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Topiramate

4000894
EP11802A

Trokendi XR
25 mg Extended-Release Capsule
50 mg Extended-Release Capsule
100 mg Extended-Release Capsule

1 INDICATIONS AND USAGE

1.1 Monotherapy Epilepsy
Topiramate (TROKENDI XR) is indicated as initial monotherapy for the treatment of partial-onset or primary generalized tonic-clonic seizures in patients 6 years of age and older *[see Clinical Studies (14.2)]*.

1.2 Adjunctive Therapy Epilepsy
Topiramate (TROKENDI XR) is indicated as adjunctive therapy for the treatment of partial-onset seizures, primary generalized tonic-clonic seizures, and seizures associated with Lennox-Gastaut syndrome in patients 6 years of age and older *[see Clinical Studies (14.3)]*.

1.3 Migraine
Topiramate (TROKENDI XR) is indicated for the prophylaxis of migraine headache in patients 12 years of age and older *[see Clinical Studies (14.4)]*.

2 DOSAGE AND ADMINISTRATION
2.1 Dosing Monotherapy Epilepsy
Adults and Pediatric Patients 10 Years of Age and Older with Partial Onset or Primary Generalized Tonic-Clonic Seizures
The recommended dose for Topiramate monotherapy in adults and in pediatric patients 10 years of age and older is 400 mg orally once daily. Titrate Topiramate (Trokendi XR) according to the following schedule:

Week 1 50 mg once daily
Week 2 100 mg once daily
Week 3 150 mg once daily
Week 4 200 mg once daily
Week 5 300 mg once daily
Week 6 400 mg once daily

Pediatric Patients Ages 6 to 9 Years of Age
Dosing in patients 6 to 9 years of age is based on weight. During the titration period, the initial dose of Topiramate (Trokendi XR) is 25 mg/day nightly for the first week. Based upon tolerability, the dosage can be increased to 50 mg/day in the second week. Dosage can be increased by 25 mg to 50 mg/day each subsequent week as tolerated. Titration to the minimum maintenance dose should be attempted over 5-7 weeks of the total titration period. Based upon tolerability and clinical response, additional titration to a higher dose (up to the maximum maintenance dose) can be attempted at 25 mg to 50 mg/day weekly increments. The total daily dose should not exceed the maximum maintenance dose for each range of body weight (see Table 1).

Table 1: Monotherapy Target Total Daily Maintenance Dosing for Patients 6 to 9 Years of Age

Weight (Kg)	Total Daily Dose (mg/day) Minimum Maintenance Dose	Total Daily Dose (mg/day) Maximum Maintenance Dose
Up to 11	150	250
12-22	200	300
23-31	200	350
32-38	250	350
Greater than 38	250	400

2.2 Dosing in Adjunctive Therapy Epilepsy

Adults (17 Years of Age and Older)
The recommended total daily dose of Topiramate (Trokendi XR) as adjunctive therapy in adults with partial-onset seizures or Lennox-Gastaut Syndrome in 200 mg to 400 mg orally once daily and with primary generalized tonic-clonic seizures is 400 mg orally once daily. Initiate therapy at 25 mg to 50 mg once daily followed by titration to an effective dose in increments of 25 mg to 50 mg every week. Titrating in increments of 25 mg/day every week may delay the time to reach an effective dose. Doses above 400 mg/day have not been shown to improve responses in adults with partial-onset seizures.

Pediatric Patients 6 to 16 Years of Age
The recommended total daily dose of Topiramate (Trokendi XR) as adjunctive therapy for patients 6 to 16 years of age with partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome is approximately 5 mg/kg to 9 mg/kg orally once daily. Begin titration at 25 mg once daily (or less, based on a range of 1 mg/kg/day to 3 mg/kg/day) given nightly for the first week. Subsequently, increase the dosage at 1- or 2-week intervals by increments of 1 mg/kg/day to 3 mg/kg/day to achieve optimal clinical response. Dose titration should be guided by clinical outcome. The total daily dose should not exceed 400mg/day.

2.3 Dosing in Migraine Prophylaxis
The recommended total daily dose of Topiramate (Trokendi XR) as treatment for prophylaxis of migraine headache in patients 12 years of age and older is 100 mg once daily. Titrate Topiramate (Trokendi XR) for migraine prophylaxis according to the following schedule:

Week 1: 25 mg once daily
Week 2: 50 mg once daily
Week 3: 75 mg once daily
Week 4: 100 mg once daily

Dose and titration rate should be guided by clinical outcome. If required, longer intervals between dose adjustments can be used.

2.4 Administration with Alcohol
Alcohol use should be completely avoided within 6 hours prior to and 6 hours after Topiramate (Trokendi XR) administration *[see Warnings and Precautions (5.5)]*.

2.5 Dose Modifications in Patients with Renal Impairment
In patients with renal impairment (creatinine clearance less than 70 mL/min/1.73 m^2), one-half of the usual adult dose of Topiramate (Trokendi XR) is recommended. *[see Use in Specific Population (8.5, 8.6), Clinical Pharmacology (12.3)]*

2.6 Dosage Modifications in Patients Undergoing Hemodialysis
To avoid rapids drops in topiramate plasma concentration during hemodialysis, a supplement dose of Topirate (Trokendi XR) may be required. The actual adjustment should take into account 1) the duration of dialysis period, 2) the clearance rate of the dialysis system being used, and 3) the effective renal clearance of topiramate in the patient being dialyzed *[see Use in Specific Populations (8.7), Clinical Pharmacology (12.3)]*.

2.7 Administration Instructions
Topiramate (Trokendi XR) can be taken without regard to meals.

Swallow capsule whole and intact. Do not sprinkle on food, chew, or crush.

3 DOSAGE FORMS AND STRENGTHS
Topiramate (Trokendi XR) extended-release capsules are available in the following strengths and colors:

- 25 mg: Size 2 capsules, light green opaque body/yellow opaque cap (printed "SPN" on the cap, "25" on the body)
- 50 mg: Size 0 capsules, light green opaque body/orange opaque cap (printed "SPN" on the cap, "50" on the body)
- 100 mg: Size 00 capsules, green opaque body/blue opaque cap (printed "SPN" on the cap, "100" on the body)

4 CONTRAINDICATIONS
Topiramate (Trokendi XR) is contraindicated in patients:
- With recent alcohol use (i.e., within 6 hours prior to and 6 hours after Topiramate (Trokendi XR) use) *[see Warnings and Precautions (5.5)]*

5 WARNINGS AND PRECAUTIONS
5.1 Acute Myopia and Secondary Angle Closure Glaucoma
A syndrome consisting of acute myopia associated with secondary angle closure glaucoma has been reported in patients receiving topiramate. Symptoms include acute onset of decreased visual acuity and/or ocular pain. Ophthalmologic findings can include myopia, anterior chamber shallowing, ocular hyperemia (redness) and increased intraocular pressure. Mydriasis may or may not be present. This syndrome may be associated with supracilliary effusion resulting in anterior displacement of the lens and iris, with secondary angle closure glaucoma. Symptoms typically occur within 1 month of initiating topiramate therapy. In contrast to primary narrow angle glaucoma, which is rare under 40 years of age, secondary angle closure glaucoma associated with topiramate has been reported in pediatric patients as well as adults. The primary treatment to reverse symptoms is discontinuation of Topiramate (Trokendi XR) as rapidly as possible, according to the judgment of the treating physician. Other measures, in conjunction with discontinuation of Topiramate (Trokendi XR), may be helpful.

Elevated intraocular pressure of any etiology, if left untreated, can lead to serious sequelae including permanent vision loss.

5.2 Visual Field Defects
Visual Field Defects (independent of elevated intraocular pressure) have been reported in clinical trials and in postmarketing experience in patients receiving topiramate. In clinical trials, most of these events were reversible after topiramate discontinuation. If visual problems occur at any time during treatment with Topiramate (Trokendi XR), consideration should be given to discontinuing the drug.

5.3 Oligohydrosis and Hyperthermia
Oligohydrosis (decreased sweating), resulting in hospitalization in some cases, has been reported in association with topiramate use. Decreased sweating and an elevation in body temperature above normal characterized these cases. Some of the cases were reported after exposure to elevated environmental temperatures.

The majority of the reports have been in pediatric patients. Patients, especially pediatric patients, treated with Topiramate (Trokendi XR) should be monitored closely for evidence of decreased sweating and increased body temperature, especially in hot weather. Caution should be used when Topiramate (Trokendi XR) is given with other drugs that predispose patients to heat-related disorders; these drugs include, but are not limited to, other carbonic anhydrase inhibitors and drugs with anticholinergic activity.

5.4 Metabolic Acidosis
Topiramate (Trokendi XR) can cause hyperchloremic, non-anion gap, metabolic acidosis (i.e., decreased serum bicarbonate below the normal reference range in the absence of chronic respiratory alkalosis). This metabolic acidosis is caused by renal bicarbonate loss due carbonic anhydrase inhibition by Topiramate (Trokendi XR). Topiramate (Trokendi XR)-induced metabolic acidosis can occur at any time during treatment. Bicarbonate decrements are usually mild to moderate (average decrease of 4 mEq/L at daily doses of 400 mg in adults and at approximately 6 mg/ Kg/day in pediatric patients); rarely, patients can experience severe decrements to values below 10 mEq/L. Conditions or therapies that predispose patients to acidosis (such as renal disease, severe respiratory disorders, status epilepticus, diarrhea, ketogenic diet or specific drugs) may be additive to the bicarbonate lowering effects of Topiramate (Trokendi XR).

Metabolic acidosis was commonly observed in adult and pediatric patients treated with immediate-release topiramate in clinical trials. The incidence of decreased serum bicarbonate in pediatric trials for adjunctive treatment of Lennox-Gastaut syndrome or refractory partial onset seizures was as high as 67% for immediate-release topiramate (at approximately 6 mg/kg/day), and 10% for placebo. The incidence of a markedly abnormally low serum bicarbonate (i.e., absolute value <17 mEq/L and >5mEq/L decrease from pretreatment) in these trials was up to 11%, compared to ≤2% for placebo.

Manifestations of acute or chronic metabolic acidosis may include hyperventilation, nonspecific symptoms such as fatigue and anorexia, or more severe sequelae including cardiac arrhythmias or stupor. Chronic, untreated metabolic acidosis may increase the risk for nephrolithiasis or nephrocalcinosis, and may also result in osteomalacia (referred to as rickets in pediatric patients) and/or osteoporosis with an increased risk for fractures. Chronic metabolic acidosis in pediatric patients may also reduce growth rates, which may decrease the maximal height achieved. The effect of topiramate on growth and bone-related sequelae has not been systematically investigated in long-term, placebo-controlled trials. Long-term, open-label treatment of pediatric patients 1 to 24 months old with intractable partial epilepsy, for up to 1 year, showed reductions from baseline in length, weight, and head circumference compared to age and sex-matched normative data, although these patients with epilepsy are likely to have different growth rates than normal 1 to 24 month old pediatrics. Reductions in length and weight were correlated to the degree of acidosis *[see Use in Specific Populations (8.4)]*. Topiramate (Trokendi XR) treatment that causes metabolic acidosis during pregnancy can possibly produce adverse effects on the fetus and might also cause metabolic acidosis in the neonate from possible transfer of topiramate to the fetus *[see Warnings and Precautions (5.8) and Use in Specific Populations (8.1)]*.

Measurement of Serum Bicarbonate in Epilepsy and Migraine Patients
Measurement of baseline and periodic serum bicarbonate during topiramate treatment is recommended. If metabolic acidosis develops and persists, consideration should be given to reducing the dose or discontinuing Topiramate (Trokendi XR) (using dose tapering). If the decision is made to continue patients on Topiramate (Trokendi XR) in the face of persistent acidosis, alkali treatment should be considered.

5.5 Interaction with Alcohol
In vitro data show that, in the presence of alcohol, the pattern of topiramate release from Topiramate (Trokendi XR) capsules is significantly altered. As a result, plasma levels of topiramate with Topiramate (Trokendi XR) may be markedly higher soon after dosing and subtherapeutic later in the day. Therefore, alcohol use should be completely avoided within 6 hours prior to and 6 hours after Topiramate (Trokendi XR) administration.

5.6 Suicidal Behavior and Ideation
Antiepileptic drugs (AEDs) increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED, including Topiramate (Trokendi XR) for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior.

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 effect on suicide.

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 assessed.

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 AEDs.

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 Topiramate (Trokendi XR) 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.

5.7 Cognitive/Neuropsychiatric Adverse Reactions
Immediate-release topiramate can cause, and therefore expected to be caused by Topiramate (Trokendi XR), cognitive/neuropsychiatric adverse reactions. The most frequent of these can be classified into three general categories: 1) Cognitive-related dysfunction (e.g., confusion, psychomotor slowing, difficulty with concentration/attention, difficulty with memory, speech or language problems, particularly word-finding difficulties); 2) Psychiatric/behavioral disturbances (e.g.,depression or mood problems); and 3) Somnolence or fatigue.

Adult Patients
Cognitive Related Dysfunction
Rapid titration rate and higher initial dose were associated with higher incidences of cognitive-related dysfunction.

