

HIGHLIGHTS OF PRESCRIBING INFORMATION These highlights do not include all the information needed to use DIVALPROEX SODIUM EXTENDED-RELEASE TABLETS safely and effectively. See full formation for DIVALPROEX SODIUM EXTENDED-RELEASE TABLETS.

DIVALPROEX SODIUM extended-release tablets, for oral use

WARNING: LIFE THREATENING ADVERSE REACTIONS Hepatotoxicity, including fatalities, usually during the first 6 months of treatment. Children under the age of two years and patients with mitochondrial disorders are at higher risk. Monitor patients closely, and perform serum liver testing prior to therapy and at frequent interval

Fetal Risk, particularly neural tube defects, other major malformations, and decreased IQ (5.2, 5.3, 5.4) Pancreatitis, including fatal hemorrhagic cases (5.5)

....INDICATIONS AND USAGE--Divalproex sodium extended-release tablets are indicated for: Acute treatment of manic or mixed episodes associated with bipolar disorder, with or without psychotic features (1.1)

Monotherapy and adjunctive therapy of complex partial seizures and simple and complex absence seizures; adjunctive therapy in patients with multiple seizure

 Prophylaxis of migraine headaches (1.3) ---DOSAGE AND ADMINISTRATION---Divalproex sodium extended-release tablets are intended for once-a-day oral administration. Divalproex sodium extended-release tablets should be swallowed whole and should not be crushed or chewed (2.1, 2.2).

 Mania: Initial dose is 25 mg/kg/day, increasing as rapidly as possible to achieve therapeutic response or desired plasma level (2.1). The maximum recommended Complex Partial Seizures: Start at 10 to 15 mg/kg/day, increasing at 1 week intervals by 5 to 10 mg/kg/day to achieve optimal clinical response; if response is not

satisfactory, check valproate plasma level; see full prescribing information for conversion to monotherapy (2.2). The maximum recommended dosage is Absence Seizures: Start at 15 mg/kg/day, increasing at 1 week intervals by 5 to 10 mg/kg/day until seizure control or limiting side effects (2.2). The maximum

 Migraine: The recommended starting dose is 500 mg/day for 1 week, thereafter increasing to 1,000 mg/day (2.3). ---DOSAGE FORMS AND STRENGTHS---Tablets: 250 mg and 500 mg (3)

--- CONTRAINDICATIONS Hepatic disease or significant hepatic dysfunction (4, 5.1)

 $Known\,mit ochondrial\,disorders\,caused\,by\,mutations\,in\,mit ochondrial\,DNA\,polymerase\,\gamma\,(POLG)\,(4,5.1)$ Suspected POLG-related disorder in children under two years of age (4, 5.1) Known hypersensitivity to the drug (4, 5.12)

 Prophylaxis of migraine headaches: Pregnant women, women of childbearing potential not using effective contraception (4, 8.1)WARNINGS AND PRECAUTIONS...

Hepatotoxicity; evaluate high risk populations and monitor serum liver tests (5.1)
Birth defects, decreased IQ, and neurodevelopmental disorders following in utero exposure; should not be used to treat women with epilepsy or bipolar disorder who are pregnant or who plan to become pregnant or to treat a woman of childbearing potential unless other medications have failed to provide adequate symptom

Suicidal behavior or ideation; Antiepileptic drugs, including divalproex sodium extended-release tablets, increase the risk of suicidal thoughts or behavior (5.7) Bleeding and other hematopoietic disorders; monitor platelet counts and coagulation tests (5.8) Hyperammonemia and hyperammonemic encephalopathy; measure ammonia level if unexplained lethargy and vomiting or changes in mental status, and also with ncomitant topiramate use; consider discontinuation of valproate therapy (5.6, 5.9, 5.10)

Hypothermia; Hypothermia has been reported during valproate therapy with or without associated hyperammonemia. This adverse reaction can also occur in Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)/Multiorgan hypersensitivity reaction; discontinue divalproex sodium extended release tablets Somnolence in the elderly can occur. Divalproex sodium extended-release tablets dosage should be increased slowly and with regular monitoring for fluid and nutritional intake (5.14)

....ADVERSE REACTIONS..... Most common adverse reactions (reported > 5%) are abdominal pain, alopecia, amblyopia/blurred vision, amnesia, anorexia, asthenia, ataxia, back pain, bronchitis, constipation, depression, diarrhea, diplopia, dizziness, dyspnea, dyspepsia, ecchymosis, emotional lability, fever, flu syndrome, headache, increased appetite, infection, insomnia, nausea, nervousness, nystagmus, peripheral edema, pharyngitis, rash, rhinitis, somnolence, thinking abnormal, thrombocytopenia, innitus, tremor, vomiting, weight gain, weight loss (6.1, 6.2, 6.3).

To report SUSPECTED ADVERSE REACTIONS, contact Annora Pharma Private Limited at 1-866-495-1995 or FDA at 1-800-FDA-1088 or

Hepatic enzyme-inducing drugs (e.g., phenytoin, carbamazepine, phenobarbital, primidone, rifampin) can increase valproate clearance, while enzyme inhibitors (e.g., felbamate) can decrease valproate clearance. Therefore increased monitoring of valproate and concomitant drug concentrations and dosage adjustment are indicated whenever enzyme-inducing or inhibiting drugs are introduced or withdrawn (7.1) $As pirin, carbapenem\ antibiotics, estrogen-containing\ hormonal\ contraceptives, methot rexate:\ Monitoring\ of\ valproate\ concentrations and the contraceptives is a supplied of the contraceptives of the contraceptives is a supplied of the contraceptives of the contraceptives of the contraceptive o$

Co-administration of valproate can affect the pharmacokinetics of other drugs (e.g. diazepam, ethosuximide, lamotrigine, phenytoin) by inhibiting their metabolism Patients stabilized on rufinamide should begin valproate therapy at a low dose, and titrate to clinically effective dose (7.2) Dosage adjustment of amitriptyline/nortriptyline, propofol, warfarin, and zidovudine may be necessary if used concomitantly with divalproex sodium extended-

release tablets (7.2) Topiramate: Hyperammonemia and encephalopathy (5.10, 7.3) Cannabidiol: ALT and/or AST elevation (7.4)

.....USE IN SPECIFIC POPULATIONS..... Pregnancy: Divalproex sodium extended-release tablets can cause congenital malformations including neural tube defects, decreased IQ, and neurodevelopmental disorders (5.2, 5.3, 8.1)

 $Pediatric: Children\,under\,the\,age\,of\,two\,years\,are\,at\,considerably\,higher\,risk\,of\,fatal\,hepatotoxicity\,(5.1,8.4)$ • Geriatric: Reduce starting dose; increase dosage more slowly; monitor fluid and nutritional intake, and somnolence (5.14, 8.5)

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occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as malaise weakness, lethargy, facial edema, anorexia, and vomiting. In patients with epilepsy, a loss of seizure control may also occur. Patients should be monitored closely for appearance of these symptoms. Serum liver tests should be performed prior to therapy and at frequent intervals thereaft

especially during the first six months (see Warnings and Precautions (5.1)). Children under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those on multiple anticonvulsants, those with congenital metabolic disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease. When divalproex sodium extended release tablets are used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. The incidence of fatal hepatotoxicity decreases considerably in progressiv Patients with Mitochondrial Disease: There is an increased risk of valproate-induced acute liver failure and resultant deaths in patients with heredit. neurometabolic syndromes caused by DNA mutations of the mitochondrial DNA Polymerase y (POLG) gene (e.g. Alpers Huttenlocher Syndrome Divalproex sodium extended-release tablets are contraindicated in patients known to have mitochondrial disorders caused by POLG mutations an Divaproex socium extended-release tablets are contraindicated in patients known to have mitochondrial disorders caused by PULG mitrations and children under two years of age who are clinically suspected of having a hereditary mitochondrial disease, divalproex sodium extended-release tablets should only be used after other anticonvulsants have failed. This older group of patients should be closely monitored during treatment with divalproex sodium extended-release tablets for the development of acute liver injury with regular clinical assessments and serum liver testing. POLG mutation screening should be

performed in accordance with current clinical practice (see Warnings and Precautions (5.1)). Valproate can cause major congenital malformations, particularly neural tube defects (e.g., spina bifida). In addition, valproate can cause decr scores and neurodevelopmental disorders following *in utero* exposure.

Valproate is therefore contraindicated for prophylaxis of migraine headaches in pregnant women and in women of childbearing potential who are not using effective contraception *(see Contraindications (4)).* Valproate should not be used to treat women with epilepsy or bipolar disorder who are pregnant or who plan to become pregnant unless other medications have failed to provide adequate symptom control or are otherwise unacceptable Valproate should not be administered to a woman of childbearing potential unless other medications have failed to provide adequate symptom con or are otherwise unacceptable. In such situations, effective contraception should be used (see Warnings and Precautions (5.2, 5.3, 5.4)) A Medication Guide describing the risks of valproate is available for patients (see Patient Counseling Information (17))

Cases of life threatening pancreatitis have been reported in both children and adults receiving valproate. Some of the cases have been described a hemorrhagic with a rapid progression from initial symptoms to death. Cases have been reported shortly after initial use as well as after several years of use. Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical evaluation. If pancreatitis is diagnosed, valproate should ordinarily be discontinued. Alternative treatment for the underlying medical condition should be initiated as clinically indicated *(see Warnings and Precautions (5.5))*.

INDICATIONS AND USAGE 1.1 Mania ended-release tablets are a valproate and are indicated for the treatment of acute manic or mixed episodes associated with bipolar disorder, with or Divalproex sodium without psychotic features. A manic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood. Typical symptoms of mania include

pressure of speech, motor hyperactivity, reduced need for sleep, flight of ideas, grandiosity, poor judgment, aggressiveness, and possible hostility. A mixed episode is characterized by the criteria for a manic episode in conjunction with those for a major depressive episode (depressed mood, loss of interest or pleasure in nearly all The efficacy of divalproex sodium extended-release tablets is based in part on studies of divalproex sodium delayed-release tablets in this indication, and was confirmed in a 3 week trial with patients meeting DSM-IV TR criteria for bipolar I disorder, manic or mixed type, who were hospitalized for acute mania [see Clinical Studies (14.1]]. $The \,effectiveness\, of\, valproate\, for\, long-term\, use\, in\, mania,\, i.e.,\, more\, than\, 3\, weeks,\, has\, not\, been\, demonstrated\, in\, controlled\, clinical\, trials.\, Therefore,\, healthcare\, providers the controlled\, clinical\, trials\, th$ who elect to use divalproex sodium extended release tablets for extended periods should continually reevaluate the long-term risk-benefits of the drug for the individual

1.2 Epilepsy Divalproex sodium extended-release tablets are indicated as monotherapy and adjunctive therapy in the treatment of adult patients and pediatric patients down to the age of 10 years with complex partial seizures that occur either in isolation or in association with other types of seizures. Divalproex sodium extended-release tablets are also indicated for use as sole and adjunctive therapy in the treatment of simple and complex absence seizures in adults and children 10 years of age or older, and adjunctively in adults and children 10 years of age or older with multiple seizure types that include absence seizures.

Simple absence is defined as very brief clouding of the sensorium or loss of consciousness accompanied by certain generalized epileptic discharges without other

Divalproor sodium extended-release tablets are indicated for prophylaxis of migraine headaches. There is no evidence that divalproex sodium extended-release tablets are useful in the acute treatment of migraine headaches. 1.4 Important Limitations Because of the risk to the fetus of decreased IQ, neurodevelopmental disorders, neural tube defects, and other major congenital malformations, which may occur very early in pregnancy, valproate should not be used to treat women with epilepsy or bipolar disorder who are pregnant or who plan to become pregnant unless other medications have failed to provide adequate symptom control or are otherwise unacceptable. Valproate should not be administered to a woman of childbearing potential unless other medications have failed to provide adequate symptom control or are otherwise unacceptable (see Warnings and Precautions (5,2, 5,3, 5,4), Use in Specific

potential who are not using effective contraception [see Contraindications (4)]. 2 DOSAGE AND ADMINISTRATION Divalproex sodium extended-release tablets are an extended-release product intended for once-a-day oral administration. Divalproex sodium extended-release tablets should be swallowed whole and should not be crushed or chewed

For prophylaxis of migraine headaches, divalproex sodium extended-release tablets are contraindicated in women who are pregnant and in women of childbearing

Divalproex sodium extended-release tablets are administered orally. The recommended initial dose is 25 mg/kg/day given once daily. The dose should be increased as rapidly as possible to achieve the lowest therapeutic dose which produces the desired clinical effect or the desired range of plasma concentrations. In a placebo-controlled clinical trial of acute mania or mixed type, patients were dosed to a clinical response with a trough plasma concentration between 85 and 125 mcg/mL. The maximum 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 divalproex sodium extended-release tablets treatment of an acute manic episode. While it is generally agreed that pharmacological treatment beyond an acute response in mania is desirable, both for maintenance of the initial response and for prevention of new manic episodes, there are no data to support the benefits of divalproex sodium extended-release

2.2 Epilepsy
Divalproex sodium extended-release tablets are administered orally, and must be swallowed whole. As divalproex sodium extended-release tablets dosage is titrated upward, concentrations of clonazepam, diazepam, ethosuximide, lamotrigine, tolbutamide, phenobarbital, carbamazepine, and/or phenytoin may be affected /see Drug Interactions (7.2)]. **Complex Partial Seizures** For adults and children 10 years of age or older.

