0.7%) and in no placebo-treated patients (0%).

In the US placebo-controlled trial with risperidone as adjunctive therapy to mood stabilizers, there was no overall difference in the incidence of discontinuation due to adverse events (4% for RISPERDAL<sup>®</sup> vs. 4% for placebo).

### **Incidence in Controlled Trials**

#### **Commonly Observed Adverse Events in Controlled Clinical Trials**

##### *Schizophrenia*

In two 6- to 8-week placebo-controlled trials, spontaneously-reported, treatment-emergent adverse events with an incidence of 5% or greater in at least one of the RISPERDAL<sup>®</sup> groups and at least twice that of placebo were anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, nausea, dyspepsia, rhinitis, rash, and tachycardia.

Adverse events were also elicited in one of these two trials (i.e., in the fixed-dose trial comparing RISPERDAL<sup>®</sup> at doses of 2, 6, 10, and 16 mg/day with placebo) utilizing a checklist for detecting adverse events, a method that is more sensitive than spontaneous reporting. By this method, the following additional common and drug-related adverse events occurred at an incidence of at least 5% and twice the rate of placebo: increased dream activity, increased duration of sleep, accommodation disturbances, reduced salivation, micturition disturbances, diarrhea, weight gain, menorrhagia, diminished sexual desire, erectile dysfunction, ejaculatory dysfunction, and orgasmic dysfunction.

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### *Bipolar Mania*

In the US placebo-controlled trial with risperidone as monotherapy, the most commonly observed adverse events associated with the use of RISPERDAL<sup>®</sup> (incidence of 5% or greater and at least twice that of placebo) were somnolence, dystonia, akathisia, dyspepsia, nausea, parkinsonism, vision abnormal, and saliva increased. In the US placebo-controlled trial with risperidone as adjunctive therapy to mood stabilizers, the most commonly observed adverse events associated with the use of RISPERDAL<sup>®</sup> were somnolence, dizziness, parkinsonism, saliva increased, akathisia, abdominal pain, and urinary incontinence.

### **Adverse Events Occurring at an Incidence of 1% or More Among RISPERDAL<sup>®</sup>-Treated Patients - Schizophrenia**

The table that follows enumerates adverse events that occurred at an incidence of 1% or more, and were more frequent among RISPERDAL<sup>®</sup>-treated patients treated at doses of  $\leq 10$  mg/day than among placebo-treated patients in the pooled results of two 6- to 8-week controlled trials. Patients received RISPERDAL<sup>®</sup> doses of 2, 6, 10, or 16 mg/day in the dose comparison trial, or up to a maximum dose of 10 mg/day in the titration study. This table shows the percentage of patients in each dose group ( $\leq 10$  mg/day or 16 mg/day) who spontaneously reported at least one episode of an event at some time during their treatment. Patients given doses of 2, 6, or 10 mg did not differ materially in these rates. Reported adverse events were classified using the World Health Organization preferred terms.

The prescriber should be aware that these figures cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in this clinical trial. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the side effect incidence rate in the population studied.

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**Table 1: Incidence of Treatment-Emergent Adverse Events in 6- to 8-Week Controlled Clinical Trials in Schizophrenia<sup>1</sup>**

Body System/ Preferred Term	RISPERDAL <sup>®</sup>		
	<10mg/day (N=324)	16 mg/day (N=77)	Placebo (N=142)
<b>Psychiatric</b>			
Insomnia	26%	23%	19%
Agitation	22%	26%	20%
Anxiety	12%	20%	9%
Somnolence	3%	8%	1%
Aggressive reaction	1%	3%	1%
<b>Central &amp; peripheral nervous system</b>			
Extrapyramidal symptoms <sup>2</sup>	17%	34%	16%
Headache	14%	12%	12%
Dizziness	4%	7%	1%
<b>Gastrointestinal</b>			
Constipation	7%	13%	3%
Nausea	6%	4%	3%
Dyspepsia	5%	10%	4%
Vomiting	5%	7%	4%
Abdominal pain	4%	1%	0%
Saliva increased	2%	0%	1%
Toothache	2%	0%	0%
<b>Respiratory system</b>			
Rhinitis	10%	8%	4%
Coughing	3%	3%	1%
Sinusitis	2%	1%	1%
Pharyngitis	2%	3%	0%
Dyspnea	1%	0%	0%
<b>Body as a whole – general</b>			
Back pain	2%	0%	1%
Chest pain	2%	3%	1%
Fever	2%	3%	0%
<b>Dermatological</b>			
Rash	2%	5%	1%
Dry skin	2%	4%	0%
Seborrhea	1%	0%	0%
<b>Infections</b>			
Upper respiratory	3%	3%	1%
<b>Visual</b>			
Abnormal vision	2%	1%	1%
<b>Musculo-Skeletal</b>			
Arthralgia	2%	3%	0%
<b>Cardiovascular</b>			
Tachycardia	3%	5%	0%

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- 
- <sup>1</sup> Events reported by at least 1% of patients treated with RISPERDAL<sup>®</sup> ≤10 mg/day are included, and are rounded to the nearest %. Comparative rates for RISPERDAL<sup>®</sup> 16 mg/day and placebo are provided as well. Events for which the RISPERDAL<sup>®</sup> incidence (in both dose groups) was equal to or less than placebo are not listed in the table, but included the following: nervousness, injury, and fungal infection.
- <sup>2</sup> Includes tremor, dystonia, hypokinesia, hypertonia, hyperkinesia, oculogyric crisis, ataxia, abnormal gait, involuntary muscle contractions, hyporeflexia, akathisia, and extrapyramidal disorders. Although the incidence of 'extrapyramidal symptoms' does not appear to differ for the '10 mg/day' group and placebo, the data for individual dose groups in fixed dose trials do suggest a dose/response relationship (see [ADVERSE REACTIONS – Dose Dependency of Adverse Events](#)).