In adult adjunctive epilepsy controlled trials, which used rapid titration (100-200 mg/day weekly increments), and target immediate-release topiramate doses of 200 mg – 1000 mg/day, 56% of patients in the 800 mg/day and 1000 mg/day dose groups experienced cognitive-related dysfunction compared to approximately 42% of patients in the 200 - 400 mg/day groups and 14% for placebo. In this rapid titration regimen, these dose-related adverse reactions began in the titration or in the maintenance phase, and in some patients these events began during titration and persisted into the maintenance phase.

In the monotherapy epilepsy-controlled trial conducted with immediate-release topiramate, the proportion of patients who experienced one or more cognitive-related adverse reactions was 19% for topiramate 50 mg per day and 26% for 400 mg per day.

In the 6-month migraine prophylaxis controlled trials of immediate release topiramate using a slower titration regimen (25mg per day weekly increments), the proportion of patients who experienced one or more cognitive-related adverse reactions was 19% for topiramate 50 mg per day, 22% for 100 mg per day (the recommended dose), 28% for 200 mg per day and 10% for placebo. Cognitive adverse reactions most commonly developed during titration and sometimes persisted after completion of titration.

Psychiatric/Behavioral Disturbances
Psychiatric/behavioral disturbances (e.g., depression or mood) were dose-related for both the adjunctive epilepsy and migraine populations treated with topiramate *[see Warnings and Precautions (5.6)]*.

Somnolence/Fatigue
Somnolence and fatigue were the adverse reactions most frequently reported during clinical trials of topiramate for adjunctive epilepsy. For the adjunctive epilepsy population, the incidence of fatigue was dose-related. For the monotherapy epilepsy population, the incidence of somnolence was dose-related. For the migraine population, the incidences of both somnolence and fatigue were dose-related and more common in the titration phase.

Pediatric Patients
In pediatric epilepsy trials (adjunctive and monotherapy) conducted with topiramate, the incidence of cognitive/neuropsychiatric adverse reactions in pediatric patients was generally lower than that observed in adults. These reactions included psychomotor slowing, difficulty with concentration/attention, speech disorders/related speech problems and language problems. The most frequently reported neuropsychiatric reactions in pediatric epilepsy patients during adjunctive therapy double-blind studies were somnolence and fatigue. The most frequently reported cognitive/neuropsychiatric reactions in pediatric epilepsy patients in the 50 mg/day and 400 mg/day groups during the monotherapy double-blind study were headache, dizziness, anorexia, and somnolence.

In pediatric migraine patients, the incidence of cognitive/neuropsychiatric adverse reactions was increased in immediate-release topiramate-treated patients compared to placebo.

The risk for cognitive/neuropsychiatric adverse reactions was dose-dependent, and was greatest at the highest dose (200 mg). This risk for cognitive/neuropsychiatric adverse reactions was also greater in younger patients (6 to 11 years of age) than in older patients (12 to 17 years of age). The most common cognitive/neuropsychiatric adverse reaction in these trials was difficulty with concentration/attention. Cognitive adverse reactions most commonly developed during titration and sometimes persisted for various durations after completion of titration. The Cambridge Neuropsychological Test Automated Battery (CANTAB) was administered to adolescents (12 to 17 years of age) to assess the effects of topiramate on cognitive function at baseline at the end of the Study 3 *[see Clinical Studies (14.4)]*. Mean change from baseline in certain CANTAB tests suggests that topiramate treatment may result in psychomotor slowing and decreased verbal fluency.

5.8 Fetal Toxicity
Topiramate (Trokendi XR) can cause fetal harm when administered to a pregnant woman. Data from pregnancy registries indicate that infants exposed to topiramate *in utero* have an increased risk for cleft lip and/or cleft palate (oral clefts) and for being small for gestational age. When multiple species of pregnant animals received topiramate at clinically relevant doses, structural malformations, including craniofacial defects, and reduced fetal weights occurred in offspring *[see Use in Specific Populations (8.1)]*.

Consider the benefits and risks of Topiramate (Trokendi XR) when administering the drug in women of childbearing potential, particularly when Topiramate (Trokendi XR) is considered for a condition not usually associated with permanent injury or death *[see Use in Specific Populations (8.1)]*. Topiramate (Trokendi XR) should be used during pregnancy only if the potential benefit outweighs the potential risk. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be informed of the potential hazard to a fetus *[see Use in Specific Populations (8.1)]*.

5.9 Withdrawal of Antiepileptic Drugs
In patients with or without a history of seizures or epilepsy, antiepileptic drugs including Topiramate (Trokendi XR) should be gradually withdrawn to minimize the potential for seizures or increased seizure frequency *[see Clinical Studies (14)]*. In situations where rapid withdrawal of Topiramate (Trokendi XR) is medically required, appropriate monitoring is recommended.

5.10 Hyperammonemia and Encephalopathy (Without and With Concomitant Valproic Acid Use)
Topiramate treatment can cause hyperammonemia with or without encephalopathy *[see Adverse Reactions (6.2)]*. The risk for hyperammonemia with topiramate appears dose-related. Hyperammonemia has been reported more frequently when topiramate is used concomitantly with valproic acid. Postmarketing cases of hyperammonemia with or without encephalopathy have been reported with topiramate and valproic acid in patients who previously tolerated either drug alone *[see Drug Interactions (7.2)]*.

Clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level of consciousness and/or cognitive function with lethargy and/or vomiting. In most cases, hyperammonemic encephalopathy abated with discontinuation of treatment.

The incidence of hyperammonemia in pediatric patients 12 to 17 years of age in migraine prophylaxis trials was 26% in patients taking topiramate monotherapy at 100 mg/day, and 14% in patients taking topiramate at 50 mg/day, compared to 9% in patients taking placebo. There was also an increased incidence of markedly increased hyperammonemia at the 100 mg dose.

Dose-related hyperammonemia was also seen in pediatric patients 1 to 24 months of age treated with topiramate and concomitant valproic acid for partial onset epilepsy, and this was not due to a pharmacokinetic interaction.
In some patients, hyperammonemia can be asymptomatic.

Monitoring for Hyperammonemia
Patients with inborn errors of metabolism or reduced hepatic mitochondrial activity may be at an increased risk for hyperammonemia with or without encephalopathy. Although not studied, topiramate or Topiramate (Trokendi XR) treatment or an interaction of concomitant topiramate-based product and valproic acid treatment may exacerbate existing defects or unmask deficiencies in susceptible persons.

In patients who develop unexplained lethargy, vomiting, or changes in mental status associated with any topiramate treatment, hyperammonemic encephalopathy should be considered and an ammonia level should be measured.

5.11 Kidney Stones
Topiramate increases the risk of kidney stones. During adjunctive epilepsy trials, the risk for kidney stones in immediate-release topiramate-treated adults was 1.5%, an incidence about 2 to 4 times greater than expected in a similar, untreated population. As in the general population, the incidence of stone formation among topiramate-treated patients was higher in men. Kidney stones have also been reported in pediatric patients taking topiramate for epilepsy or migraine. During long-term (up to 1 year) topiramate treatment in an open-label extension study of 284 pediatric patients 1-24 months old with epilepsy, 7% developed kidney or bladder stones. Topiramate (Trokendi XR) would be expected to have the same effect as immediate- release topiramate on the formation of kidney stones. Topiramate (Trokendi XR) is not approved for treatment of epilepsy in pediatric patients less than 6 years old *[see Use in Specific Populations (8.4)]*.

Topiramate is a carbonic anhydrase inhibitor. Carbonic anhydrase inhibitors can promote stone formation by reducing urinary citrate excretion and by increasing urinary pH *[see Warnings and Precautions (5.4)]*. The concomitant use of Topiramate (Trokendi XR) with any other drug producing metabolic acidosis, or potentially in patients on a ketogenic diet, may create a physiological environment that increases the risk of kidney stone formation, and should therefore be avoided.

Increased fluid intake increases the urinary output, lowering the concentration of substances involved in stone formation. Hydration is recommended to reduce new stone formation.

5.12 Hypothermia with Concomitant Valproic Acid Use
Hypothermia, defined as an unintentional drop in body core temperature to < 35ºC (95ºF) has been reported in association with topiramate use with concomitant valproic acid (VPA) both in conjunction with and in the absence of hyperammonemia. This adverse reaction in patients using concomitant topiramate and valproate can occur after starting topiramate treatment or after increasing the daily dose of topiramate *[see Drug Interactions (7.2)]*. Consideration should be given to stopping topiramate (Trokendi XR) or 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 systems such as the cardiovascular and respiratory systems. Clinical management and assessment should include examination of blood ammonia levels.

6 ADVERSE REACTIONS
The following serious adverse reactions are discussed in more detail in other sections of the labeling:
- Acute Myopia and Secondary Angle Closure Glaucoma *[see Warnings and Precautions (5.1)]*
- Visual Field Defects *[see Warnings and Precautions 5.2]*
- Oligohydrosis and Hyperthermia *[see Warnings and Precautions (5.3)]*
- Metabolic Acidosis *[see Warnings and Precautions (5.4)]*
- Suicidal Behavior and Ideation *[see Warnings and Precautions (5.6)]*
- Cognitive/Neuropsychiatric Adverse Reactions *[see Warnings and Precautions (5.7)]*
- Withdrawal of Antiepileptic Drugs *[see Warnings and Precautions (5.9)]*
- Hyperammonemia and Encephalopathy (Without and With Concomitant Valproic Acid Use) *[see Warnings and Precautions (5.10)]*
- Kidney Stones *[see Warnings and Precautions (5.11)]*
- Hypothermia With Concomitant Valproic Acid Use *[see Warnings and Precautions (5.12)]*

The data described in the following sections were obtained using immediate-release topiramate tablets. Topiramate (Trokendi XR) has not been studied in a randomized, placebo-controlled Phase III clinical study; however, is expected that Topiramate (Trokendi XR) would produce a similar adverse reaction profile as immediate-release topiramate.

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

Monotherapy Epilepsy
Adults 16 Years of Age and Older
The most common adverse reactions in the controlled trial (Study 1) that occurred in adults in the 400 mg/day topiramate group and at an incidence higher (≥ 10%) than in the 50 mg per day group were: paresthesia, weight loss, and anorexia (see Table 3).

Approximately 21% of the 159 adult patients in the 400 mg/day group who received topiramate as monotherapy in Study 1 discontinued therapy due to adverse reactions. The most common (≥ 2% more frequent than low-dose 50 mg/day topiramate) adverse reactions causing discontinuation were difficulty with memory, fatigue, asthenia, insomnia, somnolence, and paresthesia.

Pediatric Patients 6 Years to 15 Years of Age
The most common adverse reactions in the controlled trial (Study 1) that occurred in pediatric patients in the 400 mg/day topiramate group and at an incidence higher (≥ 10%) than in the 50 mg/day group were fever and weight loss (see Table 3).

Approximately 14% of the 77 pediatric patients in the 400 mg/day group who received topiramate as monotherapy in the controlled clinical trial discontinued therapy due to adverse reactions. The most common (≥ 2% more frequent than in the 50 mg/day group) adverse reactions resulting in discontinuation in this trial were difficulty with concentration/attention, fever, flushing, and confusion.

Table 3 represents the incidence of adverse reactions occurring in at least 3% of adult and pediatric patients treated with 400 mg/day immediate-release topiramate and occurring with greater incidence than 50 mg/day topiramate.

Table 3: Adverse Reactions in the High Dose As Compared to the Low Dose Group, in Monotheraphy Epilepsy Trials in Adult and Pediatric Patients

	Age Group			
	Pediatric (6 to 15 Years)		Adult (Age≥16 Years)	
	Immediate-release Topiramate Daily Dosage Group (mg/day)			
Body System/ Adverse Reaction	50 (N=74) %	400 (N=77) %	50 (N=160) %	400 (N=159) %
Body as a Whole-General Disorders				
Asthenia	0	3	4	6
Fever	1	12		
Leg pain			2	3
Central & Peripheral Nervous System Disorders				
Paresthesia	3	12	21	40
Dizziness			13	14
Ataxia			3	4
Hypoesthesia			4	5
Hypertonia			0	3
Involuntary Muscle contraction	0	3		
Vertigo	0	3		
Gastro-intestinal System Disorders				
Constipation			1	4
Diarrhea	8	9		
Gastritis			0	3
Dry mouth			1	3
Liver and Biliary System Disorders				
Increase in Gamma-GT			1	3
Metabolic and Nutritional Disorders				
Weight Loss	7	17	6	17
Platelet, Bleeding & Clotting Disorders				
Epistaxis	0	4		
Psychiatric Disorders				
Anorexia			4	14
Anxiety			4	6
Cognitive problems	1	6	1	4
Confusion	0	3		
Depression	0	3	7	9
Difficulty with concentration or attention	7	10	7	8
Difficulty with memory	1	3	6	11
Insomnia			8	9
Decrease in libido			0	3
Mood problems	1	8	2	5
Personality disorder (behavior problems)	0	3		
Psychomotor slowing			3	5
Sonmolence			10	15
Red Blood Cell Disorders				
Anemia	1	3		
Reproductive Disorders, Female				
Intermenstrual bleeding	0	3		
Vaginal hemorrhage			0	3
Resistance Mechanism Disorders				
Infection	3	8	2	3
Viral infection	3	6	6	8
Respiratory System Disorders				
Bronchitis	1	5	3	4
Upper respiratory tract infection	16	18		
Rhinitis	5	6	2	4
Sinusitis	1	4		
Skin and Appendages Disorders				
Alopecia	1	4	3	4
Pruritus			1	4
Rash	3	4	1	4
Acne			2	3
Special Senses Other, Disorders				
Taste perversion			3	5
Urinary System Disorders				
Cystitis			1	3
Micturition frequency	0	3	0	2
Renal calculus			0	3
Urinary incontinence	1	3		
Vascular (Extracardiac) Disorders				
Flushing	0	5		

Adjunctive Therapy Epilepsy

Adults 16 Years of Age and Older
In pooled controlled clinical trials in adults with partial-onset seizures, primary generalized tonic-clonic seizures, or Lennox-Gastaut syndrome, 183 patients received adjunctive therapy with immediate-release topiramate at dosages of 200 to 400 mg/day (recommended dosage range), and 291 patients received placebo. Patients in these trials were receiving 1 to 2 concomitant antiepileptic drugs in addition to immediate-release topiramate or placebo.