Monotherapy (Initial Therapy) tablets have not been systematically studied as initial therapy. Patients should initiate therapy at 10 to 15 mg/kg/day. The dosage should be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 mcg/mL). mendation regarding the safety of valproate for use at doses above 60 mg/kg/day can be made. The probability of thrombocytopenia increases significantly at total trough valproate plasma concentrations above 110 mcg/mL in females and 135 mcg/mL in males. The benefit of improved seizure control with higher doses should be weighed against the possibility of a greater incidence of adverse reactions.

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

withdrawal of the concomitant AED can be highly variable, and patients should be monitored closely during this period for increased seizure fre Divalproex sodium extended-release tablets may be added to the patient's regimen at a dosage of 10 to 15 mg/kg/day. The dosage may be increased by 5 to 10 mg/kg/week to achieve optimal clinical response. Ordinarily, optimal clinical response is achieved at daily doses below 60 mg/kg/day. If satisfactory clinical response has not been achieved, asma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 mcg/mL). No recommendation regarding the safety

f valproate for use at doses above 60 mg/kg/day can be made In a study of adjunctive therapy for complex partial seizures in which patients were receiving either carbamazepine or phenytoin in addition to valproate, no adjustment of carbamazepine or phenytoin dosage was needed [see Clinical Studies (14.2]]. However, since valproate may interact with these or other concurrently administered AEDs as well as other drugs, periodic plasma concentration determinations of concomitant AEDs are recommended during the early course of therapy [see Drug Interactions].

The recommended initial dose is 15 mg/kg/day, increasing at one week intervals by 5 to 10 mg/kg/day until seizures are controlled or side effects preclude further A good correlation has not been established between daily dose, serum concentrations, and therapeutic effect. However, therapeutic valproate serum concentration for most patients with absence seizures is considered to range from 50 to 100 mcg/mL. Some patients may be controlled with lower or higher serum concentrations /see Clinical Pharmacology (12.3)].

As divalproex sodium extended-release tablets dosage is titrated upward, blood concentrations of phenobarbital and/or phenytoin may be affected (see Drug Interactions Antiepilepsy drugs should not be abruptly discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. 2.3 Migraine Divalproex sodium extended-release tablets are indicated for prophylaxis of migraine headaches in adults.

The recommended starting dose is 500 mg once daily for 1 week, thereafter increasing to 1,000 mg once daily. Although doses other than 1,000 mg once daily of divalproex sodium extended-release tablets have not been evaluated in patients with migraine, the effective dose range of divalproex sodium delayed-release tablets in these patients is 500 to 1,000 mg/day. As with other valproate products, doses of divalproex sodium extended-release tablets should be individualized and dose adjustment may be necessary. If a patient requires smaller dose adjustments than that available with divalproex sodium extended release tablets, divalproex sodium

diarrhea
pain on the right side of your stom
dark urine
yellowing of your skin or the white
loss of seizure control in people w
ne cases, liver damage may continue
a and during treatment with divalproe

Il you

2.4 Conversion from Divalproex Sodium Delayed-Release Tablets to Divalproex Sodium Extended-Release Tablets In adult patients and pediatric patients 10 years of age or older with epilepsy previously receiving divalproex sodium delayed-release tablets, divalproex sodium extended release tablets should be administered once daily using a dose 8 to 20% higher than the total daily dose of divalproex sodium delayed release tablets (Table 1). For nts whose divalproex sodium delayed-release tablets total daily dose cannot be directly converted to divalproex sodium extended-release tablets, consider be given at the clinician's discretion to increase the patient's divalproex sodium delayed-release tablets total daily dose to the next higher dosage before converting to the

Table 1. Dose Conversion	
Divalproex Sodium Delayed-Release Tablets	Divalproex Sodium Extended-Release Tablets
Total Daily Dose (mg)	(mg)
500* - 625	750
750* - 875	1,000
1,000* - 1,125	1,250
1,250-1,375	1,500
1,500 -1,625	1,750
1,750	2,000
1,875 - 2,000	2,250
2,125 - 2,250	2,500
2,375	2,750
2,500 - 2,750	3,000
2,875	3,250
3,000 - 3,125	3,500
* These total daily doses of divalproex sodium delayed-re higher total daily dose of divalproex sodium extended-divalproex sodium extended-release tablets are not availab increase the patient's divalproex sodium delayed-release converting to the appropriate total daily dose of divalproex	elease tablets because the required dosing strengths e. Consideration may be given at the clinician's discretio tablets total daily dose to the next higher dosage bel

There is insufficient data to allow a conversion factor recommendation for patients with divalproex sodium delayed-release tablets doses above 3,125 mg/day. Plasma valproate C_ concentrations for divalproex sodium extended-release tablets on average are equivalent to divalproex sodium delayed-release tablets, but may vary across patients after conversion. If satisfactory clinical response has not been achieved, plasma levels should be measured to determine whether or not they are in the usually accepted therapeutic range (50 to 100 mcg/mL) /see Clinical Pharmacology (12.2)/. 2.5 General Dosing Advice

Dosing in Elderly Patients Due to a decrease in unbound clearance of valproate and possibly a greater sensitivity to somnolence in the elderly, the starting dose should be reduced in these patients Starting doses in the elderly lower than 250 mg can only be achieved by the use of divalproex sodium delayed-release tablets. Dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse reactions. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence. The ultimate therapeutic dose should be achieved on the basis of both tolerability and clinical response/see Warnings and Precautions (5.14), Use in Specific Populations (8.5), and Clinical Pharmacology (12.3).

The frequency of adverse effects (particularly elevated liver enzymes and thrombocytopenia) may be dose-related. The probability of thrombocytopenia appears to increase significantly at total valproate concentrations of ≥ 110 mcg/mL (females) or ≥ 135 mcg/mL (males) /see Warnings and Precautions (5.8)]. The benefit of

improved therapeutic effect with higher doses should be weighed against the possibility of a greater incidence of adverse reaction G.I. Irritation ients who experience G.I. irritation may benefit from administration of the drug with food or by slowly building up the dose from an initial low level

Patients should be informed to take divalproex sodium extended-release tablets every day as prescribed. If a dose is missed it should be taken as soon as possible, unless it is almost time for the next dose. If a dose is skipped, the patient should not double the next dose.

2.6 Dosing in Patients Taking Rufinamide stabilized on rufinamide before being prescribed valproate should begin valproate therapy at a low dose, and titrate to a clinically effective dose (see Drug Interactions (7.2)].

3 DOSAGE FORMS AND STRENGTHS Divalproex sodium extended-release tablets USP 250 mg contains divalproex sodium USP equivalent to 250 mg of valproic acid in each tablet and are available as white to off white, oval shaped film-coated tablets imprinting with 'V 23' on one side and plain on other side.

Divalproex sodium extended-release tablets USP 500 mg contains divalproex sodium USP equivalent to 500 mg of valproic acid and are available as white to off white, oval shaped film-coated tablets imprinting with 'V 24' on one side and plain on other side CONTRAINDICATIONS Divalproex sodium extended-release tablets should not be administered to patients with hepatic disease or significant hepatic dysfunction /see Warnings and Precautions (5.1). Divalproex sodium extended-release tablets are contraindicated in patients known to have mitochondrial disorders caused by mutations in mitochondrial DNA

polymerase y (POLG; e.g., Alpers Huttenlocher Syndrome) and children under two years of age who are suspected of having a POLG-related disorder (see Warnings and Precautions (5.1)]. Divalproex sodium extended-release tablets are contraindicated in patients with known hypersensitivity to the drug (see Warnings and Precautions (5.12)). Divalproex sodium extended-release tablets are contraindicated in patients with known urea cycle disorders [see Warnings and Precautions (5.6)]. For use in prophylaxis of migraine headaches: Divalproex sodium extended-release tablets are contraindicated in women who are pregnant and in women of dbearing potential who are not using effective contraception (see Warnings and Precautions (5.2, 5.3, 5.4) and Use in Specific Populations (8.1)]. WARNINGS AND PRECAUTIONS

Hepatic failure resulting in fatalities has occurred in patients receiving valproate. These incidents usually have occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as malaise, weakness, lethargy, facial edema, anorexia, and vomiting. In patients with epilepsy, a loss of seizure control may also occur. Patients should be monitored closely for appearance of these symptoms. Serum liver tests should be performed prior to therapy and at frequent intervals thereafter, especially during the first six months of valproate therapy. However, healthcare providers should not rely totally on serum biochemistry since these tests may not be abnormal in all instances, but should also consider the results of careful interim medical history and physical e Caution should be observed when administering valproate products to patients with a prior history of hepatic disease. Patients on multiple anticonvulsants, children those with congenital metabolic disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease may be at particular risk. See below, "Patients with Known or Suspected Mitochondrial Disease." Experience has indicated that children under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the

Experience has indicated that clinical indication age of two years are at a considerably increased his of developing laten repartorisative, especially mose with the aforementioned conditions. When divalprox sodium extended-release tablets are used in this patient group; it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. In progressively older patient groups experience in epilepsy has indicated that the incidence of fatal Patients with Known or Suspected Mitochondrial Disease
Divalproex sodium extended-release tablets are contraindicated in patients known to have mitochondrial disorders caused by POLG mutations and children under two years of age who are clinically suspected of having a mitochondrial disorder (see Contraindications (4)). Valproate-induced acute liver failure and liver-related disorder (see Contraindications (4)).

been reported in patients with hereditary neurometabolic syndromes caused by mutations in the gene for mitochondrial DNA polymerase y (POLG) (e.g., Alpers-Huttenlocher Syndrome) at a higher rate than those without these syndromes. Most of the reported cases of liver failure in patients with these syndromes have beer POLG-related disorders should be suspected in patients with a family history or suggestive symptoms of a POLG-related disorder, including but not limited to unexplained encephalopathy, refractory epilepsy (focal, myoclonic), status epilepticus at presentation, developmental delays, psychomotor regression, axonal sensorimotor neuropathy, myopathy cerebellar ataxia, ophthalmoplegia, or complicated migraine with occipital aura. POLG mutation testing should be performed in accordance with current clinical practice for the diagnostic evaluation of such disorders. The A467T and W748S mutations are present in approximately 2/3 of patients with autosomal

In patients over two years of age who are clinically suspected of having a hereditary mitochondrial disease, divalproex sodium extended-release tablets should only be used after other anticonvulsants have failed. This older group of patients should be closely monitored during treatment with divalproex sodium extended-release tablets for the development of acute liver injury with regular clinical assessments and serum liver test monitoring. The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of drug /see Boxed Warning and Contraindications (4)).

5.2 Structural Birth Defects Valproate can cause fetal harm when administered to a pregnant woman. Pregnancy registry data show that maternal valproate use can cause neural tube defects and other structural abnormalities (e.g., craniofacial defects, cardiovascular malformations, hypospadias, limb malformations). The rate of congenital malformations among suggests that folic acid supplementation prior to conception and during the first trimester of pregnancy decreases the risk for congenital neural tube defects in the general population [see Use in Specific Populations (8.1)].

5.3 Decreased IQ Following in utero Exposure te can cause decreased IQ scores following in utero exposure. Published epidemiological studies have indicated that children exposed to valproate in utero have lower cognitive test scores than children exposed in utero to either another antiepileptic drug or to no antiepileptic drugs. The largest of these studies' is a prospective cohort study conducted in the United States and United Kingdom that found that children with prenatal exposure to valproate (n – 52) had lower IQ scores at age 6 (97 (95% C.I. 94 to 101)) than children with prenatal exposure to the other antiepileptic drug monotherapy treatments evaluated: lamotrigine (108 (95% C.I. 105 to 110)), carbamazepine (105 (95% C.I. 102 to 108)), and phenytoin (108 (95% C.I. 104 to 112)). It is not known when during pregnancy cognitive effects in valproate-exposed children occur. Because the women in this study were exposed to antiepileptic drugs throughout pregnancy, whether the risk for decreased IQ was related to a particula time period during pregnancy could not be assessed.

Although all of the available studies have methodological limitations, the weight of the evidence supports the conclusion that valproate exposure in utero can cause decreased IQ in children. In animal studies, offspring with prenatal exposure to valproate had malformations similar to those seen in humans and demonstrated neurobehavioral deficits (see Use in Specific Populations (8.1)].