### Adverse Events Occurring at an Incidence of 2% or More Among RISPERDAL<sup>®</sup>-Treated Patients - Bipolar Mania

[Tables 2](#) and [3](#) display adverse events that occurred at an incidence of 2% or more, and were more frequent among patients treated with flexible doses of RISPERDAL<sup>®</sup> (1-6 mg daily as monotherapy and as adjunctive therapy to mood stabilizers, respectively) than among patients treated with placebo. Reported adverse events were classified using the World Health Organization preferred terms.

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**Table 2: Incidence of Treatment-Emergent Adverse Events in a 3-Week, Placebo-Controlled Trial - Monotherapy in Bipolar Mania<sup>1</sup>**

Body System/ Preferred Term	RISPERDAL <sup>®</sup> (N=134)	Placebo (N=125)
<b>Central &amp; peripheral nervous system</b>		
Dystonia	18%	6%
Akathisia	16%	6%
Dizziness	11%	9%
Parkinsonism	6%	3%
Hypoaesthesia	2%	1%
<b>Psychiatric</b>		
Somnolence	28%	7%
Agitation	8%	6%
Manic reaction	8%	6%
Anxiety	4%	2%
Concentration impaired	2%	1%
<b>Gastrointestinal system</b>		
Dyspepsia	11%	6%
Nausea	11%	2%
Saliva increased	5%	1%
Mouth dry	3%	2%
<b>Body as a whole - general</b>		
Pain	5%	3%
Fatigue	4%	2%
Injury	2%	0%
<b>Respiratory system</b>		
Sinusitis	4%	1%
Rhinitis	3%	2%
Coughing	2%	2%
<b>Skin and appendages</b>		
Acne	2%	0%
Pruritus	2%	1%
<b>Musculo-Skeletal</b>		
Myalgia	5%	2%
Skeletal pain	2%	1%
<b>Metabolic and nutritional</b>		
Weight increase	2%	0%
<b>Vision disorders</b>		
Vision abnormal	6%	2%
<b>Cardiovascular, general</b>		
Hypertension	3%	1%
Hypotension	2%	0%
<b>Heart rate and rhythm</b>		
Tachycardia	3%	2%

<sup>1</sup> Events reported by at least 2% of patients treated with RISPERDAL<sup>®</sup> are included and are rounded to the nearest %. Events reported by at least 2% of patients treated with RISPERDAL<sup>®</sup> that were less than the incidence reported by patients treated with placebo are not listed in the table, but included the following: headache, tremor, insomnia, constipation, back pain, upper respiratory tract infection, pharyngitis, and arthralgia.

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**Table 3: Incidence of Treatment-Emergent Adverse Events in a 3-Week, Placebo-Controlled Trial - Adjunctive Therapy in Bipolar Mania<sup>1</sup>**

<b>Body System/ Preferred Term</b>	<b>RISPERDAL<sup>®</sup> + Mood Stabilizer (N=52)</b>	<b>Placebo + Mood Stabilizer (N=51)</b>
<b>Gastrointestinal system</b>		
Saliva increased	10%	0%
Diarrhea	8%	4%
Abdominal pain	6%	0%
Constipation	6%	4%
Mouth dry	6%	4%
Tooth ache	4%	0%
Tooth disorder	4%	0%
<b>Central &amp; peripheral nervous system</b>		
Dizziness	14%	2%
Parkinsonism	14%	4%
Akathisia	8%	0%
Dystonia	6%	4%
<b>Psychiatric</b>		
Somnolence	25%	12%
Anxiety	6%	4%
Confusion	4%	0%
<b>Respiratory system</b>		
Rhinitis	8%	4%
Pharyngitis	6%	4%
Coughing	4%	0%
<b>Body as a whole - general</b>		
Asthenia	4%	2%
<b>Urinary system</b>		
Urinary incontinence	6%	2%
<b>Heart rate and rhythm</b>		
Tachycardia	4%	2%
<b>Metabolic and nutritional</b>		
Weight increase	4%	2%
<b>Skin and appendages</b>		
Rash	4%	2%

<sup>1</sup> Events reported by at least 2% of patients treated with RISPERDAL<sup>®</sup> are included and are rounded to the nearest %. Events reported by at least 2% of patients treated with RISPERDAL<sup>®</sup> that were less than the incidence reported by patients treated with placebo are not listed in the table, but included the following: dyspepsia, nausea, vomiting, headache, tremor, insomnia, chest pain, fatigue, pain, skeletal pain, hypertension, and vision abnormal.