The most common adverse reactions in the controlled clinical trial that occurred in adult patients in the 200-400 mg/day topiramate group with an incidence higher (≥10%) than in the placebo group were: dizziness, speech disorders/related speech problems, somnolence, nervousness, psychomotor slowing, and vision abnormal (see Table 4) *[see Clinical Studies (14.3)]*.

Table 4 presents the incidence of adverse reactions occurring in at least 3% of adult patients treated with 200 to 400 mg/day topiramate and was greater than placebo incidence. The incidence of some adverse reactions (e.g., fatigue, dizziness, paresthesia, language problems, psychomotor slowing, depression, difficulty with concentration/attention, mood problems) was dose-related and much greater at higher than recommended topiramate dosing (i.e., 600 to 1000 mg/day) compared to the incidence of these adverse reactions at the recommended dosing (200 to 400 mg/day) range.

Table 4: Most Common Adverse Reactions in Pooled Placebo-Controlled, Adjunctive Epilepsy Trials in Adults[a,b]

Body System/ Adverse Reaction	Placebo (N=291) %	Topiramate Dosage (mg/day) 200-400 (N=183) %
Body as a Whole-General Disorders		
Fatigue	13	15
Asthenia	1	6
Back pain	4	5
Chest pain	3	4
Influenza-like symptoms	2	3
Central & Peripheral Nervous System Disorders		
Dizziness	15	25
Ataxia	7	16
Speech disorders/Related speech problems	2	13
Paresthesia	4	11
Nystagmus	7	10
Tremor	6	9
Language problems	1	6
Coordination abnormal	2	4
Gait abnormal	1	3
Gastro-Intestinal System Disorders		
Nausea	8	10
Dyspepsia	6	7
Abdominal pain	4	6
Constipation	2	4
Metabolic and Nutritional Disorders		
Weight loss	3	9
Psychiatric Disorders		
Somnolence	12	29
Nervousness	6	16
Psychomotor slowing	2	13
Difficulty with memory	3	12
Confusion	5	11
Anorexia	4	10
Difficulty with concentration/attention	2	6
Mood problems	2	4
Agitation	2	3
Aggressive reaction	2	3
Emotional liability	1	3
Cognitive problems	1	3
Reproductive Disorders, Female		
Breast pain	2	4
Respiratory System Disorders		
Rhinitis	6	7
Pharyngitis	2	6
Sinusitis	4	5
Vision Disorders		
Vision abnormal	2	13
Diplopia	5	10

[a]Patients in these adjunctive trials were receiving 1 to 2 concomitant antiepileptic drugs in addition to topiramate or placebo
[b]Values represent the percentage of patients reporting a given reaction. Patient may have reported more than one adverse reaction during the study and can be included in more than one adverse reaction category.

In controlled clinical trials in adults, 11% of patients receiving immediate-release topiramate 200 to 400 mg per day as adjunctive therapy discontinued due to adverse reactions. This rate appeared to increase at dosages above 400 mg per day. Adverse reactions associated with discontinuing therapy included somnolence, dizziness, anxiety, difficulty with concentration or attention, fatigue, and paresthesia.

Pediatric Patients 2 to 15 Years of Age
In pooled, controlled clinical trials in pediatric patients (2 to 15 years of age) with partial-onset seizures, primary generalized tonic-clonic seizures, or Lennox-Gastaut syndrome, 98 patients received adjunctive therapy with immediate-release topiramate at dosages of 5 mg to 9 mg/kg/day (recommended dosage range) and 101 patients received placebo.

The most common adverse reactions in the controlled clinical trial that occurred in pediatric patients in the 5 mg to 9 mg/kg/day immediate-release topiramate group with an incidence higher (≥10%) than in the placebo group were: fatigue and somnolence (see Table 5).

Table 5 presents the incidence of adverse reactions that occurred in at least 3% of pediatric patients 2 to 15 years of age receiving 5 mg to 9 mg/kg/day (recommended dosage range) of immediate-release topiramate and was greater than placebo incidence.

Table 5: Adverse Reactions in Pooled Placebo-Controlled, Adjunctive Epilepsy Trial in Pediatric Patients 2 to 15 Years of Age[a,b]

Body System/ Adverse Reaction	Placebo (N=101) %	Topiramate (N=98) %
Body as a Whole-General Disorders		
Fatigue	5	16
Injury	3	14
Central & Peripheral Nervous System Disorders		
Gait abnormal	5	8
Ataxia	2	6
Hyperkinesia	4	5
Dizziness	2	4
Speech disorders/Related speech problems	2	4
Gastro-Intestinal System Disorders		
Nausea	5	6
Saliva increased	4	6
Constipation	4	5
Gastroenteritis	2	3
Metabolic and Nutritional Disorders		
Weight loss	1	9
Platelet, Bleeding & Clotting Disorders		
Purpura	4	8
Epistaxis	1	4
Psychiatric Disorders		
Somnolence	16	26
Anorexia	15	24
Nervousness	7	14
Personality disorder (Behavior Problems)	9	11
Difficulty with concentration/attention	2	10
Aggressive reaction	4	9
Insomnia	7	8
Difficulty with memory	0	5
Confusion	3	4
Psychomotor slowing	2	3
Resistance Mechanism Disorders		
Infection viral	3	7
Respiratory System Disorders		
Pneumonia	1	5
Skin and Appendages Disorders		
Skin Disorder	2	3
Urinary System Disorders		
Urinary incontinence	2	4

[a]Patients in these adjunctive trials were receiving 1 to 2 concomitant antiepileptic drugs in addition to topiramate or placebo
[b]Values represent the percentage of patients reporting a given adverse reaction. Patients may have reported more than one adverse reaction during the study and can be included in more than one adverse reaction category

None of the pediatric patients who received topiramate adjunctive therapy at 5 mg/kg/day to 9 mg/kg/day in controlled clinical trials discontinued due to adverse reactions.

Migraine
Adults
In the four multicenter, randomized, double-blind, placebo-controlled, parallel group migraine prophylaxis clinical trials (which included 35 pediatric patients 12 to 15 years of age), most adverse reactions occurred more frequently during the titration period than during the maintenance period.

The most common adverse reactions with immediate-release topiramate 100mg in migraine prophylaxis clinical trials of predominantly adults that were seen at an incidence higher (≥5%) than in the placebo group were: paresthesia, anorexia, weight loss, taste perversion, diarrhea, difficulty with memory, hypoesthesia, and nausea (see Table 6).

Table 6 includes those adverse reactions that occurred in the placebo-controlled trials where the incidence in any immediate-release topiramate group was at least 3% and was greater than that for placebo patients. The incidence of some adverse reactions (e.g., fatigue, dizziness, somnolence, difficulty with memory, difficulty with concentration/attention) was dose-related and greater at higher than recommended topiramate dosing (200 mg/day) compared to the incidence of these adverse reactions at the recommended dosing (100 mg/day).

Table 6: Adverse Reactions in Pooled, Placebo-Controlled, Migraine Trials in Adults[a,b,c]

		Topiramate Dosage (mg/day)	
Body System/ Adverse Reaction	Placebo (N=445) %	50 (N=235) %	100 (N=386) %
Body as a Whole-General Disorders			
Fatigue	11	14	15
Injury	7	9	6
Central & Peripheral Nervous System Disorders			
Paresthesia	6	35	51
Dizziness	10	8	9
Hypoaesthesia	2	6	7
Language problems	2	7	6
Gastro-Intestinal System Disorders			
Nausea	8	9	13
Diarrhea	4	9	11
Abdominal pain	5	6	6
Dyspepsia	3	4	5
Dry mouth	2	2	3
Gastroenteritis	1	3	3
Metabolic and Nutritional Disorders			
Weight loss	1	6	9
Musculoskeletal System Disorders			
Arthralgia	2	7	3
Psychiatric Disorders			
Anorexia	6	9	15
Somnolence	5	8	7
Difficulty with memory	2	7	7
Insomnia	5	6	7
Difficulty with concentration/attention	2	3	6
Mood problems	2	3	6
Anxiety	3	4	5
Depression	4	3	4
Nervousness	2	4	4
Confusion	2	2	3
Psychomotor slowing	1	3	2
Reproductive Disorders, Female			
Menstrual disorder	2	3	2
Reproductive Disorders, Male			
Ejaculation premature	0	3	0
Resistance Mechanism Disorders			
Viral Infection	3	4	4
Respiratory System Disorders			
Upper respiratory tract infection	12	13	14
Sinusitis	6	10	6
Pharyngitis	4	5	6
Coughing	2	2	4
Bronchitis	2	3	3
Dyspnea	2	1	3
Skin and Appendages Disorders			
Pruritis	2	4	2
Special Sense Other, Disorders			
Taste perversion	1	15	8
Urinary System Disorders			
Urinary tract infection	2	4	2
Vision Disorders			
Blurred vision	2	4	2

[a]Includes 35 adolescent patients age 12 to 15 years
[b]Values represent the percentage of patients reporting a given reaction. Patients may have reported more than one adverse reaction during the study and can be included in more than one adverse reaction category.
[c]Blurred vision was the most common term considered as vision abnormal. Blurred vision was an included term that accounted for more than 50% of reactions coded as vision abnormal, a preferred term

Of the 1135 patients exposed to immediate-release topiramate in the adult placebo-controlled studies, 25% discontinued due to adverse reactions, compared to 10% of the 445 placebo patients. The adverse reactions associated with discontinuing therapy in the immediate-release topiramate-treated patients in these studies included paresthesia (7%), fatigue (4%), nausea (4%), difficulty with concentration/attention (3%), insomnia (3%), anorexia (2%), and dizziness (2%).

Patients treated in these studies experienced mean percent reductions in body weight that were dose-dependent. This change was not seen in the placebo group. Mean changes of 0%, -2%, -3%, and -4% were seen for the placebo group, immediate-release topiramate 50 mg, 100 mg, and 200 mg groups, respectively.

Pediatric Patients 12 to 17 Years of Age

In five randomized, double-blind, placebo-controlled, parallel group migraine prophylaxis clinical trials, most of the adverse reactions occurred more frequently during the titration period than during the maintenance period. Among adverse reactions with onset during titration, approximately half persisted into the maintenance period.

In four, fixed-dose, double-blind migraine prophylaxis clinical trials in pediatric patients 12 to 17 years of age, the most common adverse reactions with immediate-release topiramate 100 mg that were seen at an incidence higher (≥5%) than in the placebo group were: paresthesia, upper respiratory tract infection, anorexia, and abdominal pain (see Table 7). Table 7 shows adverse reactions from the pediatric trial (Study 3 *[see Clinical Studies (14.4)]*) in which 103 pediatric patients were treated with placebo or 50 mg or 100 mg of immediate release topiramate, and three predominantly adult trials in which 49 pediatric patients (12 to 17 years of age) were treated with placebo or 50 mg, 100 mg or 200 mg of immediate release topiramate *[see Clinical Studies (14.4)]*. Table 7 also shows adverse reactions in pediatric patients in controlled migraine trials when the incidence in an immediate-release topiramate dose group was at least 5% or higher and greater than the incidence of placebo. Many adverse reactions shown in Table 7 indicate a dose-dependent relationship. The incidence of some adverse reactions (e.g., allergy, fatigue, headache, anorexia, insomnia, somnolence, and viral infection) was dose-related and greater at higher than recommended immediate-release topiramate dosing (200 mg daily) compared to the incidence of these adverse reactions at the recommended dosing (100 mg daily).

Table 7: Adverse Reactions in Pooled Double-Blind Migraine Prophylaxis Studies in Pediatric Patients 12 to 17 Years of Age)[ab]

Body System/ Adverse Reaction	Placebo (N=45) %	Immediate-Release Topiramate Dosage: 50 mg/day (N=46) %	100 mg/day (N=48) %
Body as a Whole – General Disorders			
Fatigue	7	7	8
Fever	2	4	6
Central & Peripheral Nervous System Disorders			
Paresthesia	7	20	19
Dizziness	4	4	6
Gastrointestinal System Disorders			
Abdominal pain	9	7	15
Nausea	4	4	8
Metabolic and Nutritional Disorders			
Weight loss	2	7	4
Psychiatric Disorders			
Anorexia	4	9	10
Somnolence	2	2	6
Insomnia	2	9	2
Resistance Mechanism Disorders			
Infection viral	4	4	8
Respiratory System Disorders			
Upper respiratory tract infection	11	26	23
Rhinitis	2	7	6
Sinusitis	2	9	4
Coughing	0	7	2
Special Senses Other, Disorders			
Taste perversion	2	2	6
Vision Disorders			
Conjunctivitis	4	7	4

[a]35 adolescent patients aged 12 to <16 years were also included in adverse reaction assessment for adults
[b]Incidence is based on the number of subjects experiencing at least 1 adverse event, not the number of events.