5.4 Use in Women of Childbearing Pote Because of the risk to the fetus of decreased IQ, neurodevelopmental disorders, and major congenital malformations (including neural tube defects), which may occur very early in pregnancy, valproate should not be administered to a woman of childbearing potential unless other medications have failed to provide adequate symptom control or are otherwise unacceptable. This is especially important when valproate use is considered for a condition not usually associated with permanent injury or death such as prophylaxis of migraine headaches [see Contraindications (4)]. Women should use effective contraception while using valproate. Women of childbearing potential should be counseled regularly regarding the relative risks and benefits of valproate use during pregnancy. This is especially important for women planning a pregnancy and for girls at the onset of puberty; alternative therapeutic options should be considered for these patients /see Boxed Warning and Use in Specific Populations (8.11). To prevent major seizures, valproate should not be discontinued abruptly, as this can precipitate status epilepticus with resulting maternal and fetal hypoxia and threat to

Evidence suggests that folic acid supplementation prior to conception and during the first trimester of pregnancy decreases the risk for congenital neural tube defects in the general population. It is not known whether the risk of neural tube defects or decreased IQ in the offspring of women receiving valproate is reduced by folic acid supplementation. Dietary folic acid supplementation both prior to conception and during pregnancy should be coutinely recommended for patients using valoroate

Cases of life-threatening pancreatitis have been reported in both children and adults receiving valoroate. Some of the cases have been described as bemorrhagic with rapid progression from initial symptoms to death. Some cases have occurred shortly after initial use as well as after several years of use. The rate based upon the reported cases exceeds that expected in the general population and there have been cases in which pancreatitis recurred after rechallenge with valproate. In clinical trials, there were 2 cases of pancreatitis without alternative etiology in 2.416 patients, representing 1.044 patient-years experience. Patients and guardians should be warned that dominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical evaluation. If pancreatitis is diagnosed, divalproex sodiu extended-release tablets should ordinarily be discontinued. Alternative treatment for the underlying medical condition should be initiated as clinically indicated /see Boxed

5.6 Urea Cycle Disorders Divalproex sodium extended-release tablets are contraindicated in patients with known urea cycle disorders (UCD).

Hyperammonemic encephalopathy, sometimes fatal, has been reported following initiation of valproate therapy in patients with urea cycle disorders, a group of uncommon genetic abnormalities, particularly ornithine transcarbamylase deficiency. Prior to the initiation of divalproex sodium extended-release tablets therapy evaluation for UCD should be considered in the following patients: 1) those with a history of unexplained encephalopathy or coma, encephalopathy associated with a protein load, pregnancy-related or postpartum encephalopathy, unexplained mental retardation, or history of elevated plasma ammonia or glutamine; 2) those with cyclical vomiting and lethargy, episodic extreme irritability, ataxia, low BUN, or protein avoidance; 3) those with a family history of UCD or a family history of unexplained infant deaths (particularly males); 4) those with other signs or symptoms of UCD. Patients who develop symptoms of unexplained hyperammonemic encephalopathy while atment (including discontinuation of valproate therapy) and be evaluated for underlying urea cycle disorders (see Contraindications (4) and Warnings and Precautions (5.10)].

5.7 Suicidal Behavior and Ideation Antiepileptic drugs (AEDs), including divalproex sodium extended-release tablets, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any Pooled analyses of 199 placebo-controlled clinical trials (mono- and adjunctive therapy) of 11 different AEDs showed that patients randomized to one of the AEDs had approximately twice the risk (adjusted Relative Risk 1.8, 95% CI:1.2, 2.7) of suicidal thinking or behavior compared to patients randomized to placebo. In these trials which had a median treatment duration of 12 weeks, the estimated incidence rate of suicidal behavior or ideation among 27,863 AED-treated patients was 0.43%, compared to 0.24% among 16,029 placebo-treated patients, representing an increase of approximately one case of suicidal thinking or behavior for every 530 patients

treated. There were four suicides in drug-treated patients in the trials and none in placebo-treated patients, but the number is too small to allow any conclusion about drug

The increased risk of suicidal thoughts or behavior with AEDs was observed as early as one week after starting drug treatment with AEDs and persisted for the duration of treatment assessed. Because most trials included in the analysis did not extend beyond 24 weeks, the risk of suicidal thoughts or behavior beyond 24 weeks could not be The risk of suicidal thoughts or behavior was generally consistent among drugs in the data analyzed. The finding of increased risk with AEDs of varying mechanisms of action and across a range of indications suggests that the risk applies to all AEDs used for any indication. The risk did not vary substantially by age (5 to 100 years) in the

clinical trials analyzed. Table 2 shows absolute and relative risk by indication for all evaluated AFD

5.8 Bleeding and Other Hematopoietic Disorders

1 able 2 Snows absolute and relative risk by indication for an evaluated ACDs.					
Table 2. Risk by Indication for Antiepileptic Drugs in the Pooled Analysis					
Indication	Placebo Patients with Events Per 1,000 Patients	Drug Patients with Events Per 1,000 Patients	Relative Risk: Incidence of Events in Drug Patients/Incidence in Placebo Patients	Risk Difference: Additional Drug Patients with Events Per 1,000 Patients	
Epilepsy	1.0	3.4	3.5	2.4	
Psychiatric	5.7	8.5	1.5	2.9	
Other	1.0	1.8	1.9	0.9	
Total	2.4	4.3	1.8	1.9	

The relative risk for suicidal thoughts or behavior was higher in clinical trials for epilepsy than in clinical trials for psychiatric or other conditions, but the absolute risk differences were similar for the epilepsy and psychiatric indications. Anyone considering prescribing divalproex sodium extended-release tablets or any other AED must balance the risk of suicidal thoughts or behavior with the risk of untreated illness. Epilepsy and many other illnesses for which AEDs are prescribed are themselves associated with morbidity and mortality and an increased risk of suicidal thoughts and behavior. Should suicidal thoughts and behavior emerge during treatment, the prescriber needs to consider whether the emergence of these symptoms in any given patient may be related to the illness being treated

Valproate is associated with dose-related thrombocytopenia. In a clinical trial of valproate as monotherapy in patients with epilepsy, 34/126 patients (27%) receiving approximately 50 mg/kg/day on average, had at least one value of platelets $\leq 75 \times 10^9$ /L. Approximately half of these patients had treatment discontinued, with return of platelet counts to normal. In the remaining patients, platelet counts normalized with continued treatment. In this study, the probability of thrombocytopenia appeared to increase significantly at total valproate concentrations of $\geq 110 \, \text{mcg/mL}$ (females) or $\geq 135 \, \text{mcg/mL}$ (males). The therapeutic benefit which may accompany the higher doses should therefore be weighed against the possibility of a greater incidence of adverse effects. Valproate use has also been associated with decreases in other cell lines and myelodysplasia. Because of reports of cytopenias, inhibition of the secondary phase of platelet aggregation, and abnormal coagulation parameters, (e.g., low fibrinogen, coagulation factor deficiencies, acquired von Willebrand's disease), measurements of complete blood counts and coagulation tests are recommended before initiating therapy and at periodic intervals. It is recommended that patients receiving divalproex sodium extended-release tablets be monitored for blood counts and coagulation parameters prior periodic intervals. The econtinented of unit patients receiving unsuppress solution extended received an extended to plant a superior and during pregnancy *(see Use in Specific Populations (8.1))*. Evidence of hemorrhage, bruising, or a disorder of hemostasis/coagulation is an indication for reduction of the dosage or withdrawal of therapy.

5.9 Hyperamm nia has been reported in association with valproate therapy and may be present despite normal liver function tests. In patients who develop unexplain lethargy and vomiting or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured. Hyperammonemia should also be considered in patients who present with hypothermia [see Warnings and Precautions (5.11]. If ammonia is increased, valproate therapy should be discontinued. Appropriate interventions for treatment of hyperammonemia should be initiated, and such patients should undergo investigation for underlying urea cycle disorders/see Contraindications (4) and Warnings and Precautions (5.6, 5.10]. During the placebo controlled pediatric mania trial, one (1) in twenty (20) adolescents (5%) treated with valproate developed increased plasma ammonia levels compare

Asymptomatic elevations of ammonia are more common and when present, require close monitoring of plasma ammonia levels. If the elevation persists, discontinuation of valproate therapy should be considered. $5.10 \quad \text{Hyperammonemia and Encephalopathy Associated with Concomitant Topiramate Use} \\$ Concomitant administration of topiramate and valproate has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. Clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level of consciousness and/or cognitive function with lethargy or vomiting. Hypothermia can also be a manifestation of hyperammonemia /see Warnings and Precautions (5.11)/. In most cases, symptoms and signs abated with discontinuation of either drug. This adverse reaction is not due to a pharmacokinetic interaction. Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, an interaction of topiramate and valproate may exacerbate existing defects or unmask deficiencies in susceptible persons. In patients who develop unexplained lethargy, vomiting, or changes in mental status, hyperammonemic encephalopathy should be considered and an ammonia level should be measured (see Contraindications (4) and Warnings and Precautions (5.6, 5.9)].

Hypothermia, defined as an unintentional drop in body core temperature to < 35°C (95°F), has been reported in association with valproate therapy both in conjunction with and in the absence of hyperammonemia. This adverse reaction can also occur in patients using concomitant topiramate with valproate after starting topiramate treatment or after increasing the daily dose of topiramate (see Drug Interactions (7.3)). Consideration should be given to stopping valproate in patients who develop hypothermia, which may be manifested by a variety of clinical abnormalities including lethargy, confusion, coma, and significant alterations in other major organ system such as the cardiovascular and respiratory systems. Clinical management and assessment should include examination of blood ammonia levels

5.12 Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)/Multiorgan Hypersensitivity Reactions Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS), also known as Multiorgan Hypersensitivity, has been reported in patients taking valproate. DRESS may be fatal or life-threatening. DRESS typically, although not exclusively, presents with fever, rash, lymphadenopathy, and/or facial swelling, in association with other organ system involvement, such as hepatitis, nephritis, hematological abnormalities, myocarditis, or myositis sometimes resembling an acute viral infection. Eosinophilia is often present. Because this disorder is variable in its expression, other organ systems not noted here may be involved. It is important to note that early manifestations of hypersensitivity, such as fever or lymphadenopathy, may be present even though rash is not evident. If such signs or symptoms are present, the patient should be ntinued and not be resumed if an alternative etiology for the signs or symptoms cannot be established

Carbanenem antibiotics (for example, ertanenem, iminenem, meronenem; this is not a complete list) may reduce serum valgroate concentrations to subtheraneutic levels. resulting in loss of seizure control. Serum valproate concentrations should be monitored frequently after initiating carbapenem therapy. Alternative antibacterial or anticonvulsant therapy should be considered if serum valproate concentrations drough the monitored frequently after initiating carbapenem therapy. Alternative antibacterial or anticonvulsant therapy should be considered if serum valproate concentrations drop significantly or seizure control deteriorates (see Drug Interactions (7.1)).

5.14 Somnolence in the Elderly In a double-blind, multicenter trial of valproate in elderly patients with dementia (mean age = 83 years), doses were increased by 125 mg/day to a target dose of 20 mg/kg/day. A significantly higher proportion of valproate patients had somnolence compared to placebo, and although not statistically significant, there was a higher proportion of patients with dehydration. Discontinuations for somnolence were also significantly higher than with placebo. In some patients with somnolence (approximately one-half), there was associated reduced nutritional intake and weight loss. There was a trend for the patients who experienced these events to have a lower baseline albumin concentration, lower valproate clearance, and a higher BUN. In elderly patients, dosage should be increased more slowly and with regular monitoring for fluid and nutritional intake, dehydration, somnolence, and other adverse reactions. Dose reductions or discontinuation of valproate should be considered in patients with decreased food or fluid intake and in patients with excessive somnolence (see Dosage and Administration (2.4))

5.15 Monitoring: Drug Plasma Concentration Since valproate may interact with concurrently administered drugs which are capable of enzyme induction, periodic plasma concentration determinations of valproate and itant drugs are recommended during the early course of therapy (see Drug Interactions (7)). 5.16 Effect on Ketone and Thyroid Function Tests

Valproate is partially eliminated in the urine as a keto-metabolite which may lead to a false interpretation of the urine ketone test. here have been reports of altered thyroid function tests associated with valproate. The clinical significance of these is unknown 5.17 Effect on HIV and CMV Viruses Replication

ere are in vitro studies that suggest valproate stimulates the replication of the HIV and CMV viruses under certain experimental conditions. The clinical consequence, if any, is not known. Additionally, the relevance of these in vitro findings is uncertain for patients receiving maximally suppressive antiretroviral therapy. Nevertheless, these data should be borne in mind when interpreting the results from regular monitoring of the viral load in HIV infected patients receiving valproate or when following CMV infected patients clinically. 5.18 Medication Residue in the Stool

There have been rare reports of medication residue in the stool. Some patients have had anatomic (including ileostomy or colostomy) or functional gastrointestinal disorders with shortened GI transit times. In some reports, medication residues have occurred in the context of diarrhea. It is recommended that plasma valproate levels be checked in patients who experience medication residue in the stool, and patients' clinical condition should be monitored. If clinically indicated, alternative treatment ma