## Dose Dependency of Adverse Events

### *Extrapyramidal Symptoms*

Data from two fixed-dose trials provided evidence of dose-relatedness for extrapyramidal symptoms associated with risperidone treatment.

Two methods were used to measure extrapyramidal symptoms (EPS) in an 8-week trial comparing 4 fixed doses of risperidone (2, 6, 10, and 16 mg/day), including (1) a parkinsonism

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score (mean change from baseline) from the Extrapyramidal Symptom Rating Scale, and (2) incidence of spontaneous complaints of EPS:

<b>Dose Groups</b>	<b>Placebo</b>	<b>Ris 2</b>	<b>Ris 6</b>	<b>Ris 10</b>	<b>Ris 16</b>
Parkinsonism	1.2	0.9	1.8	2.4	2.6
EPS Incidence	13%	13%	16%	20%	31%

Similar methods were used to measure extrapyramidal symptoms (EPS) in an 8-week trial comparing 5 fixed doses of risperidone (1, 4, 8, 12, and 16 mg/day):

<b>Dose Groups</b>	<b>Ris 1</b>	<b>Ris 4</b>	<b>Ris 8</b>	<b>Ris 12</b>	<b>Ris 16</b>
Parkinsonism	0.6	1.7	2.4	2.9	4.1
EPS Incidence	7%	12%	18%	18%	21%

### Other Adverse Events

Adverse event data elicited by a checklist for side effects from a large study comparing 5 fixed doses of RISPERDAL<sup>®</sup> (1, 4, 8, 12, and 16 mg/day) were explored for dose-relatedness of adverse events. A Cochran-Armitage Test for trend in these data revealed a positive trend (p<0.05) for the following adverse events: sleepiness, increased duration of sleep, accommodation disturbances, orthostatic dizziness, palpitations, weight gain, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, asthenia/lassitude/increased fatigability, and increased pigmentation.

### Vital Sign Changes

RISPERDAL<sup>®</sup> is associated with orthostatic hypotension and tachycardia (see [PRECAUTIONS](#)).

### Weight Changes

The proportions of RISPERDAL<sup>®</sup> and placebo-treated patients meeting a weight gain criterion of  $\geq 7\%$  of body weight were compared in a pool of 6- to 8-week, placebo-controlled trials, revealing a statistically significantly greater incidence of weight gain for RISPERDAL<sup>®</sup> (18%) compared to placebo (9%).

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### Laboratory Changes

A between-group comparison for 6- to 8-week placebo-controlled trials revealed no statistically significant RISPERDAL<sup>®</sup>/placebo differences in the proportions of patients experiencing potentially important changes in routine serum chemistry, hematology, or urinalysis parameters. Similarly, there were no RISPERDAL<sup>®</sup>/placebo differences in the incidence of discontinuations for changes in serum chemistry, hematology, or urinalysis. However, RISPERDAL<sup>®</sup> administration was associated with increases in serum prolactin (see [PRECAUTIONS](#)).

### ECG Changes

Between-group comparisons for pooled placebo-controlled trials revealed no statistically significant differences between risperidone and placebo in mean changes from baseline in ECG parameters, including QT, QTc, and PR intervals, and heart rate. When all RISPERDAL<sup>®</sup> doses were pooled from randomized controlled trials in several indications, there was a mean increase in heart rate of 1 beat per minute compared to no change for placebo patients. In short-term schizophrenia trials, higher doses of risperidone (8-16 mg/day) were associated with a higher mean increase in heart rate compared to placebo (4-6 beats per minute).

### Adverse Events and Other Safety Measures in Pediatric Patients With Autistic Disorder

In the two 8-week, placebo-controlled trials in pediatric patients treated for irritability associated with autistic disorder (n=156), two patients (one treated with RISPERDAL<sup>®</sup> and one treated with placebo) discontinued treatment due to an adverse event.

In addition to spontaneous reporting, in one of the studies, adverse events were also elicited from a checklist for detecting selected events, a method that is more sensitive than spontaneous reporting.

The most common adverse events with RISPERDAL<sup>®</sup> that occurred at an incidence equal to or greater than 5% and at a rate of at least twice that of placebo are shown in [Table 4](#).

**Table 4 Incidence of Treatment-Emergent Adverse Events in Two 8-Week, Placebo-Controlled Trials in Pediatric Patients with Autistic Disorder**

Body System Preferred Term	RISPERDAL <sup>®</sup> (n=76)	Placebo (n=80)
<b>Psychiatric</b>		
Somnolence	67%	23%
Appetite increased	49%	19%
Confusion	5%	0%
<b>Gastrointestinal</b>		
Saliva increased	22%	6%
Constipation	21%	8%

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Dry mouth	13%	6%
<b>Body as a whole - general</b>		
Fatigue	42%	13%
<b>Central &amp; peripheral nervous system</b>		
Tremor	12%	1%
Dystonia	12%	6%
Dizziness	9%	3%
Automatism	7%	1%
Dyskinesia	7%	0%
Parkinsonism	8%	0%
<b>Respiratory</b>		
Upper respiratory tract infection	34%	15%
<b>Metabolic and nutritional</b>		
Weight increase	5%	0%
<b>Heart rate and rhythm</b>		
Tachycardia	7%	0%

Weight increase was reported more frequently with RISPERDAL<sup>®</sup> than with placebo. The average weight increase over 8 weeks was 2.6 kg in patients treated with RISPERDAL<sup>®</sup> compared with 0.9 kg in patients treated with placebo. (See also [PRECAUTIONS – Pediatric Use – Weight Gain](#).)