In the double-blind placebo-controlled studies, adverse reactions led to discontinuation of treatment in 8% of placebo patients compared with 6% of immediate-release topiramate-treated patients. Adverse reactions associated with discontinuing therapy that occurred in more than one immediate-release topiramate-treated patient were fatigue (1%), headache (1%), and somnolence (1%).

Increased Risk for Bleeding
Topiramate is associated with an increased risk for bleeding. In a pooled analysis of placebo-controlled studies of approved and unapproved indications, bleeding was more frequently reported as an adverse reaction for topiramate than for placebo (4.5% versus 3.0% in adult patients, and 4.4% versus 2.3% in pediatric patients). In this analysis, the incidence of serious bleeding events for topiramate and placebo was 0.3% versus 0.2% for adult patients, and 0.4% versus 0% for pediatric patients.

Adverse bleeding reactions reported with topiramate ranged from mild epistaxis, ecchymosis, and increased menstrual bleeding to life-threatening hemorrhages. In patients with serious bleeding events, conditions that increased the risk for bleeding were often present, or patients were often taking drugs that cause thrombocytopenia (other antiepileptic drugs) or affect platelet function or coagulation (e.g., aspirin, nonsteroidal anti-inflammatory drugs, selective serotonin reuptake inhibitors, or warfarin or other anticoagulants).

Other Adverse Reactions Observed During Clinical Trials
Other adverse reactions seen during clinical trials were: abnormal coordination, eosinophilia, gingival bleeding, hematuria, hypotension, myalgia, myopia, postural hypotension, scotoma, suicide attempt, syncope, and visual field defect.

Laboratory Test Abnormalities

Adult Patients
In addition to changes in serum bicarbonate (i.e., metabolic acidosis), sodium chloride, and ammonia, immediate-release topiramate was associated with changes in several clinical laboratory analytes in randomized, double-blind, placebo-controlled studies *[see Warnings and Precautions (5.4, 5.10)]*. Controlled trials of adjunctive topiramate treatment of adults for partial-onset seizures showed an increased incidence of markedly decreased serum phosphorus (6% topiramate versus 2% placebo), markedly increased serum alkaline phosphatase (3% topiramate versus 1% placebo), and decreased serum potassium (0.4% topiramate versus 0.1% placebo).

Pediatric Patients
In pediatric patients (1-24 months) receiving adjunctive topiramate for partial-onset seizures, there was an increased incidence for an increased result (relative to normal analyte reference range) associated with immediate-release topiramate (vs placebo) for the following clinical laboratory analytes: creatinine, BUN, alkaline phosphatase, and total protein. The incidence was also increased for a decreased result for bicarbonate (i.e., metabolic acidosis) and potassium with immediate-release topiramate (vs. placebo) *[see Use in Specific Populations (8.4)]*. Topiramate (Trokendi XR) is not indicated for partial-onset seizures in pediatric patients less than 6 years of age.

In pediatric patients (ranging from 6-17 years of age) receiving immediate-release topiramate for migraine prophylaxis, there was an increased incidence for an increased result (relative to normal analyte reference range) associated with immediate-release topiramate (vs placebo) for the following clinical laboratory analytes: creatinine, BUN, uric acid, chloride, ammonia, alkaline phosphatase, total protein, platelets, and eosinophils. The incidence was also increased for a decreased result for phosphorus, bicarbonate, total white blood count, and neutrophils *[see Use in Specific Populations (8.4)]*. Topiramate (Trokendi XR) is not indicated for prophylaxis of migraine headache in pediatric patients less than 12 years of age.

6.2 Postmarketing Experience

The following adverse reactions have been identified during post-approval use of immediate-release topiramate. 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.

Body as a Whole-General Disorders: oligohydrosis and hyperthermia *[see Warnings and Precautions (5.3)]*, hyperammonemia, hyperammonemic encephalopathy *[see Warnings and Precautions (5.10)]*, hypothermia with concomitant valproic acid *[see Warnings and Precautions 5.12)]*.

Gastrointestinal System Disorders: hepatic failure (including fatalities), hepatitis, pancreatitis

Skin and Appendage Disorders: bullous skin reactions (including erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis), pemphigus

Urinary System Disorders: kidney stones *[see Warnings and Precautions (5.11)]*

Vision disorders: acute myopia, secondary angle closure glaucoma *[see Warnings and Precautions (5.1)]*, Maculopathy

Hematological Disorders: decrease of the International Normalized Ratio (INR) or prothrombin time when given concomitantly with vitamin K antagonist anticoagulant medications such as warfarin.

7 DRUG INTERACTIONS

7.1 Alcohol
Alcohol use is contraindicated within 6 hours prior to and 6 hours after Topiramate (Trokendi XR) administration *[see Contraindications (4) and Warnings and Precautions (5.5)]*.
7.2 Antiepileptic Drugs
Concomitant administration of phenytoin or carbamazepine with topiramate resulted in a clinically significant decrease in plasma concentrations of topiramate when compared to topiramate given alone. A dosage adjustment may be needed *[see Dosage and Administration (2.1), Clinical Pharmacology (12.3)]*. Concomitant administration of valproic acid and topiramate has been associated with hypothermia and hyperammonemia with and without encephalopathy. Examine blood ammonia levels in patients in whom the onset of hypothermia has been reported *[see Warnings and Precautions (5.10, 5.12) and Clinical Pharmacology (12.3)]*.
7.3 Other Carbonic Anhydrase Inhibitors
Concomitant use of topiramate, a carbonic anhydrase inhibitor, with any other carbonic anhydrase inhibitor (e.g., zonisamide or acetazolamide) may increase the severity of metabolic acidosis and may also increase the risk of kidney stone formation. Patients should be monitored for the appearance or worsening of metabolic acidosis when Topiramate (Trokendi XR) is given concomitantly with another carbonic anhydrase inhibitor *[see Clinical Pharmacology (12.3)]*.
7.4 CNS Depressants
Concomitant administration of topiramate with other CNS depressant drugs or alcohol has not been evaluated in clinical studies. Because of the potential of topiramate to cause CNS depression, as well as other cognitive and/or neuropsychiatric adverse reactions, Topiramate (Trokendi XR) should be used with extreme caution if used in combination with alcohol and other CNS depressants *[see Contraindications (4) and Warnings and Precautions (5.7)]*.
7.5 Oral Contraceptives
The possibility of decreased contraceptive efficacy and increased breakthrough bleeding may occur in patients taking combination oral contraceptive products with Topiramate (Trokendi XR). Patients taking estrogen-containing contraceptives should be asked to report any change in their bleeding patterns. Contraceptive efficacy can be decreased even in the absence of breakthrough bleeding *[see Clinical Pharmacology (12.3)]*.
7.6 Hydrochlorothiazide (HCTZ)
Topiramate Cmax and AUC increased when HCTZ was added to immediate-release topiramate. The clinical significance of this change is unknown. The addition of HCTZ to Topiramate (Trokendi XR) may require a decrease in the Topiramate (Trokendi XR) dose *[see Clinical Pharmacology (12.3)]*.
7.7 Pioglitazone
A decrease in the exposure of pioglitazone and its active metabolites were noted with the concurrent use of pioglitazone and immediate-release topiramate in a clinical trial. The clinical relevance of these observations is unknown; however, when Topiramate (Trokendi XR) is added to pioglitazone therapy or pioglitazone is added to Topiramate (Trokendi XR) therapy, careful attention should be given to the routine monitoring of patients for adequate control of their diabetic disease state *[see Clinical Pharmacology (12.3)]*.
7.8 Lithium
An increase in systemic exposure of lithium following topiramate doses of up to 600 mg/day can occur. Lithium levels should be monitored when co-administered with high-dose Topiramate (Trokendi XR) *[see Clinical Pharmacology (12.3)]*.
7.9 Amitriptyline
Some patients may experience a large increase in amitriptyline concentration in the presence of Topiramate (Trokendi XR) and any adjustments in amitriptyline dose should be made according to the patients' clinical response and not on the basis of plasma levels *[see Clinical Pharmacology (12.3)]*.

8 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), such as Topiramate (Trokendi XR), during pregnancy. Patients should be encouraged to enroll in the North American Antiepileptic Drug (NAAED) Pregnancy Registry if they become pregnant. This registry is collecting information about the safety of antiepileptic drugs during pregnancy. To enroll, patients can call the toll-free number 1-888-233-2334. Information about the North American Drug Pregnancy Registry can be found at http://www.aedpregnancyregistry.org/.

Risk Summary
Topiramate (Trokendi XR) an cause fetal harm when administered to a pregnant woman. Data from pregnancy registries indicate that infants exposed to topiramate *in utero* have increased risk for cleft lip and/or cleft palate (oral clefts) and for being small for gestational age (SGA) *[see Human Data]*. SGA has been observed at all doses and appears to be dose-dependent. The prevalence of SGA is greater in infants of women who received higher doses of topiramate during pregnancy. In addition, the prevalence of SGA in infants of women who continued topiramate use until later in pregnancy is higher compared to the prevalence in infants of women who stopped topiramate use before the third trimester.
In multiple animal species, topiramate demonstrated developmental toxicity, including increased incidences of fetal malformations, in the absence of maternal toxicity at clinically relevant doses *[see Animal Data]*. In the U.S. general population, the estimated background risks of major birth defects and miscarriage in clinically recognized pregnancies are 2-4% and 15-20%, respectively.

Clinical Considerations
Fetal/Neonatal Adverse reactions
Consider the benefits and risks of topiramate when prescribing this drug to women of childbearing potential, particularly when topiramate is considered for a condition not usually associated with permanent injury or death. Because of the risk of oral clefts to the fetus, which occur in the first trimester of pregnancy before many women know they are pregnant, all women of childbearing potential should be informed of the potential risk to the fetus from exposure to topiramate. Women who are planning a pregnancy should be counseled regarding the relative risks and benefits of topiramate use during pregnancy, and alternative therapeutic options should be considered for these patients.

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

Topiramate (Trokendi XR) treatment can cause metabolic acidosis *[see Warnings and Precautions (5.4)]*. The effect of topiramate-induced metabolic acidosis has not been studied in pregnancy; however, metabolic acidosis in pregnancy (due to other causes) can cause decreased fetal growth,

decreased fetal oxygenation, and fetal death, and may affect the fetus' ability to tolerate labor. Pregnant patients should be monitored for metabolic acidosis and treated as in the nonpregnant state *[see Warnings and Precautions (5.4)]*. Newborns of mothers treated with Topiramate (Trokendi XR) should be monitored for metabolic acidosis because of transfer of topiramate to the fetus and possible occurrence of transient metabolic acidosis following birth. Based on limited information, topiramate has also been associated with pre-term labor and premature delivery.

Data

Human Data

Data from pregnancy registries indicate an increased risk of oral clefts in infants exposed to topiramate during the first trimester of pregnancy. In the NAAED pregnancy registry, the prevalence of oral clefts among topiramate-exposed infants (1.1%) was higher than the prevalence of infants exposed to reference AEDs (0.36%) , or the prevalence in infants of mothers without epilepsy and without exposure to AEDs (0.12%). It was also higher than the background prevalence in United States (0.17%) as estimated by the Centers for Disease Control and Prevention (CDC). The relative risk of oral clefts in topiramate-exposed pregnancies in the NAAED Pregnancy Registry was 9.6 (95% Confidence Interval=[CI] 4.0-23.0) as compared to the risk in a background population of untreated women. The UK Epilepsy and Pregnancy Register reported a prevalence of oral clefts among infants exposed to topiramate monotherapy (3.2%) that was 16 times higher than the background rate in the UK (0.2%).

Data from the NAAED pregnancy registry and a population-based birth registry cohort indicate that exposure to topiramate *in utero* is associated with an increased risk of SGA newborns (birth weight <10th percentile). In the NAAED pregnancy registry, 19.7% of topiramate-exposed newborns were SGA compared to 7.9% of newborns exposed to a reference AED, and 5.4% of newborns of mothers without epilepsy and without AED exposure. In the Medical Birth Registry of Norway (MBRN), a population-based pregnancy registry, 25% of newborns in the topiramate monotherapy exposure group were SGA compared to 9% in the comparison group who were unexposed to AEDs. The long-term consequences of the SGA findings are not known.

Animal Data

When topiramate (0, 20, 100, or 500 mg/kg/day) was administered orally to pregnant mice during the period of organogenesis, incidences of fetal malformations (primarily craniofacial defects) were increased at all doses. Fetal body weights and skeletal ossification were reduced at the highest dose tested in conjunction with decreased maternal body weight gain. A no-effect dose for embryofetal developmental toxicity in mice was not identified. The lowest dose tested, which was associated with an increased incidence of malformations, is less than the maximum recommended human dose (MRHD) for epilepsy (400 mg/day) or migraine (100 mg/day) on a body surface area (mg/m^2) basis.