6 ADVERSE REACTIONS ne following serious adverse reactions are described below and elsewhere in the labeling: Hepatic failure (see Warnings and Precautions (5.1))

Birth defects (see Warnings and Precautions (5.2)) Decreased IQ following in utero exposure [see Warnings and Precautions (5.3)] Pancreatitis (see Warnings and Precautions (5.5))

Hyperammonemic encephalopathy [see Warnings and Precautions (5.6, 5.9, 5.10)] Suicidal behavior and ideation (see Warnings and Precautions (5.7)) Bleeding and other hematopoietic disorders (see Warnings and Precautions (5.8)) Hypothermia (see Warnings and Precautions (5.11)) Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)/Multiorgan hypersensitivity reactions (see Warnings and Precautions (5.12)) ence in the elderly *[see Warnings and Precautions (5.14)]*

Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice. Information on pediatric adverse reactions is presented in section 8. The incidence of treatment-emergent events has been ascertained based on combined data from two three week placebo-controlled clinical trials of divalproex sodium

 $extended \hbox{-release tablets in the treatment of manic episodes associated with bipolar disorder.}$ Table 3 summarizes those adver

Table 3. Adverse Reactions Reported by > 5% of Divalproex Sodium Extended-Release Tablets-Treated Patients During Placebo-Controlled Trials of Acute Mania			
Adverse Event	Divalproex Sodium Extended-Release Tablets (n=338) %	Placebo (n=263) %	
Somnolence	26	14	
Dyspepsia	23	11	
Nausea	19	13	
Vomiting	13	5	
Diarrhea	12	8	
Dizziness	12	7	
Pain	11	10	
Abdominal Pain	10	5	
Accidental Injury	6	5	
Asthenia	6	5	
Pharyngitis	6	5	

The following adverse reactions/event occurred at an equal or greater incidence for placebo that for divalproex sodium extended-release tablets: headache reactions were reported by greater than 1% of the divalproex sodium extended-release tablets-treated patients in controlled clinica

Body as a Whole: Back Pain, Chills, Chills and Fever, Drug Level Increased, Flu Syndrome, Infection, Infection Fungal, Neck Rigidity. $\underline{Cardiovascular\,System:}\,Arrhythmia,\,Hypertension,\,Hypotension,\,Postural\,Hypotension.$ Digestive System: Constipation, Dry Mouth, Dysphagia, Fecal Incontinence, Flatulence, Gastroenteritis, Glossitis, Gum Hemorrhage, Mouth Ulceration. Hemic and Lymphatic System: Anemia, Bleeding Time Increased, Ecchymosis, Leucopenia. Metabolic and Nutritional Disorders: Hypoproteinemia, Peripheral Edema,

Musculoskeletal System: Arthrosis, Myalgia. Nervous System: Abnormal Gait, Agitation, Catatonic Reaction, Dysarthria, Hallucinations, Hypertonia, Hypokinesia, Psychosis, Reflexes Increased, Sleep Disorder, Respiratory System: Hiccup, Rhinitis. $\underline{Skin\,and\,Appendages:}\,Discoid\,Lupus\,Erythematosus,\,Erythema\,Nodosum,\,Furunculosis,\,Maculopapular\,Rash,\,Pruritus,\,Rash,\,Seborrhea,\,Sweating,\,Vesiculobullous\,Rash.$ <u>Special Senses:</u> Conjunctivitis, Dry Eyes, Eye Disorder, Eye Pain, Photophobia, Taste Perversion.

<u>Urogenital System:</u> Cystitis, Urinary Tract Infection, Menstrual Disorder, Vaginitis. Based on a placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures, divalproex sodium delayed release tablets were generally well tolerated with most adverse reactions rated as mild to moderate in severity. Intolerance was the primary reason for discontinuation in the divalproex sodium delayedrelease tablets-treated patients (6%), compared to 1% of placebo-treated patients. Table 4 lists treatment-emergent adverse reactions which were reported by ≥ 5% of divalproex sodium delayed-release tablets-treated patients and for which the incidence was greater than in the placebo group, in the placebo-controlled trial of adjunctive therapy for treatment of complex partial seizures. Since patients were also treated with other antiepilepsy drugs, it is not possible, in most cases, to determine whether the following adverse reactions can be ascribed to divalproex sodium delayed

release tablets alone, or the combination of divaloroex sodium delayed-release tablets and other antiepilepsy drugs

	Reported by $\geq 5\%$ of Patients Treated I Trial of Adjunctive Therapy for Comple	
Body System/Event	Divalproex Sodium Delayed-Release Tablets (N=77) %	Placebo (N=70) %
Body as a Whole	, ,,	
Headache	31	21
Asthenia	27	7
Fever	6	4
Gastrointestinal System		<u> </u>
N		

Table 4. Adverse Reactions Reported by $\,\geq\,5\%$ of Patients Treated with Valproate During Placebo-Controlled Trial of Adjunctive Therapy for Complex Partial Seizures (N = 70)Delayed-Release Tablet: (N = 77)Anorexia Dyspepsia Nervous System Somnolence Tremor Dizziness Diplopia Amblyopia/Blurred Vision Ataxia Nystagmus Emotional Lability Thinking Abnormal Amnesia Respiratory System Flu Syndrome Bronchitis Rhinitis Alopecia

nergent adverse reactions which were reported by $\geq 5\%$ of patients in the high dose valproate group, and for which the incidence was greater than in the low dose gro titrated off another ar

Weight Loss

Table 5. Adverse Reactions Repo Controlled Trial of Valpr	rted by $\geq 5\%$ of Patients in th coate Monotherapy for Comple:		
Body System/Event	High Dose (n=131) %	Low Dose (n=134) %	
Body as a Whole			
Asthenia	21	10	
Digestive System			
Nausea	34	26	
Diarrhea	23	19	
Vomiting	23	15	
Abdominal Pain	12	9	
Anorexia	11	4	
Dyspepsia	11	10	
Hemic/Lymphatic System			
Thrombocytopenia	24	1	
Ecchymosis	5	4	
Metabolic/Nutritional			
Weight Gain	9	4	
Peripheral Edema	8	3	
Nervous System			
Tremor	57	19	
Somnolence	30	18	
Dizziness	18	13	
Insomnia	15	9	
Nervousness	11	7	
Amnesia	7	4	
Nystagmus	7	1	
Depression	5	4	
Respiratory System			
Infection	20	13	
Pharyngitis	8	2	
Dyspnea	5	1	
Skin and Appendages			
Alopecia	24	13	
Special Senses			
Amblyopia/Blurred Vision	8	4	
Tinnitus	7	1	

Body as a Whole: Back pain, chest pain, malaise. Cardiovascular System: Tachycardia, hypertension, palpitation. <u>Digestive System:</u> Increased appetite, flatulence, hematemesis, eructation, pancreatitis, periodontal abscess.

The following addition

Hemic and Lymphatic System: Petechia. $\underline{\textit{Metabolic and Nutritional Disorders:}} \, \textit{SGOT increased}, \, \textit{SGPT increased}.$ Musculoskeletal System: Myalgia, twitching, arthralgia, leg cramps, myasthenia.

Nervous System: Anxiety, confusion, abnormal gait, paresthesia, hypertonia, incoordination, abnormal dreams, personality disorder Respiratory System: Sinusitis, cough increased, pneumonia, epistaxis.

Skin and Appendages: Rash, pruritus, dry skin. Special Senses: Taste perversion, abnormal vision, deafness, otitis media. <u>Urogenital System:</u> Urinary incontinence, vaginitis, dysmenorrhea, amenorrhea, urinary frequency.

Based on two placebo-controlled clinical trials and their long term extension, valproate was generally well tolerated with most adverse reactions rated as mild to moderate in severity. Of the 202 patients exposed to valproate in the placebo-controlled trials, 17% discontinued for intolerance. This is compared to a rate of 5% for the 81 placebo patients. Including the long term extension study, the adverse reactions reported as the primary reason for discontinuation by $\geq 1\%$ of 248 valproate-treated patients. were alopecia (6%), nausea and/or vomiting (5%), weight gain (2%), tremor (2%), somnolence (1%), elevated SGOT and/or SGPT (1%), and depression (1%). Table 6 includes those adverse reactions reported for patients in the placebo-controlled trial where the incidence rate in the divalproex sodium extended-release tablets

Tablets-Treated F	is Reported by > 5% of Divalproex Sodiur Patients During the Migraine Placebo-Cont e than Patients Taking Placebo'	
Body System Event	Divalproex Sodium Extended-Release Tablets (n= 122) %	Placebo (n=115) %
Gastrointestinal System		
Nausea	15	9
Dyspepsia	7	4
Diarrhea	7	3
Vomiting	7	2
Abdominal Pain	7	5
Nervous System		
Somnolence	7	2
Other		
Infection	15	14
	ctions occurred in greater than 5% of divalg	roex sodium extend

The following additional adverse reactions were reported by greater than 1% but not more than 5% of divalproex sodium extended-release tablets-treated patients and with a greater incidence than placebo in the placebo-controlled clinical trial for migraine Body as a Whole: Accidental injury, viral infection. Digestive System: Increased appetite, tooth disorder

Metabolic and Nutritional Disorders: Edema, weight gain. Nervous System: Abnormal gait, dizziness, hypertonia, insomnia, nervousness, tremor, vertigo. Respiratory System: Pharyngitis, rhinitis.

Skin and Appendages: Rash. Special Senses: Tinnitus. Table 7 includes those adverse reactions reported for patients in the placebo-controlled trials where the incidence rate in the valproate-treated group was greater than 5% and was greater than that fo

	is Reported by > 5% of Valproate-Treated P -Controlled Trials with a Greater Incidence 1	
Body System Reaction	Divalproex Sodium Delayed-Release Tablets (n=202) %	Placebo (n=81)
Gastrointestinal System		_
Nausea	31	10
Dyspepsia	13	9
Diarrhea	12	7
Vomiting	11	1
Abdominal Pain	9	4
Increased Appetite	6	4
Nervous System		
Asthenia	20	9
Somnolence	17	5
Dizziness	12	6
Tremor	9	0
Other		
Weight Gain	8	2
Back Pain	8	6
Alopecia	7	1

The following additional adverse reactions were reported by greater than 1% but not more than 5% of the 202 valproate-treated patients in the cor Body as a Whole: Chest pain. Cardiovascular System: Vasodilatation Digestive System: Constipation, dry mouth, flatulence, and stomatitis.

-release tablets: flu syndrome and pharyngitis.

Hemic and Lymphatic System: Ecchymosis Metabolic and Nutritional Disorders: Peripheral edema Musculoskeletal System: Leg cramps

encephalonathy reversed partially or fully after valoroate discontinuation

Nervous System: Abnormal dreams, confusion, paresthesia, speech disorder, and thinking abnormalities.

Respiratory System: Dyspnea, and sinusitis. Urogenital System: Metrorrhagia

6.4 Postmarketing Experience The following adverse reactions have been identified during post approval use of divalproex sodium delayed-release tablets. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure Dermatologic: Hair texture changes, hair color changes, photosensitivity, erythema multiforme, toxic epidermal necrolysis, nail and nail bed disorders, and Stevens

Psychiatric: Emotional upset, psychosis, aggression, psychomotor hyperactivity, hostility, disturbance in attention, learning disorder, and behavioral deterioration Neurologic: Paradoxical convulsion, parkinsonism There have been several reports of acute or subacute cognitive decline and behavioral changes (apathy or irritability) with cerebral pseudoatrophy on imaging as with valproate therapy; both the cognitive/behavioral changes and cerebral pseudoatrophy reversed partially or fully after valproate discontinuation. There have been reports of acute or subacute encephalopathy in the absence of elevated ammonia levels, elevated valproate levels, or neuroimaging changes. The

Musculoskeletal: Fractures, decreased bone mineral density, osteopenia, osteoporosis, and weakness Hematologic: Relative lymphocytosis, macrocytosis, leukopenia, anemia including macrocytic with or without folate deficiency, bone marrow suppression, pancytopeni aplastic anemia, agranulocytosis, and acute intermittent porphyria. Endocrine: Irregular menses, secondary amenorrhea, hyperandrogenism, hirsutism, elevated testosterone level, breast enlargement, galactorrhea, parotid gland swelling, polycystic ovary disease, decreased carnitine concentrations, hyponatremia, hyperglycinemia, and inappropriate ADH secretion There have been rare reports of Fanconi's syndrome occurring chiefly in children. Metabolism and nutrition: Weight gain.