There was a higher incidence of adverse events reflecting extrapyramidal symptoms (EPS) in the RISPERDAL<sup>®</sup> group (27.6%) compared with the placebo group (10.0%). In addition, between-group comparison of the severity of EPS were assessed objectively by the following rating instruments: the Simpson-Angus Rating Scale (SARS) and the Abnormal Involuntary Movement Scale (AIMS) in one study, and the Extrapyramidal Symptom Rating Scale (ESRS) in the other study. The mean changes between baseline and endpoint in the total ESRS score were –0.3 in the RISPERDAL<sup>®</sup> group and –0.4 in the placebo group. The median change from baseline to endpoint was 0 in both treatment groups for each EPS rating scale.

Somnolence was the most frequent adverse event, and was reported at a higher incidence in the RISPERDAL<sup>®</sup> group compared with the placebo group. The vast majority of cases (96%) were either mild or moderate in severity. These events were most often of early onset with peak incidence occurring during the first 2 weeks of treatment, and median duration was 16 days. Patients experiencing persistent somnolence may benefit from a change in dosing regimen (see [DOSAGE AND ADMINISTRATION – Irritability Associated with Autistic Disorder – Pediatrics \[Children and Adolescents\]](#)).

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### **Other Events Observed During the Premarketing Evaluation of RISPERDAL<sup>®</sup>**

During its premarketing assessment, multiple doses of RISPERDAL<sup>®</sup> were administered to 2607 adult patients with schizophrenia and 1923 pediatric patients in Phase 2 and 3 studies. The conditions and duration of exposure to RISPERDAL<sup>®</sup> varied greatly, and included (in overlapping categories) open-label and double-blind studies, uncontrolled and controlled studies, inpatient and outpatient studies, fixed-dose and titration studies, and short-term or longer-term exposure. In most studies, untoward events associated with this exposure were obtained by spontaneous report and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of untoward events into a smaller number of standardized event categories. In two large studies, adverse events were also elicited utilizing the UKU (direct questioning) side effect rating scale, and these events were not further categorized using standard terminology. (Note: These events are marked with an asterisk in the listings that follow.)

In the listings that follow, spontaneously reported adverse events were classified using World Health Organization (WHO) preferred terms. The frequencies presented, therefore, represent the proportion of the 2607 adult or 1923 pediatric patients exposed to multiple doses of RISPERDAL<sup>®</sup> who experienced an event of the type cited on at least one occasion while receiving RISPERDAL<sup>®</sup>. All reported events are included, except those already listed in [Table 1](#), those events for which a drug cause was remote, and those event terms which were so general as to be uninformative. It is important to emphasize that, although the events reported occurred during treatment with RISPERDAL<sup>®</sup>, they were not necessarily caused by it. Serious adverse reactions experienced by the pediatric population were similar to those seen in the adult population (see [WARNINGS](#), [PRECAUTIONS](#), and [ADVERSE REACTIONS](#)).

Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring in at least 1/100 patients (only those not already listed in the tabulated results from placebo-controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients.

#### **Psychiatric Disorders**

*Frequent:* increased dream activity\*, diminished sexual desire\*, nervousness. *Infrequent:* impaired concentration, depression, apathy, catatonic reaction, euphoria, increased libido, amnesia. *Rare:* emotional lability, nightmares, delirium, withdrawal syndrome, yawning.

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### Central and Peripheral Nervous System Disorders

*Frequent:* increased sleep duration\*. *Infrequent:* dysarthria, vertigo, stupor, paraesthesia, confusion. *Rare:* aphasia, cholinergic syndrome, hypoesthesia, tongue paralysis, leg cramps, torticollis, hypotonia, coma, migraine, hyperreflexia, choreoathetosis.

### Gastrointestinal Disorders

*Frequent:* anorexia, reduced salivation\*. *Infrequent:* flatulence, diarrhea, increased appetite, stomatitis, melena, dysphagia, hemorrhoids, gastritis. *Rare:* fecal incontinence, eructation, gastroesophageal reflux, gastroenteritis, esophagitis, tongue discoloration, cholelithiasis, tongue edema, diverticulitis, gingivitis, discolored feces, GI hemorrhage, hematemesis.

### Body as a Whole/General Disorders

*Frequent:* fatigue. *Infrequent:* edema, rigors, malaise, influenza-like symptoms. *Rare:* pallor, enlarged abdomen, allergic reaction, ascites, sarcoidosis, flushing.

### Respiratory System Disorders

*Infrequent:* hyperventilation, bronchospasm, pneumonia, stridor. *Rare:* asthma, increased sputum, aspiration.