In pregnant rats administered topiramate (0, 20, 100, and 500 mg/kg/day or 0, 0.2, 2.5, 30, and 400 mg/kg/day) orally during the period of organogenesis, the frequency of limb malformations (ectrodactyly, micromelia, and amelia) was increased in fetuses at 400 and 500 mg/kg/day. Embryotoxicity (reduced fetal body weights, increased incidences of structural variations) was observed at doses as low as 20 mg/kg/day. Clinical signs of maternal toxicity were seen at 400 mg/kg/day and above, and maternal body weight gain was reduced at doses of 100 mg/kg/day or greater. The no-effect dose (2.5 mg/kg/day) for embryofetal developmental toxicity in rats is less than the MRHD for epilepsy or migraine on a mg/m^2 basis.

In pregnant rabbits administered topiramate (0, 20, 60, and 180 mg/kg/day or 0, 10, 35, and 120 mg/kg/day orally during organogenesis, embryofetal mortality was increased at 35 mg/kg/day and an increased incidence of fetal malformations (primarily rib and vertebral malformations) was observed at 120 mg/kg/day. Evidence of maternal toxicity (decreased body weight gain, clinical signs, and/or mortality) was seen at 35 mg/kg/day and above. The no-effect dose (20 mg/kg/day) for embryofetal developmental toxicity in rabbits is equivalent to the MRHD for epilepsy and approximately 4 times the MRHD for migraine on a mg/m^2 basis.

When topiramate (0, 0.2, 4, 20, and 100 mg/kg/day or 0, 2, 20, and 200 mg/kg/day) was administered orally to female rats during the latter part of gestation and throughout lactation, offspring exhibited decreased viability and delayed physical development at 200 mg/kg/day and reductions in pre- and/or postweaning body weight gain at 2 mg/kg/day and above. Maternal toxicity (decreased body weight gain, clinical signs) was evident at 100 mg/kg/day or greater.

In a rat embryofetal development study which included postnatal assessment of offspring, oral administration of topiramate (0, 0.2, 2.5, 30, and 400 mg/kg/day) to pregnant animals during the period of organogenesis resulted in delayed physical development in offspring at 400 mg/kg/day and persistent reductions in body weight gain in offspring at 30 mg/kg/day and higher. The no-effect dose (0.2 mg/kg/day) for pre- and postnatal developmental toxicity is less than the MRHD for epilepsy or migraine on a mg/m^2 basis.

8.2 Lactation

Risk Summary

Topiramate is excreted in human milk *[see Data]*. The effects of topiramate on milk production are unknown. Diarrhea and somnolence have been reported in breastfed infants whose mothers receive topiramate treatment. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Topiramate (Trokendi XR) and any potential adverse effects on the breastfed infant from Topiramate (Trokendi XR) or from the underlying maternal condition.

Data

Limited data from 5 women with epilepsy treated with topiramate during lactation showed drug levels in milk similar to those in maternal plasma.

8.3 Females and Males of Reproductive Potential

Contraception

Women of childbearing potential who are not planning a pregnancy should use effective contraception because of the risks to the fetus of oral clefts and of being small for gestational age *[see Drug Interactions (7.5) and Use in Specific Populations (8.1)]*.

8.4 Pediatric Use

Seizures in Pediatric Patients 6 Years of Age and Older

The safety and effectiveness of Topiramate (Trokendi XR) for treatment of partial onset seizures, primary generalized tonic-clonic seizures, or Lennox-Gastaut syndromes in pediatric patients at least 6 years of age is based on controlled trials with immediate-release topiramate *[see Clinical Studies (14.2, 14.3)]*. The adverse reactions in pediatric patients treated for partial onset seizure, primary generalized tonic-clonic seizures, or Lennox-Gastaut syndrome are similar to those seen in adults *[see Warnings and Precautions (5) and Adverse Reactions (6)]*.

These include, but are not limited to:

- oligohydrosis and hyperthermia *[see Warnings and Precautions (5.3)]*
- dose-related increased incidence of metabolic acidosis *[see Warnings and Precautions (5.4)]*
- dose-related increased incidence of hyperammonemia *[see Warnings and Precautions (5.10)]*

Not Recommended for Pediatric Patients Younger than 6 Years of Age

The safety and effectiveness of Topiramate (Trokendi XR) for treatment of partial-onset seizures, primary generalized tonic-clonic seizures, or Lennox-Gastaut syndromes in pediatric patients younger than 6 years of age has not been established.

Because the capsule must be swallowed whole, and may not be sprinkled on food, crushed or chewed, Topiramate (Trokendi XR) is recommended only for children age 6 or older.

The following pediatric use information for adjunctive treatment for partial onset epilepsy in infants and toddlers (1 to 24 months) is based on studies conducted with immediate-release topiramate, which failed to demonstrate efficacy.

Safety and effectiveness of immediate-release topiramate in patients below the age of 2 years have not been established for the adjunctive therapy treatment of partial onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome. In a single randomized, double-blind, placebo controlled investigational trial, the efficacy, safety, and tolerability of immediate-release topiramate oral liquid and sprinkle formulations as an adjunct to concurrent antiepileptic drug therapy in pediatric patients 1 to 24 months of age with refractory partial- onset seizures were assessed. After 20 days of double-blind treatment, immediate-release topiramate (at fixed doses of 5, 15, and 25 mg/kg per day) did not demonstrate efficacy compared with placebo in controlling seizures.

In general, the adverse reaction profile for immediate-release topiramate in this population was similar to that of older pediatric patients, although results from the above controlled study, and an open-label, long-term extension study in these pediatric patients 1 to 24 months old suggested some adverse reactions not previously observed in older pediatric patients and adults; i.e., growth/length retardation, certain clinical laboratory abnormalities, and other adverse reactions that occurred with a greater frequency and/or greater severity than had been recognized previously from studies in older pediatric patients or adults for various indications.

These very young pediatric patients appeared to experience an increased risk for infections (any topiramate dose 12%, placebo 0%) and of respiratory disorders (any topiramate dose 40%, placebo 16%). The following adverse reactions were observed in at least 3% of patients on immediate-release topiramate and were 3% to 7% more frequent than in patients on placebo: viral infection, bronchitis, pharyngitis, rhinitis, otitis media, upper respiratory infection, cough, and bronchospasm. A generally similar profile was observed in older pediatric patients *[see Adverse Reactions (6.1)]*.

Immediate-release topiramate resulted in an increased incidence of patients with increased creatinine (any topiramate dose 5%, placebo 0%), BUN (any topiramate dose 3%, placebo 0%), and protein (any topiramate dose 34%, placebo 6%), and an increased incidence of decreased potassium (any topiramate dose 7%, placebo 0%). This increased frequency of abnormal values was not dose related. Creatinine was the only analyte showing a noteworthy increased incidence (topiramate 25 mg/kg/day 5%, placebo 0%) of a markedly abnormal increase *[see Adverse Reactions (6.1)]*. The significance of these findings is uncertain.

Immediate-release topiramate treatment also produced a dose-related increase in the percentage of patients who had a shift from normal at baseline to high/increased (above the normal reference range) in total eosinophil count at the end of treatment. The incidence of these abnormal shifts was 6 % for placebo, 10% for 5 mg/kg/day, 9% for 15 mg/kg/day, 14% for 25 mg/kg/day, and 11% for any topiramate dose *[see Adverse Reactions (6.1)]*. There was a mean dose-related increase in alkaline phosphatase. The significance of these findings is uncertain. Topiramate produced a dose-related increased incidence of hyperammonemia *[see Warnings and Precautions (5.10)]*.
Treatment with immediate-release topiramate for up to 1 year was associated with reductions in Z SCORES for length, weight, and head circumference *[see Warnings and Precautions (5.4) and Adverse Reactions (6)]*.

In open-label, uncontrolled experience, increasing impairment of adaptive behavior was documented in behavioral testing over time in this population. There was a suggestion that this effect was dose-related. However, because of the absence of an appropriate control group, it is not known if this decrement in function was treatment related or reflects the patient's underlying disease (e.g., patients who received higher doses may have more severe underlying disease) *[see Warnings and Precautions (5.7)]*.

In this open-label, uncontrolled study, the mortality was 37 deaths/1000 patient years. It is not possible to know whether this mortality rate is related to immediate-release topiramate treatment, because the background mortality rate for a similar, significantly refractory, young pediatric population (1 month to 24 months) with partial epilepsy is not known.

Other Pediatric Studies

Topiramate treatment produced a dose-related increased shift in serum creatinine from normal at baseline to an increased value at the end of 4 months treatment in adolescent patients (ages 12 years to 16 years) in a double-blind, placebo-controlled study *[see Adverse Reactions (6.1)]*.

Migraine Prophylaxis in Pediatric Patients 12 to 17 Years of Age

Safety and effectiveness of topiramate in the prophylaxis of migraine was studied in 5 double-blind, randomized, placebo-controlled, parallel-group trials in a total of 219 pediatric patients, at doses of 50 mg/day to 200 mg/day, or 2 to 3 mg/kg/day. These comprised a fixed dose study in 103 pediatric patients 12 to 17 years of age *[see Clinical Studies (14.4)]*, a flexible dose (2 to 3 mg/kg/day), placebo-controlled study in 157 pediatric patients 6 to 16 years of age (including 67 pediatric patients 12 to 16 years of age), and a total of 49 pediatric patients 12 to 17 years of age in 3 studies of migraine prophylaxis primarily in adults. Open-label extension phases of 3 studies enabled evaluation of long-term safety for up to 6 months after the end of the double-blind phase.

Efficacy of topiramate for migraine prophylaxis in pediatric patients 12 to 17 years of age is demonstrated for a 100 mg daily dose in Study 3 *[see Clinical Studies (14.4)]*. Efficacy of topiramate (2 to 3 mg/kg/day) for migraine prophylaxis was not demonstrated in a placebo-controlled trial of 157 pediatric patients (6 to 16 years of age) that included treatment of 67 pediatric patients 12 to 16 years of age) for 20 weeks.

In the pediatric trials (12 to 17 years of age) in which patients were randomized to placebo or a fixed daily dose of immediate-release topiramate, the most common adverse reactions with immediate-release topiramate that were seen at an incidence higher (≥5%) than in the placebo group were: paresthesia, upper respiratory tract infection, anorexia, and abdominal pain *[see Adverse Reactions (6.1)]*.

The most common cognitive adverse reaction in pooled double-blind studies in pediatric patients 12 to 17 years of age was difficulty with concentration/attention *[see Warnings and Precautions (5.7)]*.

Markedly abnormally low serum bicarbonate values indicative of metabolic acidosis were reported in topiramate-treated pediatric migraine patients *[see Warnings and Precautions (5.4)]*.

In topiramate-treated pediatric patients (12 to 17 years of age) compared to placebo-treated patients, abnormally increased results were more frequent for creatinine, BUN, uric acid, chloride, ammonia, total protein, and platelets. Abnormally decreased results were observed with topiramate vs placebo treatment for phosphorus and bicarbonate *[see Warnings and Precautions(5.4) and Adverse Reactions (6.1)]*.

Notable changes (increases and decreases) from baseline in systolic blood pressure, diastolic blood pressure, and pulse that were observed occurred more commonly in pediatric patients treated with topiramate compared to pediatric patients treated with placebo *[see Clinical Pharmacology (12.2)]*.

Migraine Prophylaxis in Pediatric Patients 6 to 11 Years of Age

Safety and effectiveness in pediatric patients below the age of 12 years have not been established for the prophylaxis treatment of migraine headache.

In a double-blind study in 90 pediatric patients 6 to 11 years of age (including 59 topiramate-treated and 31 placebo patients), the adverse reaction profile was generally similar to that seen in pooled double-blind studies of pediatric patients 12 to 17 years of age. The most common adverse reactions that occurred in immediate-release topiramate-treated pediatric patients 6 to 11 years of age, and at least twice as frequently than placebo, were gastroenteritis (12% topiramate, 6% placebo), sinusitis (10% topiramate, 3% placebo), weight loss (8% topiramate, 3% placebo) and paresthesia (7% topiramate, 0% placebo). Difficulty with concentration/attention occurred in 3 topiramate-treated patients (5%) and 0 placebo-treated patients.

The risk for cognitive adverse reactions was greater in younger patients (6 to 11 years of age) than in older patients (12 to 17 years of age) *[see Warnings and Precautions (5.7)]*.

Juvenile Animal Studies

When topiramate (30, 90, and 300 mg/kg/day) was administered orally to rats during the juvenile period of development (postnatal days 12 to 50), bone growth plate thickness was reduced in males at the highest dose, which is approximately 5-8 times the maximum recommended pediatric dose (9 mg/kg/day) on a body surface area (mg/m^2) basis.

8.5 Geriatric Use

Clinical studies of immediate-release topiramate did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently than younger subjects. Dosage adjustment may be necessary for elderly with creatinine clearance less than 70 mL/min/1.73 m^2. Estimate GFR should be measured prior to dosing *[see Dosage and Administration (2.5) and Clinical Pharmacology (12.3)]*.

8.6 Renal Impairment

The clearance of topiramate is reduced in patients with moderate (creatinine clearance 30 to 69 mL/min/1.73m^2) and severe (creatinine clearance less than 30 mL/min/1.73m^2) renal impairment. A dosage adjustment is recommended in patients with moderate or severe renal impairment *[see Dosage and Administration (2.5) and Clinical Pharmacology (12.3)]*.