Bef

Reproductive: Aspermia, azoospermia, decreased sperm count, decreased spermatozoa motility, male infertility, and abnormal spermatozoa morphology

roex Sodium (dye val' proe ex soe' dee um) ended-Release Tablets USP, for oral use
d know about divalproex sodium extended-release tablets? se tablets without first talking to a healthcare provider. Stopping divalproex sodium us problems. Stopping a seizure medicine suddenly in a patient who has epilepsy can cause
n cause serious side effects, including: h, especially in children younger than 2 years old and patients with mitochondrial damage is more likely to happen within the first 6 months of treatment. get any of the following symptoms: (malaise)
omen)
eyes sy ugh the medicine is stopped. Your healthcare provider will do blood tests to check your liver
extended release tablets. s may harm your unborn baby. ease tablets during pregnancy for any medical condition, your baby is at risk for serious birth as tablets during pregnancy for any medical condition, your baby is at risk for serious birth rid (such as spina bifida or neural tube defects). These defects can begin in the first month, ther birth defects that affect the structures of the heart, head, arms, legs, and the opening bottom of the penis can also happen. Decreased hearing or hearing loss can also happen. In to women who are not taking any medicines and do not have other risk factors. In pregnant and during early pregnancy can lower the chance of having a baby with a neural
during pregnancy for any medical condition, your child is at risk for deficit/hyperactivity disorder. n that have a lower chance of causing birth defects, decreaser
preventrould talk sase tabl
you become pregnant while taking divalproex sodium extended-release tablets. You and your II continue to take divalproex sodium extended-release tablets while you are pregnant. egnant while taking divalproex sodium extended-release tablets, talk to your healthcare American Antiepileptic Drug (NAAED) Pregnancy Registry. You can enroll in this registry by iting the website, http://www.aedpregnancyregistry.org/. The purpose of this registry is to epileptic drugs during pregnancy.
our hagniy) or your pancreas unar can cause ueaun. have any of these symptoms: your back
sodium extended-release tablets may cause suicidal thoughts or actions in a very
re any of these symptoms, especially if they are new, worse, or worry you:
(mania) I
I thoughts and actions? n changes in mood, behaviors, thoughts, or feelings. ovider as scheduled. led, especially if you are worried about symptoms. gs other than medicines. If you have suicidal thoughts or actions, your healthcare provider
lets? iption medicines used: dren 10 years of age and older
at include absence seizures o used to prevent migraine headaches. Iso used to treat acute manic or mixed episodes associated with bipolar disorder with or
Albe
m valproate, or any of the ingredients in divalproex sodium extended-release tablet to fingredients in divalproex sodium extended-release tablets.
ing are entirer pregnant of may become pregnant because you are not using effective birth lease tablets, tell your healthcare provider about all of your medical conditions
aused by a mitochondrial disorder such as Alpers-Huttenlocher syndrome.
hanges in mood, or thoughts ase tablets may cause fertil or you.
bove for more information. bove for more information. nay harm your baby. Talk to your healthcare provider ab tablets.
dicines you take , including prescription and over-the-counter medicines, vitamins, ect the way other medicines work, and other medicines may affect how divalproex sod
odium extended-release tablets with other medicines can cause serious side effects. Do not r healthcare provider.

not fe Like o small

Call

	Artwork inform	nation	
Customer	Camber	Market	USA
Dimensions (mm)	500 x 810 mm	Non Printing Colors	Die cut
Pharma Code No.	Front-203 & Back-204		
Printing Colours	Black		

Others: Pharma code position and Orientation are tentative, will be changed

based on folding size.

MEDICATION

Prepared by:		Appro	oved by:	
PK	PK	RA	PD	QA

r between visits as n s can be caused by 1

Genitourinary: Enuresis, urinary tract infection, and tubulointerstitial nephritis.

Special Senses: Hearing loss. Other: Allergic reaction, anaphylaxis, developmental delay, bone pain, bradycardia, and cutaneous vasculitis.

DRUGINTERACTIONS

Drugs that affect the level of expression of hepatic enzymes, particularly those that elevate levels of glucuronosyltransferases (such as ritonavir), may increase the arance of valproate. For example, phenytoin, carbamazepine, and phenobarbital (or primidone) can double the clearance of valproate. Thus, patients on monotherapy will generally have longer half-lives and higher concentrations than patients receiving polytherapy with antiepilepsy drugs. In contrast, drugs that are inhibitors of cytochrome P450 isozymes, e.g., antidepressants, may be expected to have little effect on valproate clearance because Because of these changes in valproate clearance, monitoring of valproate and concomitant drug concentrations should be increased whenever enzyme inducing drugs are

The following list provides information about the potential for an influence of several commonly prescribed medications on valproate pharmacokinetics. The list is not exhaustive nor could it be, since new interactions are continuously being reported. Drugs for which a potentially important interaction has been observed

A study involving the co-administration of aspirin at antipyretic doses (11 to 16 mg/kg) with valoroate to pediatric patients (n = 6) revealed a decrease in protein binding and an inhibition of metabolism of valproate. Valproate free fraction was increased 4-fold in the presence of a spirin compared to valproate alone. The β-oxidation pathway consisting of 2-E-valproic acid, 3-0H-valproic acid, and 3-keto valproic acid was decreased from 25% of total metabolites excreted on valproate alone to 8.3% in the presence of aspirin. Whether or not the interaction observed in this study applies to adults is unknown, but caution should be observed if valproate and aspirin are to be co-

Carbapenem Antihintics A clinically significant reduction in serum valproic acid concentration has been reported in patients receiving carbapenem antibiotics (for example, ertapenem, imipenem, meropenem; this is not a complete list) and may result in loss of seizure control. The mechanism of this interaction is not well understood. Serum valproic acid concentrations should be monitored frequently after initiating carbapenem therapy. Alternative antibacterial or anticonvulsant therapy should be considered if serum

valproic acid concentrations drop significantly or seizure control deteriorates (see Warnings and Precautions (5.13)). Estrogen-Containing Hormonal Contraceptives Estrogen-containing hormonal contraceptives may increase the clearance of valproate, which may result in decreased concentration of valproate and potentially increased seizure frequency. Prescribers should monitor serum valproate concentrations and clinical response when adding or discontinuing estrogen co

A study involving the co-administration of 1,200 mg/day of felbamate with valproate to patients with epilepsy (n = 10) revealed an increase in mean valproate peak concentration by 35% (from 86 to 115 mcg/mL) compared to valproate alone. Increasing the felbamate dose to 2,400 mg/day increased the mean valproate peak concentration to 133 mcg/mL (another 16% increase). A decrease in valproate dosage may be necessary when felbamate therapy is initiated.

Methotrexate may decrease serum valproate levels and potentially result in increased frequency of seizures or bipolar symptoms. Prescribers should monitor serum trations and clinical response when adding or discontinuing methotrexate and adjust valproate dosage, if necessa A study involving the administration of a single dose of valproate (7 mg/kg) 36 hours after 5 nights of daily dosing with rifampin (600 mg) revealed a 40% increase in the

7.2 Effects of Valproate on Other Drugs oitor of some P450 isozymes, epoxide hydrase, and glucuronosyltransferases The following list provides information about the potential for an influence of valproate co-administration on the pharmacokinetics or pharmacodynamics of several commonly prescribed medications. The list is not exhaustive, since new interactions are continuously being reported.

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

of amitriptyline/nortriptyline in the presence of valproate. Carbamazepine/carbamazepine-10,11-Epoxide Serum levels of carbamazepine (CBZ) decreased 17% while that of carbamazepine-10,11-epoxide (CBZ-E) increased by 45% upon co-administration of valproate and CBZ to epileptic patients.

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

Valproate displaces diazepam from its plasma albumin binding sites and inhibits its metabolism. Co-administration of valproate (1,500 mg daily) increased the free fraction of diazepam (10 mg) by 90% in healthy volunteers (n = 6). Plasma clearance and volume of distribution for free diazepam were reduced by 25% and 20%, respectively, in ne presence of valproate. The elimination half-life of diazepam remained unchanged upon addition of valproate.

Valproate inhibits the metabolism of ethosuximide. Administration of a single ethosuximide dose of 500 mg with valproate (800 to 1,600 mg/day) to healthy volunteers (n = 6) was accompanied by a 25% increase in elimination half-life of ethosyximide and a 15% decrease in its total clearance as compared to ethosyximide aloreceiving valproate and ethosyximide, especially along with other anticonvulsants, should be monitored for alterations in serum concentrations of both drugs. In a steady-state study involving 10 healthy volunteers, the elimination half-life of lamotrigine increased from 26 to 70 hours with valgroate co-administration (a 165%) increase). The dose of lamotrigine should be reduced when co-administered with valproate. Serious skin reactions (such as Stevens-Johnson syndrome and toxic

Phenoharhital Valproate was found to inhibit the metabolism of phenobarbital. Co-administration of valproate (250 mg BID for 14 days) with phenobarbital to normal subjects (n – 6) resulted in a 50% increase in half-life and a 30% decrease in plasma clearance of phenobarbital (60 mg single-dose). The fraction of phenobarbital dose excreted There is evidence for severe CNS depression, with or without significant elevations of barbiturate or valproate serum concentrations. All patients receiving

barbiturate therapy should be closely monitored for neurological toxicity. Serum barbiturate concentrations should be obtained, if possible, and the barbiturate dosage decreased, if appropriate. Primidone, which is metabolized to a barbiturate, may be involved in a similar interaction with valproate Valproate displaces phenytoin from its plasma albumin binding sites and inhibits its hepatic metabolism. Co-administration of valproate (400 mg TID) with phenytoin (250

mg) in normal volunteers (n = 7) was associated with a 60% increase in the free fraction of phenytoin. Total plasma clearance and apparent volume of distribution of phenytoin increased 30% in the presence of valproate. Both the clearance and apparent volume of distribution of free phenytoin were reduced by 25%. In patients with epilepsy, there have been reports of breakthrough seizures occurring with the combination of valproate and phenytoin. The dosage of phenytoin should be adjusted as required by the clinical situation.

The concomitant use of valproate and propofol may lead to increased blood levels of propofol. Reduce the dose of propofol when co-administering with valproate. Monitor and the concomitant use of valproate and propofol may lead to increased blood levels of propofol. Reduce the dose of propofol when co-administering with valproate. Monitor and the concomitant use of valproate and propofol may lead to increased blood levels of propofol. Reduce the dose of propofol when co-administering with valproate. Monitor and the concomitant use of valproate and propofol may lead to increased blood levels of propofol. Reduce the dose of propofol when co-administering with valproate. Monitor and the concomitant use of valproate and propofol may lead to increased blood levels of propofol. Reduce the dose of propofol when co-administering with valproate. Monitor and the concomitant use of valproate and propofol may lead to increase and the concomitant use of valproate and valproate andpatients closely for signs of increased sedation or cardiorespiratory depression. Based on a population pharmacokinetic analysis, rufinamide clearance was decreased by valproate. Rufinamide concentrations were increased by < 16% to 70%, dependent on concentration of valproate (with the larger increases being seen in pediatric patients at high doses or concentrations of valproate). Patients stabilized on

rufinamide before being prescribed valproate should begin valproate therapy at a low dose, and titrate to a clinically effective dose [see Dosage and Administration (2.6]]. Similarly, patients on valproate should begin at a rufinamide dose lower than 10 mg/kg per day (pediatric patients) or 400 mg per day (adults).

From in vitro experiments, the unbound fraction of tolbutamide was increased from 20% to 50% when added to plasma samples taken from patients treated with valproate. The clinical relevance of this displacement is unknow In an in vitro study, valproate increased the unbound fraction of warfarin by up to 32.8%. The therapeutic relevance of this is unknown; however, coagulation tests should

be monitored if valproate therapy is instituted in patients taking anticoagulants In six patients who were seropositive for HIV, the clearance of zidovudine (100 mg q8h) was decreased by 38% after administration of valproate (250 or 500 mg q8h); the half-life of zidovudine was unaffected.

7.3 Topiramate Concomitant administration of valproate and topiramate has been associated with hyperammonemia with and without encephalopathy (see Contraindications (4) and Warnings and Precautions (5.6, 5.9, 5.10). Concomitant administration of topiramate with valproate has also been associated with hypothermia in patients who have olerated either drug alone. It may be prudent to examine blood ammonia levels in patients in whom the onset of hypothermia has been reported is ewarnings and

Precautions (5.9, 5.11)] 7.4 Cannabidiol oncomitant administration of valproate and cannabidiol has been associated with an increased risk of ALT and/or AST elevation. This has been manageable by dose reduction or, in more severe cases, by discontinuation of one or both drugs. Liver function, including serum transaminase and total bilirubin levels, should be monitored during concomitant treatment (see Warnings and Precautions (5.1)).