### Skin and Appendage Disorders

*Frequent:* increased pigmentation\*, photosensitivity\* *Infrequent:* increased sweating, acne, decreased sweating, alopecia, hyperkeratosis, pruritus, skin exfoliation. *Rare:* bullous eruption, skin ulceration, aggravated psoriasis, furunculosis, verruca, dermatitis lichenoid, hypertrichosis, genital pruritus, urticaria.

### Cardiovascular Disorders

*Infrequent:* palpitation, hypertension, hypotension, AV block, myocardial infarction. *Rare:* ventricular tachycardia, angina pectoris, premature atrial contractions, T wave inversions, ventricular extrasystoles, ST depression, myocarditis.

### Vision Disorders

*Infrequent:* abnormal accommodation, xerophthalmia. *Rare:* diplopia, eye pain, blepharitis, photopsia, photophobia, abnormal lacrimation.

### Metabolic and Nutritional Disorders

*Infrequent:* hyponatremia, weight increase, creatine phosphokinase increase, thirst, weight decrease, diabetes mellitus. *Rare:* decreased serum iron, cachexia, dehydration, hypokalemia, hypoproteinemia, hyperphosphatemia, hypertriglyceridemia, hyperuricemia, hypoglycemia.

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### Urinary System Disorders

*Frequent:* polyuria/polydipsia\*. *Infrequent:* urinary incontinence, hematuria, dysuria. *Rare:* urinary retention, cystitis, renal insufficiency.

### Musculo-Skeletal System Disorders

*Infrequent:* myalgia. *Rare:* arthrosis, synostosis, bursitis, arthritis, skeletal pain.

### Reproductive Disorders, Female

*Frequent:* menorrhagia\*, orgasmic dysfunction\*, dry vagina\* *Infrequent:* nonpuerperal lactation, amenorrhea, female breast pain, leukorrhea, mastitis, dysmenorrhea, female perineal pain, intermenstrual bleeding, vaginal hemorrhage.

### Liver and Biliary System Disorders

*Infrequent:* increased SGOT, increased SGPT. *Rare:* hepatic failure, cholestatic hepatitis, cholecystitis, cholelithiasis, hepatitis, hepatocellular damage.

### Platelet, Bleeding, and Clotting Disorders

*Infrequent:* epistaxis, purpura. *Rare:* hemorrhage, superficial phlebitis, thrombophlebitis, thrombocytopenia.

### Hearing and Vestibular Disorders

*Rare:* tinnitus, hyperacusis, decreased hearing.

### Red Blood Cell Disorders

*Infrequent:* anemia, hypochromic anemia. *Rare:* normocytic anemia.

### Reproductive Disorders, Male

*Frequent:* erectile dysfunction\* *Infrequent:* ejaculation failure.

### White Cell and Resistance Disorders

*Infrequent:* granulocytopenia. *Rare:* leukocytosis, lymphadenopathy, leucopenia, Pelger-Huet anomaly.

### Endocrine Disorders

*Rare:* gynecomastia, male breast pain, antidiuretic hormone disorder.

### Special Senses

*Rare:* bitter taste.

\* Incidence based on elicited reports.

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### **Postintroduction Reports**

Adverse events reported since market introduction which were temporally (but not necessarily causally) related to RISPERDAL<sup>®</sup> therapy, include the following: anaphylactic reaction, angioedema, apnea, atrial fibrillation, cerebrovascular disorder, including cerebrovascular accident, diabetes mellitus aggravated, including diabetic ketoacidosis, hyperglycemia, intestinal obstruction, jaundice, mania, pancreatitis, Parkinson's disease aggravated, pituitary adenomas, pulmonary embolism, and precocious puberty. There have been rare reports of sudden death and/or cardiopulmonary arrest in patients receiving RISPERDAL<sup>®</sup>. A causal relationship with RISPERDAL<sup>®</sup> has not been established. It is important to note that sudden and unexpected death may occur in psychotic patients whether they remain untreated or whether they are treated with other antipsychotic drugs.

### **DRUG ABUSE AND DEPENDENCE**

#### **Controlled Substance Class**

RISPERDAL<sup>®</sup> (risperidone) is not a controlled substance.

#### **Physical and Psychological Dependence**

RISPERDAL<sup>®</sup> has not been systematically studied in animals or humans for its potential for abuse, tolerance, or physical dependence. While the clinical trials did not reveal any tendency for any drug-seeking behavior, these observations were not systematic and it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, patients should be evaluated carefully for a history of drug abuse, and such patients should be observed closely for signs of RISPERDAL<sup>®</sup> misuse or abuse (e.g., development of tolerance, increases in dose, drug-seeking behavior).

### **OVERDOSAGE**

#### **Human Experience**

Premarketing experience included eight reports of acute RISPERDAL<sup>®</sup> (risperidone) overdose with estimated doses ranging from 20 to 300 mg and no fatalities. In general, reported signs and symptoms were those resulting from an exaggeration of the drug's known pharmacological effects, i.e., drowsiness and sedation, tachycardia and hypotension, and extrapyramidal symptoms. One case, involving an estimated overdose of 240 mg, was associated with hyponatremia, hypokalemia, prolonged QT, and widened QRS. Another case, involving an estimated overdose of 36 mg, was associated with a seizure.