8.7 Patients Undergoing Hemodialysis

Topiramate is cleared by hemodialysis at a rate that is 4 to 6 times greater than in a normal individual. A dosage adjustment may be required *[see Dosage and Administration (2.6) and Clinical Pharmacology (12.3)]*.

10 OVERDOSAGE

Overdoses of topiramate have been reported. Signs and symptoms included convulsions, drowsiness, speech disturbance, blurred vision, diplopia, impaired mentation, lethargy, abnormal coordination, stupor, hypotension, abdominal pain, agitation, dizziness and depression. The clinical consequences were not severe in most cases, but deaths have been reported after overdoses involving topiramate.

Topiramate overdose has resulted in severe metabolic acidosis *[see Warnings and Precautions (5.4)]*.

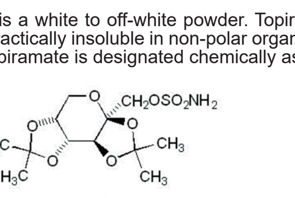
A patient who ingested a dose of immediate-release topiramate between 96 g and 110 g was admitted to a hospital with a coma lasting 20 to 24 hours followed by full recovery after 3 to 4 days.

Similar signs, symptoms, and clinical consequences are expected to occur with overdosage of Topiramate (Trokendi XR). Therefore, in acute Topiramate (Trokendi XR) overdose, if the ingestion is recent, the stomach should be emptied immediately by lavage or by induction of emesis. Activated charcoal has been shown to adsorb topiramate *in vitro*. Hemodialysis is an effective means of removing topiramate from the body.

11 DESCRIPTION

Topiramate, USP, is a sulfamate-substituted monosaccharide. Topiramate (Trokendi XR) extended-release capsules are available as 25 mg, 50 mg, 100 mg and 200 mg capsules for oral administration.

Topiramate is a white to off-white powder. Topiramate is freely soluble in polar organic solvents such as acetonitrile and acetone; and very slightly soluble to practically insoluble in non-polar organic solvents such hexanes. Topiramate has the molecular formula $C_{12}H_{21}NO_8S$ and a molecular weight of 339.4. Topiramate is designated chemically as 2,3:4,5-Di-*O*-isopropylidene-β-D-fructopyranose sulfamate and has the following structural formula:



12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

The precise mechanisms by which topiramate exerts its anticonvulsant and migraine prophylaxis effects are unknown; however, preclinical studies have revealed four properties that may contribute to topiramate's efficacy for epilepsy and migraine prophylaxis. Electrophysiological and biochemical evidence suggests that topiramate, at pharmacologically relevant concentrations, blocks voltage-dependent sodium channels, augments the activity of the neurotransmitter gamma-aminobutyrate at some subtypes of the GABA-A receptor, antagonizes the AMPA/kainate subtype of the glutamate receptor, and inhibits the carbonic anhydrase enzyme, particularly isozymes II and IV.

12.2 Pharmacodynamics

Topiramate has anticonvulsant activity in rat and mouse maximal electroshock seizure (MES) tests. Topiramate is only weakly effective in blocking clonic seizures induced by the GABA-A receptor antagonist, pentylenetetrazole. Topiramate is also effective in rodent models of epilepsy, which include tonic and absence-like seizures in the spontaneous epileptic rat (SER) and tonic and clonic seizures induced in rats by kindling of the amygdala or by global ischemia.

Changes (increases and decreases) from baseline in vital signs (systolic blood pressure-SBP, diastolic blood pressure-DBP, pulse) occurred more frequently in pediatric patients (6 to 17 years) treated with various daily doses of topiramate (50 mg, 100 mg, 200 mg, 2 to 3 mg/kg) than in patients treated with placebo in controlled trials for migraine prophylaxis. The most notable changes were SBP < 90 mm Hg, DBP < 50 mm Hg, SBP or DBP increases or decreases ≥ 20 mm Hg, and pulse increases or decreases ≥ 30 beats per minute. These changes were often dose-related, and were most frequently associated with the greatest treatment difference at the 200 mg dose level. Systematic collection of orthostatic vital signs has not been conducted. The clinical significance of these various changes in vital signs has not been clearly established.

12.3 Pharmacokinetics

Absorption and Distribution

Linear pharmacokinetics of topiramate from Topiramate (Trokendi XR) were observed following a single oral dose over the range of 50 mg to 200 mg. At 25 mg, the pharmacokinetics of Topiramate (Trokendi XR) is nonlinear possibly due to the binding of topiramate to carbonic anhydrase in red blood cells.

The peak plasma concentrations (C_{max}) of topiramate occurred at approximately 24 hours following a single 200 mg oral dose of Topiramate (Trokendi XR). At steady-state, the (AUC_{0-24}, C_{max}, and C_{min}) of topiramate from Topiramate (Trokendi XR) administered once-daily and the immediate-release tablet administered twice-daily were shown to be bioequivalent. Fluctuation of topiramate plasma concentrations at steady-state for Topiramate (Trokendi XR) administered once-daily was approximately 26% and 42% in healthy subjects and in epileptic patients, respectively, compared to approximately 40% and 51%, respectively, for immediate-release topiramate *[see Clinical Pharmacology (12.6)]*.

Compared to the fasted state, high-fat meal increased the Cmax of topiramate by 37% and shortened the Tmax to approximately 8 hour following a single dose of Topiramate (Trokendi XR) while having no effect on the AUC. Modeling of the observed single dose fed data with simulation to steady state showed that the effect on Cmax is significantly reduced following repeat administrations. Topiramate (Trokendi XR) can be taken without regard to meals.

Topiramate is 15% to 41% bound to human plasma proteins over the blood concentration range of 0.5 mcg/mL to 250 mcg/mL. The fraction bound decreased as blood concentration increased.

Carbamazepine and phenytoin do not alter the binding of immediate-release topiramate. Sodium valproate, at 500 mcg/mL (a concentration 5 to 10 times higher than considered therapeutic for valproate) decreased the protein binding of immediate-release topiramate from 23% to 13%. Immediate-release topiramate does not influence the binding of sodium valproate.

Metabolism and Excretion

Topiramate is not extensively metabolized and is primarily eliminated unchanged in the urine (approximately 70% of an administered dose). Six metabolites have been identified in humans, none of which constitutes more than 5% of an administered dose. The metabolites are formed via hydroxylation, hydrolysis, and glucuronidation. There is evidence of renal tubular reabsorption of topiramate. In rats, given probenecid to inhibit tubular reabsorption, along with topiramate, a significant increase in renal clearance of topiramate was observed. This interaction has not been evaluated in humans. Overall, oral plasma clearance (CL/F) is approximately 20 mL/min to 30 mL/min in adults following oral administration. The mean elimination half-life of topiramate was approximately 31 hours following repeat administration of Topiramate (Trokendi XR).

Specific Populations

Renal Impairment

The clearance of topiramate was reduced by 42% in subjects with moderate renal impairment (creatinine clearance 30 to 69 mL/min/1.73m^2) and by 54% in subjects with severe renal impairment (creatinine clearance less than 30 mL/min/1.73m^2) compared to subjects with normal renal function (creatinine clearance greater than 70 mL/min/1.73m^2) *[see Dosage and Administration (2.5)]*.

Hemodialysis

Topiramate is cleared by hemodialysis. Using a high-efficiency, counterflow, single pass-dialysate hemodialysis procedure, topiramate dialysis clearance was 120 mL/min with blood flow through the dialyzer at 400 mL/min. This high clearance (compared to 20 mL/min to 30 mL/min total oral clearance in healthy adults) will remove a clinically significant amount of topiramate from the patient over the hemodialysis treatment period *[see Dosage and Administration (2.6) and Use in Specific Populations (8.7)]*.

Hepatic Impairment

Plasma clearance of topiramate decreased a mean of 26% in patients with moderate to severe hepatic impairment.

Age, Gender and Race

The pharmacokinetics of topiramate in elderly subjects (65 to 85 years of age, N=16) were evaluated in a controlled clinical study. The elderly subject population had reduced renal function (creatinine clearance [- 20%]) compared to young adults. Following a single oral 100 mg dose, maximum plasma concentration for elderly and young adults was achieved at approximately 1 to 2 hours. Reflecting the primary renal elimination of topiramate, topiramate plasma and renal clearance were reduced 21% and 19%, respectively, in elderly subjects, compared to young adults. Similarly, topiramate half-life was longer (13%) in the elderly. Reduced topiramate clearance resulted in slightly higher maximum plasma concentration (23%) and AUC (25%) in elderly subjects than observed in young adults. Topiramate clearance is decreased in the elderly only to the extent that renal function is reduced *[see Dosage and Administration (2.4) and Use in Specific Populations (8.5)]*.

In a study of 13 healthy elderly subjects and 18 healthy young adults who received Topiramate (Trokendi XR), 30% higher mean Cmax and 44% higher AUC values were observed in elderly compared to young subjects. Elderly subjects exhibited shorter median Tmax at 16 hours versus 24 hours in young subjects. The apparent elimination half-life was similar across age groups. As recommended for all patients, dosage adjustment is indicated in elderly patients with a creatinine clearance rate less than 70 mL/min/1.73 m^2) *[see Dosage and Administration (2.5) and Use in Specific Populations (8.5)]*.

Clearance of topiramate in adults was not affected by gender or race.

Pediatric Pharmacokinetics

Pharmacokinetics of immediate-release topiramate were evaluated in patients ages 2 to <16 years of age. Patients received either no or a combination of other antiepileptic drugs. A population pharmacokinetic model was developed on the basis of pharmacokinetic data from relevant topiramate clinical studies. This dataset contained data from 1217 subjects including 258 pediatric patients age 2 years to <16 years of age (95 pediatric patients less than 10 years of age). Pediatric patients on adjunctive treatment exhibited a higher oral clearance (L/h) of topiramate compared to patients on monotherapy, presumably because of increased clearance from concomitant enzyme-inducing antiepileptic drugs. In comparison, topiramate clearance per kg is greater in pediatric patients than in adults and in young pediatric patients (down to 2 years of age) than in older pediatric patients. Consequently, the plasma drug concentration for the same mg/kg/day dose would be lower in pediatric patients compared to adults and also in younger pediatric patients compared to older pediatric patients. Clearance was independent of dose.
As in adults, hepatic enzyme-inducing antiepileptic drugs decrease the steady state plasma concentrations of topiramate.

Drug-Drug Interaction Studies

In vitro studies indicate that topiramate does not inhibit CYP1A2, CYP2A6, CYP2B6, CYP2C9, CYP2D6, CYP2E1, and CYP3A4/5 isozymes. *In vitro* studies indicate that immediate-release topiramate is a mild inhibitor of CYP2C19 and a mild inducer of CYP3A4. The same drug interactions can be expected with the use of Topiramate (Trokendi XR).

Antiepileptic Drugs

Potential interactions between immediate-release topiramate and standard AEDs were assessed in controlled clinical pharmacokinetic studies in patients with epilepsy. The effects of these interactions on mean plasma AUCs are summarized in Table 8. Interaction of Topiramate (Trokendi XR) and standard AEDs is not expected to differ from the experience with immediate-release topiramate products.

In Table 8, the second column (AED concentration) describes what happens to the concentration of the co-administered AED listed in the first column when topiramate is added. The third column (topiramate concentration) describes how the co-administration of a drug listed in the first column modifies the concentration of topiramate when compared to topiramate given alone.

Table 8: Summary of AED Interactions with Topiramate

AED Coadministered	AED Concentration	Topiramate Concentration
Phenytoin	NC or 25% increase*	48% decrease
Carbamazepine (CBZ)	NC	40% decrease
CBZ epoxide[†]	NC	NE
Valproic acid	11% decrease	14% decrease
Phenobarbital	NC	NE
Primidone	NC	NE
Lamotrigine	NC at TPM doses up to 400mg per day	13% decrease

* =Plasma concentration increased 25% in some patients, generally those on a twice a day dosing regimen of phenytoin
[†] =Is not administered but is an active metabolite of carbamazepine
NC=Less than 10% change in plasma concentration
AED=Antiepileptic drug
NE=Not evaluated
TPM=topiramate

Oral Contraceptives

In a pharmacokinetic interaction study in healthy volunteers with a concomitantly administered combination oral contraceptive product containing 1 mg norethindrone (NET) plus 35 mcg ethinyl estradiol (EE), immediate-release topiramate, given in the absence of other medications at doses of 50 to 200 mg/day, was not associated with statistically significant changes in mean exposure (AUC) to either component of the oral contraceptive. In another study, exposure to EE was statistically significantly decreased at doses of 200, 400, and 800 mg per day (18%, 21%, and 30%, respectively) when given as adjunctive therapy in patients taking valproic acid. In both studies, topiramate (50 mg per day to 800 mg per day) did not significantly affect exposure to NET, and there was no significant dose-dependent change in EE exposure for doses of 50 to 200 mg/day. The clinical significance of the changes observed is not known *[see Drug Interactions (7.5)]*.

Digoxin

In a single-dose study, serum digoxin AUC was decreased by 12% with concomitant topiramate administration. The clinical relevance of this observation has not been established.

Hydrochlorothiazide

A drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of hydrochlorothiazide (HCTZ) (25 mg every 24 hours) and topiramate (96 mg every 12 hours) when administered alone and concomitantly. The results of this study indicate that topiramate Cmax increased by 27% and AUC increased by 29% when HCTZ was added to topiramate. The clinical significance of this change is unknown. The steady-state pharmacokinetics of HCTZ were not significantly influenced by the concomitant administration of topiramate. Clinical laboratory results indicated decreases in serum potassium after topiramate or HCTZ administration, which were greater when HCTZ and topiramate were administered in combination *[see Drug Interactions (7.6)]*.