USE IN SPECIFIC POPULATIONS 8.1 Pregnancy
Pregnancy Exposure Registry There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to antiepileptic drugs (AEDs), including divalproex sodium extended-release

tablets, during pregnancy. Encourage women who are taking divalproex sodium extended release tablets during pregnancy to enroll in the North American Antiepileptic Drug (NAAED) Pregnancy Registry by calling toll-free 1-888-233-2334 or visiting the website, http://www.aedpregnancyregistry.org/. This must be done by the patient use in prophylaxis of migraine headaches, valproate is contraindicated in women who are pregnant and in women of childbearing potential who are not using effective

contraception (see Contraindications (4)). For use in epilepsy or bipolar disorder, valproate should not be used to treat women who are pregnant or who plan to become pregnant unless other medications have failed to provide adequate symptom control or are otherwise unacceptable [see Boxed Warning and Warnings and Precautions (5.2, 5.3)]. Women with epilepsy who become pregnant while taking valproate should not discontinue valproate abruptly, as this can precipitate status epilepticus with resulting maternal and fetal hypoxia and threat

Maternal valproate use during pregnancy for any indication increases the risk of congenital malformations, particularly neural tube defects including spina bifida, but also malformations involving other body systems (e.g., craniforacial defects including oral clefts, cardiovascular malformations, physospadias, limb malformations). This risk is dose-dependent; however, a threshold dose below which no risk exists cannot be established. In utero exposure to valproate may also result in hearing impairment or hearing loss. Valproate polytherapy with other AEDs has been associated with an increased frequency of congenital malformations compared with AED monotherapy. The risk of major structural abnormalities is greatest during the first trimester; however, other serious developmental effects can occur with valproate use throughout pregnancy. The rate of congenital malformations among babies born to epileptic mothers who used valproate during pregnancy has been shown to be about four times nigher than the rate among babies born to epileptic mothers who used other anti-seizure monotherapies (see Warnings and Precautions (5.2) and Data (Human)). Epidemiological studies have indicated that children exposed to valproate in utero have lower IQ scores and a higher risk of neurodevelopmental disorders compared to children exposed to either another AED in utero or to no AEDs in utero (see Warnings and Precautions (5.3) and Data (Human))

An observational study has suggested that exposure to valproate products during pregnancy increases the risk of autism spectrum disorders [see Data (Human)]. In animal studies, valproate administration during pregnancy resulted in fetal structural malformations similar to those seen in humans and neurobehavioral deficits in the offspring at clinically relevant doses [see Data (Animal)].

have been reports of hypoglycemia in neonates and fatal cases of hepatic failure in infants following maternal use of valproate during pregnancy Pregnant women taking valproate may develop hepatic failure or clotting abnormalities including thrombocytopenia, hypofibrinogenemia, and/or decrease in other coagulation factors, which may result in hemorrhagic complications in the neonate including death/see Warnings and Precautions (5.1, 5.8)].

Available prenatal diagnostic testing to detect neural tube and other defects should be offered to pregnant women using valproate Evidence suggests that folic acid supplementation prior to conception and during the first trimester of pregnancy decreases the risk for congenital neural tube defects in the general population. It is not known whether the risk of neural tube defects or decreased IQ in the offspring of women receiving valproate is reduced by folic acid

upplementation. Dietary folic acid supplementation both prior to conception and during pregnancy should be routinely recommended for patients using valproate [see Warnings and Precautions (5.2, 5.4)]. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively. **Clinical Considerations**

To prevent major seizures, women with epilepsy should not discontinue valproate abruptly, as this can precipitate status epilepticus with resulting maternal and fetal hypoxia and threat to life. Even minor seizures may pose some hazard to the developing embryo or fetus (see Warnings and Precautions (5.4)). However, discontinuation of the drug may be considered prior to and during pregnancy in individual cases if the seizure disorder severity and frequency do not gose a serious threat to the patient.

Maternal adverse reactions Pregnant women taking valproate may develop clotting abnormalities including thrombocytopenia, hypofibrinogenemia, and/or decrease in other coagulation factors, which may result in hemorrhagic complications in the neonate including death /see Warnings and Precautions (5.8)/. If valproate is used in pregnancy, the clotting parameters should be monitored carefully in the mother. If abnormal in the mother, then these parameters should also be monit Patients taking valproate may develop hepatic failure [see Boxed Warning and Warnings and Precautions (5.1)]. Fatal cases of hepatic failure in infants exposed to valproate in utero have also been reported following maternal use of valproate during pregnancy. Hypoglycemia has been reported in neonates whose mothers have taken valproate during pregnancy

There is an extensive body of evidence demonstrating that exposure to valproate in utero increases the risk of neural tube defects and other structural abno Based on published data from the CDC's National Birth Defects Prevention Network, the risk of spina bifida in the general population is about 0.06 to 0.07% (6 to 7 in nated to be approximately 1 to 2% (100 to 200 in 10,000 births). The NAAED Pregnancy Registry has reported a major malformation rate of 9 to 11% in the offspring of women exposed to an average of 1,000 mg/day of valproate monotherapy during pregnancy. These data show an up to a five-fold increased risk for any major malformation following valproate exposure in utero compared to the risk following exposure in utero to other AEDs taken as monotherapy. The major congenital malformations included cases of neural tube defects, cardiovascular malformations, craniofacial defects (e.g., oral clefts, craniosynostosis), hypospadias, limb malformations (e.g., clubfoot, polydactyly), and other malformations of varying severity involving other body systems (see Warnings and Precautions (5.2)). Effect on IQ and neurodevelopmental effects

ological studies have indicated that children exposed to valproate in utero have lower IQ scores than children exposed to either another AED in utero or to no AEDs in utero. The largest of these studies' is a prospective cohort study conducted in the United States and United Kingdom that found that children with prenatal exposure to valproate (n = 62) had lower IQ scores at age 6 (97 195% C.I. .94 to 101)) than children with prenatal exposure to the other anti-epileptic drug monotherapy treatments evaluated: lamotrigine (108 [95% C.I. 105 to 110]), carbamazepine (105 [95% C.I. 102 to 108]) and phenytoin (108 [95% C.I. 104 to 112]). It is not known when during pregnancy cognitive effects in valproate-exposed children occur. Because the women in this study were exposed to AEDs throughout pregnancy, whether the risk for decreased IQ was related to a particular time period during pregnancy could not be assessed/see Warnings and Precautions (5.3)]. Although the available studies have methodological limitations, the weight of the evidence supports a causal association between valproate exposure in utero and

subsequent adverse effects on neurodevelopment, including increases in autism spectrum disorders and attention deficit/hyperactivity disorder (ADHD). An observational study has suggested that exposure to valproate products during pregnancy increases the risk of autism spectrum disorders. In this study, children born to mothers who had used valproate products during pregnancy had 2.9 times the risk (95% confidence interval [CI]: 1.7 to 4.9) of developing autism spectrum disorders compared to children born to mothers not exposed to valproate products during pregnancy. The absolute risks for autism spectrum disorders were 4.4% (95% CI: 2.6% to 7.5%) in valproate-exposed children and 1.5% (95% CI: 1.5% to 1.6%) in children not exposed to valproate products. Another observational study found that children who were exposed to valproate in utero had an increased risk of ADHD (adjusted HR 1.48; 95% CI, 1.09 to 2.00) compared with the unexposed children. Because these studies were observational in nature, conclusions regarding a causal association between in utero valproate exposure and an increased risk of autism spectrum disorder and ADHD

There are published case reports of fatal hepatic failure in offspring of women who used valproate during pregnancy.

embryo-fetal death occurred following administration of valproate to pregnant animals during organogenesis at clinically relevant doses (calculated on a body surface area [mg]m³] basis). Valproate induced malformations of multiple organ systems, including skeletal, cardiac, and urogenital defects. In mice, in addition to other malformations, fetal neural tube defects have been reported following valproate administration during critical periods of organogenesis, and the teratogenic response correlated with peak maternal drug levels. Behavioral abnormalities (including cognitive, locomotor, and social interaction deficits) and brain histopathological changes have also been reported in mice and rat offspring exposed prenatally to clinically relevant doses of valproate. Risk Summary

ed in human milk. Data in the published literature describe the presence of valproate in human milk (range: 0.4 mcg/mL to 3.9 mcg/mL), corresponding to 1% to 10% of maternal serum levels. Valproate serum concentrations collected from breastfed infants aged 3 days postnatal to 12 weeks following delivery ranged from 0.7 mcg/mL to 4 mcg/mL, which were 1% to 6% of maternal serum valproate levels. A published study in children up to six years of age did not report adverse developmental or cognitive effects following exposure to valproate via breast milk (see Data (Human)). There are no data to assess the effects of divalproex sodium on milk production or excretion. **Clinical Considerations** The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for divalproex sodium and any potential adverse effects

Monitor the breastfed infant for signs of liver damage including jaundice and unusual bruising or bleeding. There have been reports of hepatic failure and clotting abnormalities in offspring of women who used valproate during pregnancy [see Use in Specific Populations (8.1)].

In a published study, breast milk and maternal blood samples were obtained from 11 epilepsy patients taking valproate at doses ranging from 300 mg/day to 2,400 mg/day on postnatal days 3 to 6. In 4 patients who were taking valproate only, breast milk contained an average valproate concentration of 1.8 mcg/mL (range: 1.1 mcg/mL to 2.2 mcg/mL), which corresponded to 4.8% of the maternal plasma concentration (range: 2.7% to 7.4%). Across all patients (7 of whom were taking other AEDs omitantly), similar results were obtained for breast milk concentration (1.8 mcg/mL, range; 0.4 mcg/mL to 3.9 mcg/mL) and maternal plasma ratio (5.1%, range; 1.3%)

A published study of 6 breastfeeding mother-infant pairs measured serum valproate levels during maternal treatment for bipolar disorder (750 mg/day or 1,000 mg/day). None of the mothers received valproate during pregnancy, and infants were aged from 4 weeks to 19 weeks at the time of evaluation. Infant serum levels ranged from 0.7 mcg/mL to 1.5 mcg/mL. With maternal serum valproate levels near or within the therapeutic range, infant exposure was 0.9% to 2.3% of maternal levels. Similarly, in 2 ed case reports with maternal doses of 500 mg/day or 750 mg/day during breastfeeding of infants aged 3 months and 1 month, infant exposure was 1.5% and 6% that of the mother, respectively. A prospective observational multicenter study evaluated the long-term neurodevelopmental effects of AED use on children. Pregnant women receiving monotherapy for

epilepsy were enrolled with assessments of their children at ages 3 years and 6 years. Mothers continued AED therapy during the breastfeeding period. Adjusted (0s measured at 3 years for breastfed and non-breastfed children were 93 (n=11) and 90 (n=24), respectively. At 6 years, the scores for breastfed and non-breastfed children were 106 (n = 11) and 94 (n = 25), respectively (p = 0.04). For other cognitive domains evaluated at 6 years, no adverse cognitive effects of continued exposure to 8.3 Females and Males of Reproductive Potential

Women of childbearing potential should use effective contraception while taking valproate (see Boxed Warning, Warnings and Precautions (5.4), Drug Interactions (7), and Use in Specific Populations (8.1)]. This is especially important when valproate use is considered for a condition not usually associated with permanent injury or death

There have been reports of male infertility coincident with valproate therapy /see Adverse Reactions (6.4)/. In animal studies, oral administration of valoroate at clinically relevant doses resulted in adverse reproductive effects in males (see Nonclinical Toxicology (1.3.1)).

erience has indicated that pediatric patients under the age of two years are at a considerably increased risk of developing fatal hepatotoxicity, especially those with the aforementioned conditions [see Baxed Warning and Warnings and Precautions [5.1]. When divalproex sodium extended-release tablets are used in this patient group, it should be used with extreme caution and as a sole agent. The benefits of therapy should be weighed against the risks. Above the age of 2 years, experience in epilepsy has indicated that the incidence of fatal hepatotoxicity decreases considerably in progressively older patient groups Younger children, especially those receiving enzyme inducing drugs, will require larger maintenance doses to attain targeted total and unbound valproate con Pediatric patients (i.e., between 3 months and 10 years) have 50% higher clearances expressed on weight (i.e., mL/min/kg) than do adults. Over the age of 10 years, children have pharmacokinetic parameters that approximate those of adults. The variability in free fraction limits the clinical usefulness of monitoring total serum valproic acid concentrations. Interpretation of valproic acid concentrations in children should include consideration of factors that affect hepatic metabolism and protein binding

Pediatric Clinical Trials Divalproex sodium was studied in seven pediatric clinical trials. Two of the pediatric studies were double-blinded placebo-controlled trials to evaluate the efficacy of divalproex sodium extended-release tablets for the indications of mania (150 patients aged 10 to 17 years, 76 of whom were on divalproex sodium extended-release tablets) and migraine (304 patients aged 12 to 17 years, 231 of whom were on divalproex sodium extended-release tablets). Efficacy was not established for either the treatment of migraine or the treatment of mania. The most common drugrelated adverse reactions (reported > 5% and twice the rate of placebo) reported in the controlled pediatric mania study were nausea, upper abdominal pain, somnolence, eased ammonia, gastritis and rash. The remaining five trials were long term safety studies. Two six-month pediatric studies were conducted to evaluate the long-term safety of divalproex sodium extendedrelease tablets for the indication of mania (292 patients aged 10 to 17 years). Two twelve-month pediatric studies were conducted to evaluate the long-term safety of divalproex sodium extended-release tablets for the indication of migraine (353 patients aged 12 to 17 years). One twelve-month study was conducted to evaluate the

afety of divalproex sodium sprinkle capsules in the indication of partial seizures (169 patients aged 3 to 10 years). In these seven clinical trials, the safety and tolerability of divalproex sodium in pediatric patients were shown to be comparable to those in adults (see Adverse Reactions Juvenile Animal Toxicology animals, toxic effects not observed in adult animals included retinal dysplasia in rats treated during the neonatal period (from postnatal