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Postmarketing experience includes reports of acute RISPERDAL<sup>®</sup> overdose, with estimated doses of up to 360 mg. In general, the most frequently reported signs and symptoms are those resulting from an exaggeration of the drug's known pharmacological effects, i.e., drowsiness, sedation, tachycardia, hypotension, and extrapyramidal symptoms. Other adverse events reported since market introduction which were temporally (but not necessarily causally) related to RISPERDAL<sup>®</sup> overdose, include torsade de pointes, prolonged QT interval, convulsions, cardiopulmonary arrest, and rare fatality associated with multiple drug overdose.

### **Management of Overdosage**

In case of acute overdose, establish and maintain an airway and ensure adequate oxygenation and ventilation. Gastric lavage (after intubation, if patient is unconscious) and administration of activated charcoal together with a laxative should be considered. Because of the rapid disintegration of RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets, pill fragments may not appear in gastric contents obtained with lavage.

The possibility of obtundation, seizures, or dystonic reaction of the head and neck following overdose may create a risk of aspiration with induced emesis. Cardiovascular monitoring should commence immediately and should include continuous electrocardiographic monitoring to detect possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide, and quinidine carry a theoretical hazard of QT-prolonging effects that might be additive to those of risperidone. Similarly, it is reasonable to expect that the alpha-blocking properties of bretylium might be additive to those of risperidone, resulting in problematic hypotension.

There is no specific antidote to RISPERDAL<sup>®</sup>. Therefore, appropriate supportive measures should be instituted. The possibility of multiple drug involvement should be considered. Hypotension and circulatory collapse should be treated with appropriate measures, such as intravenous fluids and/or sympathomimetic agents (epinephrine and dopamine should not be used, since beta stimulation may worsen hypotension in the setting of risperidone-induced alpha blockade). In cases of severe extrapyramidal symptoms, anticholinergic medication should be administered. Close medical supervision and monitoring should continue until the patient recovers.

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## **DOSAGE AND ADMINISTRATION**

### **Schizophrenia**

#### **Usual Initial Dose**

RISPERDAL<sup>®</sup> (risperidone) can be administered on either a BID or a QD schedule. In early clinical trials, RISPERDAL<sup>®</sup> was generally administered at 1 mg BID initially, with increases in increments of 1 mg BID on the second and third day, as tolerated, to a target dose of 3 mg BID by the third day. Subsequent controlled trials have indicated that total daily risperidone doses of up to 8 mg on a QD regimen are also safe and effective. However, regardless of which regimen is employed, in some patients a slower titration may be medically appropriate. Further dosage adjustments, if indicated, should generally occur at intervals of not less than 1 week, since steady state for the active metabolite would not be achieved for approximately 1 week in the typical patient. When dosage adjustments are necessary, small dose increments/decrements of 1-2 mg are recommended.

Efficacy in schizophrenia was demonstrated in a dose range of 4 to 16 mg/day in the clinical trials supporting effectiveness of RISPERDAL<sup>®</sup>; however, maximal effect was generally seen in a range of 4 to 8 mg/day. Doses above 6 mg/day for BID dosing were not demonstrated to be more efficacious than lower doses, were associated with more extrapyramidal symptoms and other adverse effects, and are not generally recommended. In a single study supporting QD dosing, the efficacy results were generally stronger for 8 mg than for 4 mg. The safety of doses above 16 mg/day has not been evaluated in clinical trials.

#### **Maintenance Therapy**

While there is no body of evidence available to answer the question of how long the schizophrenic patient treated with RISPERDAL<sup>®</sup> should remain on it, the effectiveness of RISPERDAL<sup>®</sup> 2 mg/day to 8 mg/day at delaying relapse was demonstrated in a controlled trial in patients who had been clinically stable for at least 4 weeks and were then followed for a period of 1 to 2 years. In this trial, RISPERDAL<sup>®</sup> was administered on a QD schedule, at 1 mg QD initially, with increases to 2 mg QD on the second day, and to a target dose of 4 mg QD on the third day (see [CLINICAL PHARMACOLOGY – Clinical Trials](#)). Nevertheless, patients should be periodically reassessed to determine the need for maintenance treatment with an appropriate dose.

#### **Reinitiation of Treatment in Patients Previously Discontinued**

Although there are no data to specifically address reinitiation of treatment, it is recommended that when restarting patients who have had an interval off RISPERDAL<sup>®</sup>, the initial titration schedule should be followed.

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### Switching From Other Antipsychotics

There are no systematically collected data to specifically address switching schizophrenic patients from other antipsychotics to RISPERDAL<sup>®</sup>, or concerning concomitant administration with other antipsychotics. While immediate discontinuation of the previous antipsychotic treatment may be acceptable for some schizophrenic patients, more gradual discontinuation may be most appropriate for others. In all cases, the period of overlapping antipsychotic administration should be minimized. When switching schizophrenic patients from depot antipsychotics, if medically appropriate, initiate RISPERDAL<sup>®</sup> therapy in place of the next scheduled injection. The need for continuing existing EPS medication should be re-evaluated periodically.

### Pediatric Use

The safety and effectiveness of RISPERDAL<sup>®</sup> in pediatric patients with schizophrenia have not been established.