Metformin

A drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of metformin (500 mg ever 12 hours) and topiramate in plasma when metformin was given alone and when metformin and topiramate (100 mg every 12 hours) were given simultaneously. The results of this study indicated that the mean metformin C_{max} and AUC_{0-12h} increased by 17% and 25%, respectively, when topiramate was added. Topiramate did not affect metformin Tmax. The clinical significance of the effect of topiramate on metformin pharmacokinetics is not known. Oral plasma clearance of topiramate appears to be reduced when administered with metformin. The clinical significance of the effect of metformin on topiramate or Topiramate (Trokendi XR) pharmacokinetics is unclear.

Pioglitazone

A drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of topiramate and pioglitazone when administered alone and concomitantly. A 15% decrease in the $AUC_{T,SS}$ of pioglitazone with no alteration in $C_{max,SS}$ was observed. This finding was not statistically significant. In addition, a 13% and 16% decrease in $C_{max,ss}$ and $AUC_{T,SS}$ respectively, of the active hydroxy-metabolite was noted as well as a 60% decrease in $C_{max,ss}$ and $AUC_{T,ss}$ of the active keto- metabolite. The clinical significance of these findings is not known *[see Drug Interactions (7.7)]*.

Glyburide

A drug interaction study conducted in patients with type 2 diabetes evaluated the steady-state pharmacokinetics of glyburide (5 mg per day) alone and concomitantly with topiramate (150 mg per day). There was a 22% decrease in C_{max} and 25% reduction in AUC_{24} for glyburide during topiramate administration. Systemic exposure (AUC) of the active metabolites, 4-*trans*-hydroxy glyburide (M1) and 3-*cis*-hydroxyglyburide (M2), was also reduced by 13% and 15%, reduced C_{max} by 18% and 25%, respectively. The steady-state pharmacokinetics of topiramate were unaffected by concomitant administration of glyburide.

Lithium

In patients, the pharmacokinetics of lithium were unaffected during treatment with topiramate at doses of 200 mg per day; however, there was an observed increase in systemic exposure of lithium (27% for C_{max} and 26% for AUC) following topiramate doses up to 600 mg per day *[see Drug Interactions (7.8)]*.

Haloperidol

The pharmacokinetics of a single dose of haloperidol (5 mg) were not affected following multiple dosing of topiramate (100 mg every 12 hr) in 13 healthy adults (6 males, 7 females).

Amitriptyline

There was a 12% increase in AUC and C_{max} for amitriptyline (25 mg per day) in 18 healthy subjects (9 males, 9 females) receiving 200 mg per day of immediate-release topiramate *[see Drug Interactions (7.9)]*.

Sumatriptan

Multiple dosing of topiramate (100 mg every 12 hours) in 24 healthy volunteers (14 males, 10 females) did not affect the pharmacokinetics of single-dose sumatriptan either orally (100 mg) or subcutaneously (6 mg).

Risperidone

When administered concomitantly with topiramate at escalating doses of 100, 250, and 400 mg per day, there was a reduction in risperidone systemic exposure (16% and 33% for steady-state AUC at the 250 and 400 mg per day doses of topiramate). No alterations of 9-hydroxyrisperidone levels were observed. Coadministration of topiramate 400 mg per day with risperidone resulte in a 14% increase in Cmax and a 12% increase in AUC_{12} of topiramate. There were no clinically significant changes in the systemic exposure of risperidone plus 9- hydroxyrisperidone or of topiramate; therefore, this interaction is not likely to be of clinical significance.

Propranolol

Multiple dosing of topiramate (200 mg per day) in 34 healthy volunteers (17 males, 17 females) did not affect the pharmacokinetics of propranolol following daily 160 mg doses. Propranolol doses of 160 mg per day in 39 volunteers (27 males, 12 females) had no effect on the exposure to topiramate at a dose of 200 mg/day of topiramate.

Dihydroergotamine

Multiple dosing of topiramate (200 mg/day) in 24 healthy volunteers (12 males, 12 females) did not affect the pharmacokinetics of a 1 mg subcutaneous dose of dihydroergotamine. Similarly, a 1 mg subcutaneous dose of dihydroergotamine did not affect the pharmacokinetics of a 200 mg/day dose of topiramate in the same study.

Diltiazem

Co-administration of diltiazem (240 mg Cardizem CD®) with topiramate (150 mg/day) resulted in a 10% decrease in C_{max} and 25% decrease in diltiazem AUC, 27% decrease in C_{max} and 18% decrease in des-acetyl diltiazem AUC, and no effect on N- desmethyl diltiazem. Co-administration of topiramate with diltiazem resulted in a 16% increase in C_{max} and a 19% increase in AUC_{12} of topiramate.

Venlafaxine

Multiple dosing of topiramate (150 mg/day) in healthy volunteers did not affect the pharmacokinetics of venlafaxine or O-desmethyl venlafaxine. Multiple dosing of venlafaxine (150 mg) did not affect the pharmacokinetics of topiramate.

12.6 Relative Bioavailability of Topiramate (Trokendi XR) Compared to Immediate-Release Topiramate

Study in Healthy Normal Volunteers

Topiramate (Trokendi XR) taken once a day provides steady state plasma levels comparable to immediate-release topiramate taken ever 12 hours, when administered at the same total 200-mg daily dose. In a crossover study, 33 healthy subjects were titrated to a 200-mg dose of either Topiramate (Trokendi XR) or immediate-release topiramate and were maintained at 200 mg per day for 10 days.

The 90% CI for the ratios of AUC_{0-24}, C_{max} and C_{min}, as well as partial AUC (the area under the concentration-time curve from time 0 to time p (post dose) for multiple time points were within the 80 to 125% bioequivalence limits, indicating no clinically significant difference between the two formulations. In addition, the 90% CI for the ratios of topiramate plasma concentration at each of multiple time points over 24 hours for the two formulations were within the 80 to 125% bioequivalence limits, except for the initial time points before 1.5 hour post-dose.

Study in Patients with Epilepsy

In a study in epilepsy patients treated with immediate-release topiramate alone or in combination with either enzyme-inducing or neutral AEDs who were switched to an equivalent daily dose of Topiramate (Trokendi XR), there was a 10% decrease in AUC_{0-24}, C_{max}, and C_{min} on the first day after the switch in all patients. At steady state, AUC_{0-24} and C_{max} were comparable to immediate-release topiramate in all patients. While patients treated with Topiramate (Trokendi XR) alone or in combination with neutral AEDs showed comparable C_{min} at steady state, patients treated with enzyme-inducers showed a 10% decrease in C_{min}. This difference is likely not clinically significant and probably due to the small number of patients on enzyme- inducers.

13 NON-CLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, and Impairment of Fertility

Carcinogenesis

An increase in urinary bladder tumors was observed in mice given topiramate (0, 20, 75, and 300 mg/kg/day) in the diet for 21 months. An increase in the incidence of bladder tumors in males and females receiving 300 mg/kg was primarily due to the increased occurrence of a smooth muscle tumor considered histomorphologically unique to mice. The higher of the doses not associated with an increase in tumors (75 mg/kg/day) is equivalent to the maximum recommended human dose (MRHD) for epilepsy and approximately 4 times the MRHD for migraine (100 mg) on a mg/m2 basis. The relevance of this finding to human carcinogenic risk is uncertain. No evidence of carcinogenicity was seen in rats following oral administration of topiramate for 2 years at doses up to 120 mg/kg/day (approximately 3 times the MRHD for epilepsy and 12 times the MRHD for migraine on a mg/m^2 basis).

Mutagenesis

Topiramate did not demonstrate genotoxic potential when tested in a battery of *in vitro* and *in vivo* assays. Topiramate was not mutagenic in the Ames test or the *in vitro* mouse lymphoma assay; it did not increase unscheduled DNA synthesis in rat hepatocytes *in vitro*; and it did not increase chromosomal aberrations in human lymphocytes *in vitro* or in rat bone marrow *in vivo*.

Impairment of Fertility

No adverse effects on male or female fertility were observed in rats administered oral doses of up to 100 mg/kg/day (2.5 times the MRHD for epilepsy and 10 times the MRHD for migraine on a mg/m^2 basis) prior to and during mating and early pregnancy.

14 CLINICAL STUDIES

14.1 Bridging Study to Demonstrate Pharmacokinetic Equivalence between Extended-Release and Immediate-Release Topiramate Formulations

The basis for approval of the extended-release formulation Topiramate (Trokendi XR) included the studies described below using an immediate-release formulation and the demonstration of the pharmacokinetic equivalence of Topiramate (Trokendi XR) to immediate release topiramate through the analysis of concentrations and cumulative AUCs at multiple time points *[see Clinical Pharmacology (12.6)]*.

The clinical studies described in the following sections were conducted using immediate-release topiramate.

14.2 Monotherapy Epilepsy

Patients With Partial-Onset or Primary Generalized Tonic-Clonic Seizures

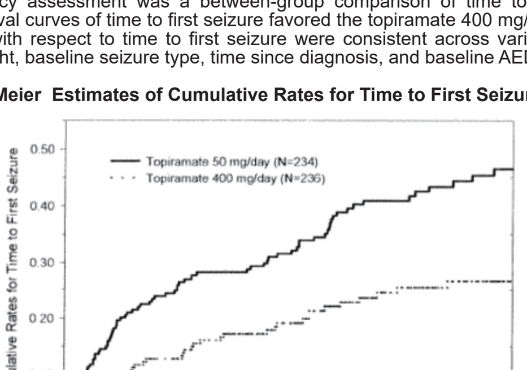
Adults and Pediatric Patients 10 Years of Age and Older

The effectiveness of topiramate as initial monotherapy in adults and pediatric patients 10 years of age and older with partial onset or primary generalized tonic-clonic seizures was established in a multicenter, randomized, double-blind, dose-controlled, parallel- group trial (Study 1).

Study 1 was conducted in 487 patients diagnosed with epilepsy (6 to 83 years of age) who had 1 or 2 well documented seizures during the 3-month retrospective baseline phase who then entered the study and received topiramate 25 mg per day for 7 days in an open-label fashion. Forty-nine percent of subjects had no prior AED treatment and 17% had a diagnosis of epilepsy for greater than 24 months. Any AED therapy used for temporary or emergency purposes was discontinued prior to randomization. In the double-blind phase, 470 patients were randomized to titrate up to 50 mg/day or 400 mg/day of topiramate. If the target dose could not be achieved, patients were maintained on the maximum tolerated dose. Fifty-eight percent of patients achieved the maximal dose of 400 mg/day for >2 weeks, and patients who did not tolerate 150 mg/day were discontinued.

The primary efficacy assessment was a between-group comparison of time to first seizure during the double-blind phase. Comparison of the Kaplan-Meier survival curves of time to first seizure favored the topiramate 400 mg/day group over the topiramate 50 mg/day group (Figure 1). The treatment effects with respect to time to first seizure were consistent across various patient subgroups defined by age, sex, geographic region, baseline body weight, baseline seizure type, time since diagnosis, and baseline AED use.

Figure 1: Kaplan-Meier Estimates of Cumulative Rates for Time to First Seizure in Study 1



Pediatric Patients 6 to 9 Years of Age

The conclusion that topiramate is effective as initial monotherapy in pediatric patients 6 to 9 years of age with partial-onset or primary generalized tonic-clonic seizures was based on a pharmacometric bridging approach using data from the controlled epilepsy trials conducted with immediate-release topiramate described in labeling.
The approach consisted of first showing a similar exposure response relationship between pediatric patients down to 2 years of age and adults when immediate-release topiramate was given as adjunctive therapy *[see Use in Specific Populations (8.4)]*. Similarity of exposure-response was demonstrated in pediatric patients 6 to less than 16 years of age and adults when topiramate was given as initial monotherapy. Specific dosing in pediatric patients 6 to 9 years of age was derived from simulations utilizing plasma exposure ranges observed in pediatric and adult patients treated with immediate-release topiramate initial monotherapy *[see Dosage and Administration (2.1)]* .

14.3 Adjunctive Therapy Epilepsy

Adult Patients With Partial-Onset Seizures

The effectiveness of topiramate as an adjunctive treatment for adults with partial-onset seizures was established in six multicenter, randomized, double-blind, placebo-controlled trials (Studies 2, 3, 4, 5, 6, and 7), two comparing several dosages of topiramate and placebo and four comparing a single dosage with placebo, in patients with a history of partial onset seizures, with or without secondarily generalized seizures.

Patients in these studies were permitted a maximum of two antiepileptic drugs (AEDs) in addition to topiramate tablets or placebo. In each study, patients were stabilized on optimum dosages of their concomitant AEDs during baseline phase lasting between 4 and 12 weeks. Patients who experienced a pre-specified minimum number of partial-onset seizures, with or without secondary generalization, during the baseline phase (12 seizures for 12-week baseline, 8 for 8-week baseline or 3 for 4-week baseline) were randomly assigned to placebo or a specified dose of topiramate tablets in addition to their other AEDs.