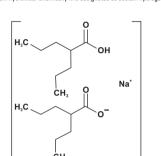
No natients above the age of 65 years were enrolled in double-blind prospective clinical trials of mania associated with bipolar illness. In a case review study of 583 patients, 72 patients (12%) were greater than 65 years of age. A higher percentage of patients above 65 years of age reported accidental injury, infection, pain, somnolence, and tremor. Discontinuation of valproate was occasionally associated with the latter two events. It is not clear whether these events indicate additional risk or whether they result from preexisting medical illness and concomitant medication use among these patients. A study of elderly patients with dementia revealed drug related somnolence and discontinuation for somnolence [see Warnings and Precautions (5,14)]. The starting dose

day 4) and nephrotoxicity in rats treated during the neonatal and juvenile (from postnatal day 14) periods. The no-effect dose for these findings was less than the

There is insufficient information available to discern the safety and effectiveness of valproate for the prophylaxis of migraines in patients over 65. The capacity of elderly patients (age range: 68 to 89 years) to eliminate valproate has been shown to be reduced compared to younger adults (age range: 22 to 26 years) 8.6 Effect of Disease

Liver disease impairs the capacity to eliminate valproate [see Boxed Warning, Contraindications (4), Warnings and Precautions (5.1), and Clinical Pharmacology (12.3)]. 10 OVERDOSAGE Overdosage with valproate may result in somnolence, heart block, deep coma, and hypernatremia. Fatalities have been reported; however patients have recovered from valproate levels as high as 2,120 mcg/mL In overdose situations, the fraction of drug not bound to protein is high and hemodialysis or tandem hemodialysis plus hemoperfusion may result in significant removal of drug. The benefit of gastric lavage or emesis will vary with the time since ingestion. General supportive measures should be applied with particular attention to the nance of adequate urinary output. Naloxone has been reported to reverse the CNS depressant effects of valproate overdosage. Because naloxone could theoretically also reverse the antiepileptic effects of

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



Divalproex sodium extended-release tablets USP 250 mg and 500 mg are for oral administration. Divalproex sodium extended-release tablets USP contain divalproex sodium USP in a once-a-day extended-release form valent to 250 mg and 500 mg of valproic acid. Hypromellose, microcrystalline cellulose, silicon dioxide. The film-coating contains lecithin, polyvinyl alcohol, talc, titanium dioxide and xanthan gum. The imprinting ink contains ammonium hydroxide, black iron oxide, propylene glycol and shellac glaze.

12 CLINICAL PHARMACOLOGY Divalproex sodium dissociates to the valproate ion in the gastrointestinal tract. The mechanisms by which valproate exerts its therapeutic effects have not been established. It has been suggested that its activity in epilepsy is related to increased brain concentrations of gamma-aminobutvric acid (GABA) 12.2 Pharmacodynamics

The relationship between plasma concentration and clinical response is not well documented. One contributing factor is the nonlinear, concentration dependent protein binding of valproate which affects the clearance of the drug. Thus, monitoring of total serum valproate may not provide a reliable index of the bioactiv For example, because the plasma protein binding of valproate is concentration dependent, the free fraction increases from approximately 10% at 40 mcg/mL to 18.5% at 130 mcg/mL. Higher than expected free fractions occur in the elderly, in hyperlipidemic patients, and in patients with hepatic and renal diseases

The therapeutic range in epilepsy is commonly considered to be 50 to 100 mcg/mL of total valproate, although some patients may be controlled with lower or higher In placebo-controlled clinical trials of acute mania, patients were dosed to clinical response with trough plasma concentrations between 85 and 125 mcg/mL/see Dosage

12.3 Pharmacokinetic The absolute bioavailability of divalproex sodium extended-release tablets administered as a single dose after a meal was approximately 90% relative to intravenous When given in equal total daily doses, the bioavailability of divalproex sodium extended-release tablets is less than that of divalproex sodium delayed-release tablets. In five multiple-dose studies in healthy subjects (N – 82) and in subjects with epilepsy (N – 86), when administered under fasting and nonfasting conditions, divalproex

sodium extended release tablets given once daily produced an average bioavailability of 89% relative to an equal total daily dose of divalproex sodium delayed release tablets given BID, TID, or QID. The median time to maximum plasma valproate concentrations (C_{max}) after divalproex sodium extended release tablets administration ranged from 4 to 17 hours. After multiple once-daily dosing of divalproex sodium extended release tablets, the peak-to-trough fluctuation in plasma valproate concentrations was 10 to 20% lower than that of regular divalproex sodium delayed-release tablets given BID, TID, or QID. sion from Divalproex Sodium Delayed-Release Tablets to Divalproex Sodium Extended-Release Tablets When divalproex sodium extended-release tablets are given in doses 8 to 20% higher than the total daily dose of divalproex sodium delayed-release tablets, the two formulations are bioequivalent. In two randomized, crossover studies, multiple daily doses of divalproex sodium delayed-release tablets were compared to 8 to 20% higher once-daily doses of divalproex sodium extended-release tablets. In these two studies, divalproex sodium extended-release tablets and divalproex sodium delayed-release.

tablets regimens were equivalent with respect to area under the curve (AUC; a measure of the extent of bioavailability). Additionally, valproate C.... was lower, and C... Table 8. Bioavailability of Divalproex Sodium Extended-Release Tablets Relative to Divalproex Sodium Delayed-Release Tablets When Divalproex

Sodium Extended Release Tablets Dose is 8 to 20% Higher					
Study Population	Regimens	Relative Bioavailability			
	Divalproex Sodium Extended-Release Tablets vs. Divalproex Sodium Delayed-Release Tablets	AUC ₂₄	C _{max}	C _{min}	
Healthy Volunteers (N = 35)	1,000 & 1,500 mg Divalproex Sodium Extended-Release Tablets vs. 875 & 1,250 mg Divalproex Sodium Delayed-Release Tablets	1.059	0.882	1.173	
Patients with epilepsy on concomitant enzyme-inducing antiepilepsy drugs (N = 64)	1,000 to 5,000 mg Divalproex Sodium Extended-Release Tablets vs. 875 to 4,250 mg Divalproex Sodium Delayed-Release Tablets	1.008	0.899	1.022	

Concomitant antiepilepsy drugs (topiramate, phenobarbital, carbamazepine, phenytoin, and lamotrigine were evaluated) that induce the cytochrome P450 isozyme system did not significantly alter valproate bioavailability when converting between divalproex sodium delayed-release tablets and divalproex sodium extended-release

The plasma protein binding of valproate is concentration dependent and the free fraction increases from approximately 10% at 40 mcg/mL to 18.5% at 130 mcg/mL. Protein binding of valproate is reduced in the elderly, in patients with chronic hepatic diseases, in patients with renal impairment, and in the presence of other drugs (e.g., aspirin). Conversely, valproate may displace certain protein-bound drugs (e.g., phenytoin, carbamazepine, warfarin, and tolbutamide)/see Drug Interactions (7.2) for more detailed information on the pharmacokinetic interactions of valproate with other drugs/. CNS Distribution

spinal fluid (CSF) approximate unbound concentrations in plasma (about 10% of total co Valproate is metabolized almost entirely by the liver. In adult patients on monotherapy, 30 to 50% of an administered dose appears in urine as a glucuronide conjugate.

Mitochondrial β-oxidation is the other major metabolic pathway, typically accounting for over 40% of the dose. Usually, less than 15 to 20% of the dose is eliminated by other oxidative mechanisms. Less than 3% of an administered dose is excreted unchanged in urine. The relationship between dose and total valproate concentration is nonlinear; concentration does not increase proportionally with the dose, but rather, increases to a lesser extent due to saturable plasma protein binding. The kinetics of unbound drug are linear. Mean plasma clearance and volume of distribution for total valproate are 0.56 L/hr/1.73 m² and 11 L/1.73 m², respectively. Mean plasma clearance and volume of

distribution for free valproate are 4.6 L/hr/1.73 m² and 92 L/1.73 m². Mean terminal half-life for valproate monotherapy ranged from 9 to 16 hours following oral dosing regimens of 250 to 1,000 mg. The estimates cited apply primarily to patients who are not taking drugs that affect hepatic metabolizing enzyme systems. For example, patients taking enzyme-inducing antiepileptic drugs (carbamazepine, phenytoin, and phenobarbital) will clear valproate more rapidly. Because of these changes in valproate clearance, monitoring of antiepileptic concentrations should be intensified whenever concomitant antiepileptics are introduced or withdrawn

Pediatric The valproate pharmacokinetic profile following administration of divalproex sodium extended-release tablets was characterized in a multiple-dose, non-fasting, open label, multi-center study in children and adolescents. Divalproex sodium extended-release tablets once daily doses ranged from 250 to 1,750 mg. Once daily administration of divalproex sodium extended-release tablets in pediatric patients (10 to 17 years) produced plasma VPA concentration-time profiles similar to those that

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

There are no differences in the body surface area adjusted unbound clearance between males and females $(4.8 \pm 0.17 \text{ and } 4.7 \pm 0.07 \text{ L/hr per } 1.73 \text{ m}^2, \text{ respectively})$ Effect of Race

The effects of race on the kinetics of valproate have not been studied Liver Disease Liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 liver disease impairs the capacity to eliminate valproate. In one study, the clearance of free valproate was decreased by 50% in 7 patients with cirrhosis and by 16% in 4 liver disease impairs the capacity of the contract of

patients with acute hepatitis, compared with 6 healthy subjects. In that study, the half-life of valproate was increased from 12 to 18 hours. Liver disease is also associated with decreased albumin concentrations and larger unbound fractions (2 to 2.6 fold increase) of valproate. Accordingly, monitoring of total concentrations may be misleading since free concentrations may be substantially elevated in patients with hepatic disease whereas total concentrations may appear to be normal [see Boxed] Warning, Contraindications (4), and Warnings and Precautions (5.1)].

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

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

Chlorocomazina

The proposition of valproate 500 mg with commonly administered antacids (Maalox, Trisogel, and Titralac · 160 mEq doses) did not reveal any effect on the extent of absorption of valproate.

Shaper GA, Browning N, et al. Fetal antiepileptic drug exposure and cognitive outcomes at age 6 years (NEAD study): a prospective observational study. Lancet Neurology 2013; 12 (3):244-252.

in trough plasma levels of valproate.

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

Cimetidine and Ranitidine

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

In psychotic patients (n = 11), no interaction was observed when valproate was co-administered with clozapine Co-administration of valoroate (500 mg BID) and lithium carbonate (300 mg TID) to normal male volunteers (n = 16) had no effect on the steady-state kinetics of lithium.

Concomitant administration of valproate (500 mg BID) and lorazepam (1 mg BID) in normal male volunteers (n = 9) was accompanied by a 17% decrease in the plasma clearance of lorazepam. No dose adjustment for olanzapine is necessary when olanzapine is administered concomitantly with valproate. Co-administration of valproate (500 mg BID) and lanzapine (5 mg) to healthy adults (n = 10) caused 15% reduction in $C_{\rm max}$ and 35% reduction in AUC of olanzapine. Oral Contraceptive Steroids

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

pharmacokinetic interaction. 13 NONCLINICAL TOXICOLOGY 13.1 Carcinogenesis, Mutagenesis, and Impairment of Fertility Carcinogenesis

The primary findings were an increase in the incidence of subcutaneous fibrosarcomas in high-dose male rats receiving valproate and a dose-related trend for benign pulmonary adenomas in male mice receiving valproate. Valproate was not mutagenic in an in vitro bacterial assay (Ames test), did not produce dominant lethal effects in mice, and did not increase chromosome aberration frequency in an in vivo cytogenetic study in rats. Increased frequencies of sister chromatid exchange (SCE) have been reported in a study of epileptic children taking

ate was administered orally to rats and mice at doses of 80 and 170 mg/kg/day (less than the maximum recommended human dose on a mg/m² basis) for two years

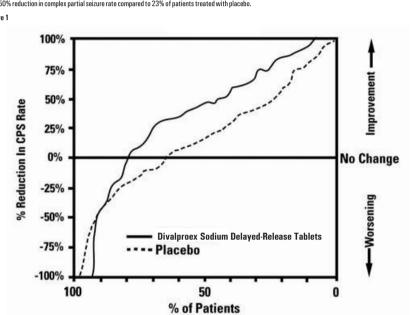
valproate; this association was not observed in another study conducted in adults. Impairment of Fertility In chronic toxicity studies in juvenile and adult rats and dogs, administration of valproate resulted in testicular atrophy and reduced spermatogenesis at oral doses of 400 mg/kg/day or greater in rats (approximately equal to or greater than the maximum recommended human dose (MRHD) on a mg/m² basis) and 150 mg/kg/day or greater in dogs (approximately equal to or greater than the MRHD on a mg/m² basis). Fertility studies in rats have shown no effect on fertility at oral doses of valproate up to 350 mg/kg/day (approximately equal to the MRHD on a mg/m² basis) for 60 days.