### Bipolar Mania

#### Usual Dose

Risperidone should be administered on a once daily schedule, starting with 2 mg to 3 mg per day. Dosage adjustments, if indicated, should occur at intervals of not less than 24 hours and in dosage increments/decrements of 1 mg per day, as studied in the short-term, placebo-controlled trials. In these trials, short-term (3 week) anti-manic efficacy was demonstrated in a flexible dosage range of 1-6 mg per day (see [CLINICAL PHARMACOLOGY – Clinical Trials](#)). RISPERDAL<sup>®</sup> doses higher than 6 mg per day were not studied.

#### Maintenance Therapy

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 treatment of an acute manic episode with risperidone. 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 use of risperidone in such longer-term treatment (i.e., beyond 3 weeks).

### Pediatric Use

The safety and effectiveness of RISPERDAL<sup>®</sup> in pediatric patients with bipolar mania have not been established.

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### **Irritability Associated with Autistic Disorder – Pediatrics (Children and Adolescents)**

The safety and effectiveness of RISPERDAL<sup>®</sup> in pediatric patients with autistic disorder less than 5 years of age have not been established.

The dosage of RISPERDAL<sup>®</sup> should be individualized according to the response and tolerability of the patient. The total daily dose of RISPERDAL<sup>®</sup> can be administered once daily, or half the total daily dose can be administered twice daily.

Dosing should be initiated at 0.25 mg per day for patients < 20 kg and 0.5 mg per day for patients ≥ 20 kg. After a minimum of four days from treatment initiation, the dose may be increased to the recommended dose of 0.5 mg per day for patients < 20 kg and 1 mg per day for patients ≥ 20 kg. This dose should be maintained for a minimum of 14 days. In patients not achieving sufficient clinical response, dose increases may be considered at ≥ 2-week intervals in increments of 0.25 mg per day for patients < 20 kg or 0.5 mg per day for patients ≥ 20 kg. Caution should be exercised with dosage for smaller children who weighed less than 15 kg.

In clinical trials, 90% of patients who showed a response (based on at least 25% improvement on ABC-I, see [CLINICAL PHARMACOLOGY – Clinical Trials](#)) received doses of RISPERDAL<sup>®</sup> between 0.5 mg and 2.5 mg per day. The maximum daily dose of RISPERDAL<sup>®</sup> in one of the pivotal trials, when the therapeutic effect reached plateau, was 1.0 mg in patients < 20 kg, 2.5 mg in patients ≥ 20 kg, or 3.0 mg in patients > 45 kg. No dosing data are available for children who weigh less than 15 kg.

Once sufficient clinical response has been achieved and maintained, consideration should be given to gradually lowering the dose to achieve the optimal balance of efficacy and safety.

Patients experiencing persistent somnolence may benefit from a once-daily dose administered at bedtime or administering half the daily dose twice daily, or a reduction of the dose.

### **Dosage in Special Populations**

The recommended initial dose is 0.5 mg BID in patients who are elderly or debilitated, patients with severe renal or hepatic impairment, and patients either predisposed to hypotension or for whom hypotension would pose a risk. Dosage increases in these patients should be in increments of no more than 0.5 mg BID. Increases to dosages above 1.5 mg BID should generally occur at intervals of at least 1 week. In some patients, slower titration may be medically appropriate.

Elderly or debilitated patients, and patients with renal impairment, may have less ability to eliminate RISPERDAL<sup>®</sup> than normal adults. Patients with impaired hepatic function may have

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increases in the free fraction of risperidone, possibly resulting in an enhanced effect (see [CLINICAL PHARMACOLOGY](#)). Patients with a predisposition to hypotensive reactions or for whom such reactions would pose a particular risk likewise need to be titrated cautiously and carefully monitored (see [PRECAUTIONS](#)). If a once-a-day dosing regimen in the elderly or debilitated patient is being considered, it is recommended that the patient be titrated on a twice-a-day regimen for 2-3 days at the target dose. Subsequent switches to a once-a-day dosing regimen can be done thereafter.

### **Co-Administration of RISPERDAL<sup>®</sup> with Certain Other Medications**

Co-administration of carbamazepine and other enzyme inducers (e.g., phenytoin, rifampin, phenobarbital) with risperidone would be expected to cause decreases in the plasma concentrations of active moiety (the sum of risperidone and 9-hydroxyrisperidone), which could lead to decreased efficacy of risperidone treatment. The dose of risperidone needs to be titrated accordingly for patients receiving these enzyme inducers, especially during initiation or discontinuation of therapy with these inducers (see [CLINICAL PHARMACOLOGY](#) and [PRECAUTIONS](#)).

Fluoxetine and paroxetine have been shown to increase the plasma concentration of risperidone 2.5-2.8 fold and 3-9 fold respectively. Fluoxetine did not affect the plasma concentration of 9-hydroxyrisperidone. Paroxetine lowered the concentration of 9-hydroxyrisperidone by about 10%. The dose of risperidone needs to be titrated accordingly when fluoxetine or paroxetine is co-administered (see [CLINICAL PHARMACOLOGY](#) and [PRECAUTIONS](#)).