14 CLINICAL STUDIES 14.1 Mania The effectiveness of divalproex sodium extended release tablets for the treatment of acute mania is based in part on studies establishing the effectiveness of divalproex sodium delayed release tablets for this indication. Divalproex sodium extended-release tablet's effectiveness was confirmed in one randomized, double-blind, placebo-controlled, parallel group, 3-week, multicenter study. The study was designed to evaluate the safety and efficacy of divalproex sodium extended-release tablets in the treatment of bipolar I disorder, manic or mixed type, in adults. Adult male and female patients who had a current DSM-IV TR primary diagnosis of bipolar I disorder, mani or mixed type, and who were hospitalized for acute mania, were enrolled into this study. Divalproex sodium extended-release tablets were initiated at a dose of 25 mg/kg/day given once daily, increased by 500 mg/day on Day 3, then adjusted to achieve plasma valproate concentrations in the range of 85 to 125 mcg/mL. Mean daily divalproex sodium extended-release tablets dose for observed cases were 2,362 mg (range: 500 to 4,000), 2,874 mg (range: 1,500 to 4,500), 2,993 mg (range: 1,500 to 5,000), and 3,353 mg (range: 1,500 to 5,500) at Days 1, 5, 10, 15, and 21, respectively. Mean valproate concentrations were 96.5 mcg/mL, 102.1 mcg/mL, 98.5 mcg/mL, 89.5 mcg/mL at Days 5, 10, 15 and 21, respectively. Patients were assessed on the Mania Rating Scale (MRS; score ranges from C

14.2 Epilepsy The efficacy of valproate in reducing the incidence of complex partial seizures (CPS) that occur in isolation or in association with other seizure types was established in In one, multi-clinic, placebo controlled study employing an add-on design (adjunctive therapy), 144 patients who continued to suffer eight or more CPS per 8 weeks during an 8 week period of monotherapy with doses of either carbamazepine or phenytoin sufficient to assure plasma concentrations within the "therapeutic range" were red to receive, in addition to their original antiepilepsy drug (AED), either divalproex sodium delayed-release tablets or placebo. Randomized patients were to be

r a total of 16 weeks. The following table presents the Table 9. Adjunctive Therapy Study Media		Veeks	
Add-on Treatment	Number of Patients	Baseline Incidence	Experimental Incidence
Divalproex Sodium Delayed-Release Tablets	75	16.0	8.9*
Placebo	69	14.5	11.5
* Reduction from baseline statistically signific	antly greater for valoroate th	an placeho at p < 0.05 lev	rel.

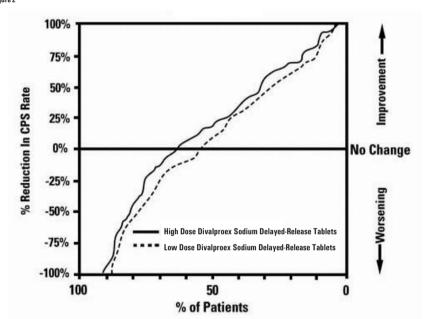
ure 1 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the adjunctive therapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency),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



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

Table 10. Monotherapy Study Median Incidence of CPS per 8 Weeks			
Treatment	Number of Patients	Baseline Incidence	Randomized Phase Incidence
High dose Valproate	131	13.2	10.7*
Low dose Valproate	134	14.2	13.8
* Reduction from baseline statistically	significantly greater for high d	ose than low dose at p	≤ 0.05 level.

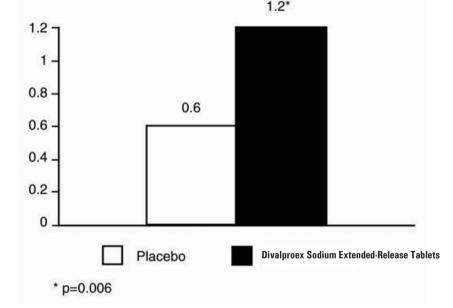
igure 2 presents the proportion of patients (X axis) whose percentage reduction from baseline in complex partial seizure rates was at least as great as that indicated on the Y axis in the monotherapy study. A positive percent reduction indicates an improvement (i.e., a decrease in seizure frequency),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



Information on pediatric studies is presented in section 8.

The results of a multicenter, randomized, double-blind, placebo-controlled, parallel-group clinical trial demonstrated the effectiveness of divalproex sodium extended release tablets in the prophylactic treatment of migraine headache. This trial recruited patients with a history of migraine headaches with or without aura occurring on average twice or more a month for the preceding three months. Patients with cluster or chronic daily headaches were excluded. Women of childbearing potential were allowed in the trial if they were deemed to be practicing an effective method of contraception. Patients who experienced ≥ 2 migraine headaches in the 4-week baseline period were randomized in a 1:1 ratio to divalproex sodium extended-release tablets or placeho and treated for 12 weeks. Patients initiated treatment on 500 mg once daily for one week, and were then increased to 1,000 mg once daily with an option to permanently decrease the dose back to 500 mg once daily during the second week of treatment if intolerance occurred. Ninety-eight of 114 divalproex sodium extended-release tablets treated nations (86%) and 100 of 110 placeho treated nations (91%) treated at least two weeks maintained the 1,000 mg once daily dose for the duration of their treatment periods. Treatment outcome was assessed on the basis of reduction in 4-week migraine headache rate in the treatment period compared to the base

Patients (50 male, 187 female) ranging in age from 16 to 69 were treated with divalproex sodium extended-release tablets (N = 122) or placebo (N = 115). Four patients were below the age of 18 and 3 were above the age of 65. Two hundred and two patients (101 in each treatment group) completed the treatment period. The mear reduction in 4-week migraine headache rate was 1.2 from a baseline mean of 4.4 in the divalproex sodium extended-release tablets group, versus 0.6 from a baseline mear of 4.2 in the placebo group. The treatment difference was statistically significant (see Figure 3). Figure 3 Mean Reduction In 4-Week Migraine Headache Rates



16 HOW SUPPLIED/STORAGE AND HANDLING Divalproex sodium extended-release tablets USP 250 mg are available as white to off white, oval shaped film-coated tablets imprinting with 'V 23' on one side and plain on other side containing divalproex sodium USP equivalent to 250 mg of valproic acid in each tablet in the following package sizes: Bottles of 100 NDC 31722-021-01

Divalproex sodium extended-release tablets USP 500 mg are available as white to off white, oval shaped film-coated tablets imprinting with 'V 24' on one side and plain on

Warn patients and guardians that nausea, vomiting, abdominal pain, anorexia, diarrhea, asthenia, and/or jaundice can be symptoms of hepatotoxicity and, therefore,

Warn patients and guardians that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis and, therefore, require further medical evaluation

Inform pregnant women and women of childbearing potential (including girls beginning the onset of puberty) that use of valproate during pregnancy increases the risk of

birth defects, decreased IQ, and neurodevelopmental disorders in children who were exposed in utero. Advise women to use effective contraception while taking

valproate. When appropriate, counsel these patients about alternative therapeutic options. This is particularly important when valproate use is considered for a condition not usually associated with permanent injury or death such as prophylaxis of migraine headache [see Contraindications [44]]. Advise patients to read the Medication Guide,

Encourage women who are taking divalproex sodium extended-release tablets to enroll in the North American Antiepileptic Drug (NAAED) Pregnancy Registry if they

ecome pregnant. This registry is collecting information about the safety of antiepileptic drugs during pregnancy. To enroll, patients can call the toll free number 1-888-

Counsel patients, their caregivers, and families that AEDs, including divalproex sodium extended-release tablets, may increase the risk of suicidal thoughts and behavior

and to be alert for the emergence or worsening of symptoms of depression, any unusual changes in mood or behavior, or the emergence of suicidal thoughts, behavior, or thoughts about self-harm. Instruct patients, caregivers, and families to report behaviors of concern immediately to the healthcare providers /see Warnings and

rm patients of the signs and symptoms associated with hyperammonemic encephalopathy and to notify the prescriber if any of these symptoms occur [see Warning.

Since valproate products may produce CNS depression, especially when combined with another CNS depressant (e.g., alcohol), advise patients not to engage in hazardous

Instruct patients that a fever associated with other organ system involvement (rash, lymphadenopathy, etc.) may be drug-related and should be reported to the physician

2102181

other side containing divalproex sodium USP equivalent to 500 mg of valproic acid in each tablet in the following packaging sizes

which appears as the last section of the labeling /see Warnings and Precautions (5.2, 5.3, 5.4) and Use in Specific Populations (8.1)].

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

Instruct patients to notify their healthcare provider if they notice a medication residue in the stool /see Warnings and Precautions (5.18).

 $233 \cdot 2334 \ or \ visit \ the \ website, \ http://www.aedpregnancyregistry.org/\textit{[see Use in Specific Populations (8.1)]}.$

NDC 31722-022-01

NDC 31722-022-05

Advise the patient to read the FDA-approved patient labeling (Medication Guide)

require further medical evaluation promptly [see Warnings and Precautions (5.1)].

Recommended Storage: Store at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature]

Bottles of 500

17 PATIENT COUNSELING INFORMATION

promptly (see Warnings and Precautions (5.5)).

Birth Defects and Decreased IQ

Pregnancy Registry

Precautions (5.7)].

Hyperammonemia

CNS Depression

Suicidal Thinking and Behavior

and Precautions (5.9, 5.10)].

Multiorgan Hypersensitivity Reactions

Medication Residue in the Stool

CAMBER

Camber Pharmaceuticals, Inc

iscataway, NJ 08854

By: Annora Pharma Pvt. Ltd

Sangareddy - 502313, Telangana, India.

Manufactured for:

Revised: 10/2023

diately (see Warnings and Precautions (5.12)).

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By: Annora Pharma Pvt. Ltd. Sangareddy - 502313, Telan

AMBER RHARMACEUTICALS, INC.

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ommon side effects of divalproex sodium extended-release tablets incl
headache
weakness
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difficulty walking

ent with divalproex sodium extended-release tablets math. Stop taking divalproex sodium extended-release tab elop any of these symptoms of a severe skin reaction:

blistering and peeling of your skin

swelling of your lymph nodes
swelling of your face, eyes, lips, tongue, or throat
trouble swallowing or breathing
rly. This extreme drowsiness may cause you to eat or dri to eat or drink as you normally do. Your healthcare puets. your se of

What are the possible side effects of divalproex sodium extended-release tablets?

Call your healthcare provider right away if you have any of the symptoms listed below. Your tests before and during your treatment with divalproex sodium extended-release tablets. Vour healt temporarily stop, or permanently stop treatment if you have certain side effects.

Divalproex sodium extended-release tablets can cause serious side effects.

Divalproex sodium extended-release tablets can cause serious side effects including:

See "What is the most important information I should know about divalproex sodium extended-release tablets can cause serious side effects including:

bleeding problems. Call your healthcare provider if you have any symptoms of bleeding, including:

bleeding from your mouth or nose

cough up blood or blood clots

increased ammonia levels in your blood. High ammonia levels can seriously affect your mental a feel tired, or cause vomiting (encephalopathy). This has happened when divalproex sodium extended a medicine called topiramate. Call your health care provider if you have any of these symptoms.

Increased ammonia levels in your blood. High ammonia levels can seriously affect your mental a feel tired, or cause vomiting (encephalopathy). This has happened when divalproex sodium extended release tablets. Call your health care provider if you have any of these symptoms.

Increased ammonia levels in your blood. High ammonia levels can seriously affect your mental a feel tired, or cause vomiting (encephalopathy). This has happened when divalproex sodium extended release tablets. Call your health care provider if you have any of these symptoms.

Increased ammonia levels in your body temperature to less than 95°F can his sodium extended release tablets are provider if you have any of the following symptoms of the following symptoms of the following symptoms of the following symptoms of these symptoms of a severe skin reaction:

Increased ammonia levels in your develop any of these symptoms of a severe skin re

ı 95°F can happe Ilowing symptom

any symptoms of bleeding, including

o vomiting blood or vomit the
o blood in your stools or blac
o pain and swelling in your je
els can seriously affect your mental
ned when divalproex sodium extend
ou have any of these symptoms.
temperature to less than 95°F can
if you have any of the following syn t looks like coffee grou k stools (looks like tar)

alproex sodium v divalproex sodio s and may affect y

 Do not stop taking divalproex sodium extended-release tablets without first divalproex sodium extended-release tablets without first divalproex sodium extended-release tablets suddenly can cause serious problems.
 Swallow divalproex sodium extended-release tablets whole. Do not crush or chew swallow divalproex sodium extended-release tablets whole. You may need a different met fyou miss a dose of divalproex sodium extended-release tablets, take it as soon as you. Take the next dose at your regular time. Do not take 2 doses at the same time.
 If you take too much divalproex sodium, call your healthcare provider or poison control control control of the ≕:

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