### **Directions for Use of RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets**

#### **Tablet Accessing**

*RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets 0.5 mg, 1 mg, and 2 mg*

RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets 0.5 mg, 1 mg, and 2 mg are supplied in blister packs of 4 tablets each.

Do not open the blister until ready to administer. For single tablet removal, separate one of the four blister units by tearing apart at the perforations. Bend the corner where indicated. Peel back foil to expose the tablet. DO NOT push the tablet through the foil because this could damage the tablet.

*RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets 3 mg and 4 mg*

RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets 3 mg and 4 mg are supplied in a child-resistant pouch containing a blister with 1 tablet each.

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The child-resistant pouch should be torn open at the notch to access the blister. Do not open the blister until ready to administer. Peel back foil from the side to expose the tablet. DO NOT push the tablet through the foil, because this could damage the tablet.

#### Tablet Administration

Using dry hands, remove the tablet from the blister unit and immediately place the entire RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablet on the tongue. The RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablet should be consumed immediately, as the tablet cannot be stored once removed from the blister unit. RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets disintegrate in the mouth within seconds and can be swallowed subsequently with or without liquid. Patients should not attempt to split or to chew the tablet.

#### HOW SUPPLIED

RISPERDAL<sup>®</sup> (risperidone) tablets are imprinted "JANSSEN", and either "Ris" and the strength "0.25", "0.5", or "R" and the strength "1", "2", "3", or "4".

0.25 mg dark yellow tablet: bottles of 60 NDC 50458-301-04, bottles of 500 NDC 50458-301-50, hospital unit dose packs of 100 NDC 50458-301-01.

0.5 mg red-brown tablet: bottles of 60 NDC 50458-302-06, bottles of 500 NDC 50458-302-50, hospital unit dose packs of 100 NDC 50458-302-01.

1 mg white tablet: bottles of 60 NDC 50458-300-06, blister pack of 100 NDC 50458-300-01, bottles of 500 NDC 50458-300-50.

2 mg orange tablet: bottles of 60 NDC 50458-320-06, blister pack of 100 NDC 50458-320-01, bottles of 500 NDC 50458-320-50.

3 mg yellow tablet: bottles of 60 NDC 50458-330-06, blister pack of 100 NDC 50458-330-01, bottles of 500 NDC 50458-330-50.

4 mg green tablet: bottles of 60 NDC 50458-350-06, blister pack of 100 NDC 50458-350-01.

RISPERDAL<sup>®</sup> (risperidone) 1 mg/mL oral solution (NDC 50458-305-03) is supplied in 30 mL bottles with a calibrated (in milligrams and milliliters) pipette. The minimum calibrated volume is 0.25 mL, while the maximum calibrated volume is 3 mL.

Tests indicate that RISPERDAL<sup>®</sup> (risperidone) oral solution is compatible in the following beverages: water, coffee, orange juice, and low-fat milk; it is NOT compatible with either cola or tea, however.

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RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> (risperidone) Orally Disintegrating Tablets are etched on one side with “R0.5”, “R1”, “R2”, “R3”, and “R4”, respectively. RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets 0.5 mg, 1 mg, and 2 mg are packaged in blister packs of 4 (2 X 2) tablets. Orally Disintegrating Tablets 3 mg and 4 mg are packaged in a child-resistant pouch containing a blister with 1 tablet.

0.5 mg light coral, round, biconvex tablets: 7 blister packages per box, NDC 50458-395-28, long-term care packaging of 30 tablets NDC 50458-395-30.

1 mg light coral, square, biconvex tablets: 7 blister packages per box, NDC 50458-315-28, long-term care packaging of 30 tablets NDC 50458-315-30.

2 mg light coral, round, biconvex tablets: 7 blister packages per box, NDC 50458-325-28.

3 mg coral, round, biconvex tablets: 28 blisters per box, NDC 50458-335-28.

4 mg coral, round, biconvex tablets: 28 blisters per box, NDC 50458-355-28.

### **Storage and Handling**

RISPERDAL<sup>®</sup> tablets should be stored at controlled room temperature 15°-25°C (59°-77°F). Protect from light and moisture.

Keep out of reach of children.

RISPERDAL<sup>®</sup> 1 mg/mL oral solution should be stored at controlled room temperature 15°-25°C (59°-77°F). Protect from light and freezing.

Keep out of reach of children.

RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets should be stored at controlled room temperature 15°-25°C (59°-77°F).

Keep out of reach of children.

[INSERT NEW COMPONENT CODE]

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RISPERDAL<sup>®</sup> tablets are manufactured by:

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JOLLC, Gurabo, Puerto Rico or  
Janssen-Cilag, SpA, Latina, Italy  
RISPERDAL<sup>®</sup> oral solution is manufactured by:  
Janssen Pharmaceutica N.V.  
Beerse, Belgium

RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets are manufactured by:  
JOLLC, Gurabo, Puerto Rico

RISPERDAL<sup>®</sup> tablets, RISPERDAL<sup>®</sup> M-TAB<sup>®</sup> Orally Disintegrating Tablets, and oral solution  
are distributed by:

**Janssen, L.P.**  
Titusville, NJ 08560