Following randomization, patients began the double-blind phase of treatment. In five of the six studies, patients received active drug beginning at 100 mg per day; the dose was then increased by 100 mg or 200 mg/day increments weekly or every other week until the assigned dose was reached, unless intolerance prevented increases. In Study 7, the 25 or 50 mg/day initial doses of topiramate were followed by respective weekly increments of 25 or 50 mg/day until the target dose of 200 mg/day was reached. After titration, patients entered a 4, 8 or 12-week stabilization period. The numbers of patients randomized to each dose, and the actual mean and median doses in the stabilization period are shown in Table 9.

Pediatric Patients 6 to 16 Years of Age With Partial-Onset Seizures

The effectiveness of topiramate as an adjunctive treatment for pediatric patients 6 to 16 years of age with partial-onset seizures was established in a multicenter, randomized, double-blind, placebo-controlled trial (Study 8), comparing topiramate and placebo in patients with a history of partial-onset seizures, with or without secondarily generalized seizures.

Patients in Study 8 were permitted a maximum of two antiepileptic drugs (AEDs) in addition to topiramate tablets or placebo. In Study 8, patients were stabilized on optimum dosages of their concomitant AEDs during an 8-week baseline phase. Patients who experienced at least six partial onset seizures, with or without secondarily generalized seizures, during the baseline phase were randomly assigned to placebo or topiramate in addition to their other AEDs.

Following randomization, patients began the double-blind phase of treatment. Patients received active drug beginning at 25 or 50 mg/day; the dose was then increased by 25 mg to 150 mg/day increments every other week until the assigned dosage of 125, 175, 225 or 400 mg/day based on patients' weight to approximate a dosage of 6 mg/kg per day was reached, unless intolerance prevented increases. After titration, patients entered an 8-week stabilization period.

Patients With Primary Generalized Tonic-Clonic Seizures

The effectiveness of topiramate as an adjunctive treatment for primary generalized tonic-clonic seizures in patients 6 years of age and older was established in a multicenter, randomized, double-blind, placebo-controlled trial (Study 9), comparing a single dosage of topiramate and placebo (see Table 10).

Patients in Study 9 were permitted a maximum of two antiepileptic drugs (AEDs) in addition to topiramate or placebo. Patients were stabilized on optimum dosages of their concomitant AEDs during an 8-week baseline phase. Patients who experienced at least three primary generalized tonic-clonic seizures during the baseline phase were randomly assigned to placebo or topiramate in addition to their other AEDs.

Following randomization, patients began the double-blind phase of treatment. Patients received active drug beginning at 50 mg/day for four weeks; the dose was then increased by 50 mg to 150 mg/day increments every other week until the assigned dose of 175, 225 or 400 mg/day based on patients' body weight to approximate a dosage of 6 mg/kg/day was reached, unless intolerance prevented increases. After titration, patients entered a 12-week stabilization period.

Patients With Lennox-Gastaut Syndrome

The effectiveness of topiramate as an adjunctive treatment for seizures associated with Lennox-Gastaut syndrome in patients 6 years of age and older was established in a multicenter, randomized, double-blind, placebo-controlled trial (Study 10), comparing a single dosage of topiramate with placebo (see Table 10).

Patients in Study 10 were permitted a maximum of two antiepileptic drugs (AEDs) in addition to topiramate or placebo. Patients who were experiencing at least 60 seizures per month before study entry were stabilized on optimum dosages of their concomitant AEDs during a 4 week baseline phase. Following baseline, patients were randomly assigned to placebo or topiramate in addition to their other AEDs. Active drug was titrated beginning at 1 mg/kg/day for a week; the dose was then increased to 3 mg/kg/day for one week then to 6 mg/kg/day. After titration, patients entered an 8-week stabilization period. The primary measures of effectiveness were the percent reduction in drop attacks and a parental global rating of seizure severity.

Table 9: Immediate Release Topiramate Dose Summary During the Stabilization Periods of Each of Six Double-Blind, Placebo-Controlled, Adjunctive Trials in Adults With Partial-Onset Seizures[a]

		Target Topiramate Dosage (mg per day)					
Study	**Stabilization Dose**	**Placebo[b]**	**200**	**400**	**600**	**800**	**1000**
2	N	42	42	40	41	---	---
	Mean Dose	5.9	200	390	556	---	---
	Median Dose	6.0	200	400	600	---	---
3	N	44	---	---	40	45	40
	Mean Dose	9.7	---	---	544	739	796
	Median Dose	10.0	---	---	600	800	1000
4	N	23	---	19	---	---	---
	Mean Dose	3.8	---	395	---	---	---
	Median Dose	4.0	---	400	---	---	---
5	N	30	---	---	28	---	---
	Mean Dose	5.7	---	---	522	---	---
	Median Dose	6.0	---	---	600	---	---
6	N	28	---	---	---	25	---
	Mean Dose	8.0	---	---	---	568	---
	Median Dose	8.0	---	---	---	600	---
7	N	90	157	---	---	---	---
	Mean Dose	8	200	---	---	---	---
	Median Dose	8	200	---	---	---	---

[a]Dose-response studies were not conducted for other indications or pediatric partial-onset seizures
[b]Placebo dosages are given as the number of tablets. Placebo target dosages were as follows: Study 4 (4 tablets/day); Studies 2 and 5 (6 tablets/day); Studies 6 and 7 (8 tablets/day); Study 3 (10 tablets/day)

In all adjunctive topiramate trials, the reduction in seizure rate from baseline during the entire double-blind phase was measured. The median percent reductions in seizure rates and the responder rates (fraction of patients with at least a 50% reduction) by treatment group for each study are shown below in Table 10. As described above, a global improvement in seizure severity was also assessed in the Lennox-Gastaut trial.

Table 10: Efficacy Results in Double-Blind, Placebo-Controlled, Adjunctive Epilepsy Trials

		Target Topiramate Dosage (mg per day)						
Study #	**#**	**Placebo**	**200**	**400**	**600**	**800**	**1000**	**≈6mg/kg/day***
Partial Onset Seizures Studies in Adults								
2	N	45	45	45	46	---	---	---
	Median % Reduction	12	27[a]	48[b]	45[c]	---	---	---
	% Responders	18	24	44[d]	46[d]	---	---	---
3	N	47	---	---	48	48	47	---
	Median % Reduction	2	---	---	41[c]	41[c]	36[c]	
	% Responders	9	---	---	40[c]	41[c]	36[d]	
4	N	24	---	23	---	---	---	---
	Median % Reduction	1	---	41[e]	---	---	---	---
	% Responders	8	---	35[d]	---	---	---	---
5	N	30	---	---	30	---	---	---
	Median % Reduction	-12	---	---	46[f]	---	---	---
	% Responders	10	---	---	47[c]	---	---	---
6	N	28	---	---	---	28	---	---
	Median % Reduction	-21	---	---	---	24[c]	---	---
	% Responders	0	---	---	---	43[c]	---	---
7	N	91	168	---	---	---	---	---
	Median % Reduction	20	44[c]	---	---	---	---	---
	% Responders	24	45[c]	---	---	---	---	---
Partial Onset Seizures Studies in Pediatric Patients[k]								
8	N	45	---	---	---	---	---	41
	Median % Reduction	11	---	---	---	---	---	33[d]
	% Responders	20	---	---	---	---	---	39
Primary Generalized Tonic-Clonic[h, k]								
9	N	40	---	---	---	---	---	39
	Median % Reduction	9	---	---	---	---	---	57[d]
	% Responders	20	---	---	---	---	---	56[c]
Lennox-Gastaut Syndrome[i, k]								
10	N	49	---	---	---	---	---	46
	Median % Reduction	-5	---	---	---	---	---	15[d]
	% Responders	14	---	---	---	---	---	28[g]
	Improvement in Seizure Severity[j]	28	---	---	---	---	---	52[d]

Comparisons with placebo: [a]p=0.080; [b]p ≤ 0.010; [c]p ≤ 0.001; [d]p ≤ 0.050; [e]p=0.065; [f]p ≤0.005; [g]p=0.071;
[h]Median % reduction and % responders are reported for PGTC seizures;
[i]Median % reduction and % responders for drop attacks, i.e., tonic or atonic seizures
[j]Percentage of subjects who were minimally, much, or very much improved from baseline.
K Studies included pediatric patients 2 years of age and older, an age group for which TROKENDI XR is not indicated *[see Indications and Usage (1.2) and Use in Specific Populations (8.4)]*
*For Studies 8 and 9, specified target dosages (<9.3 mg/kg/day) were assigned based on subject's weight to approximate a dosage of 6mg/kg per day; these dosages corresponded to mg/day dosages of 125, 175, 225, and 400 mg/day

Subset analyses of the antiepileptic efficacy of topiramate tablets in these studies showed no differences as a function of gender, race, age, baseline seizure rate, or concomitant AED.

In clinical trials for epilepsy, daily dosages were decreased in weekly intervals by 50 mg per day to 100 mg per day in adults and over a 2- to 8-week period in pediatric patients; transition was permitted to a new antiepileptic regimen when clinically indicated.

14.4 Migraine Prophylaxis

Adult Patients

The results of 2 multicenter, randomized, double-blind, placebo-controlled, parallel-group clinical trials conducted in US (Study 11) or the US and Canada (Study 12) established the effectiveness of immediate-release topiramate in the prophylactic treatment of migraine headache. The design of both trials was identical, enrolling patients with a history of migraine with or without aura, for at least 6 months, according to the International Headache Society (IHS) diagnostic criteria. Patients with a history of cluster headaches or basilar, opthalmoplegic, hemiplegic, or transformed migraine headaches were excluded from the trials. Patients were required to have completed up to a 2-week washout of any prior migraine preventative medications before starting the baseline phase.

Patients who experienced 3 to 12 migraine headaches over the 4 weeks in the baseline phase were randomized to either immediate-release topiramate 50 mg/day, 100 mg/day, 200 mg/day (twice the recommended daily dosage for migraine prophylaxis) or placebo, and treated for a total of 26 weeks (8-week titration period and 18- week maintenance period.). Treatment was initiated at 25 mg/day for one week, and then the daily dosage was increased by 25 mg increments each week until reaching the assigned target dose or maximum tolerated dose (administered twice daily).

Effectiveness of treatment was assessed by the reduction in migraine headache frequency, as measured by the change in 4-week migraine rate (according to migraines classified by IHS criteria) from the baseline phase to double-blind treatment period in each immediate-release topiramate treatment group compared to placebo in the Intent-To-Treat (ITT) population.

In Study 11, a total of 469 patients (416 females, 53 males) ranging in age from 13 to 70 years, were randomized and provided efficacy data. Two hundred sixty-five patients completed the entire 26-week double-blind phase. The median average daily dosages were 48 mg/day, 88 mg/day, and 132 mg/day in the target dose groups of topiramate 50, 100 and 200 mg/day, respectively.

The mean migraine headache frequency rate at baseline was approximately 5.5 migraine headaches per 28 days, and was similar across treatment groups. The change in the mean 4-week migraine headache frequency from baseline to the double-blind phase was -1.3, -2.1, and -2.2 in the immediate-release topiramate 50, 100, and 200 mg/day groups, respectively, versus -0.8 in the placebo group (see Figure 2). The treatment differences between the immediate release topiramate 100 and 200 mg/day groups versus placebo were similar and statistically significant (p less than 0.001 for both comparisons).

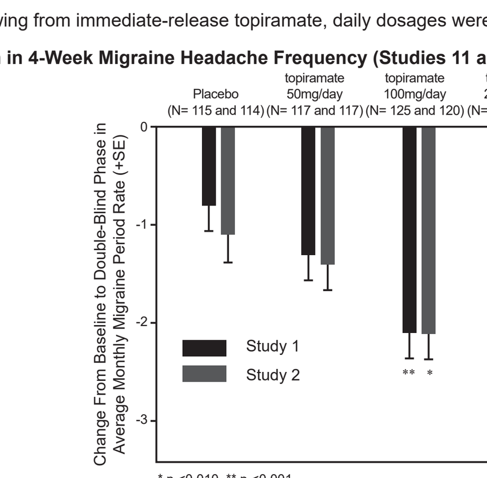
In Study 12, a total of 468 patients (406 females, 62 males) ranging in age from 12 to 65 years, were randomized and provided efficacy data. Two hundred fifty-five patients completed the entire 26-week double-blind phase. The median average daily dosages were 47 mg/day, 86 mg/day, and 150 mg/day in the target dose groups of immediate-release topiramate 50, 100, and 200 mg/day, respectively.

The mean migraine headache frequency rate at baseline was approximately 5.5 migraine headaches per 28 days and was similar across treatment groups. The change in the mean 4-week migraine headache period frequency from baseline to the double-blind phase was -1.4, -2.1, and -2.4 in the immediate-release topiramate 50, 100, and 200 mg/day groups, respectively, versus -1.1 in the placebo group (see Figure 2). The differences between the immediate-release topiramate 100 and 200 mg per day groups versus placebo were similar and statistically significant (p equals 0.008 and p less than 0.001, respectively).

In both studies there were no apparent differences in treatment effect within age or gender subgroups. Because most patients were Caucasian, there were insufficient numbers of patients from different races to make a meaningful comparison of race.

For patients withdrawing from immediate-release topiramate, daily dosages were decreased in weekly intervals by 25 to 50 mg/day.

Figure 2: Reduction in 4-Week Migraine Headache Frequency (Studies 11 and 12 for Adults and Adolescents)



Pediatric Patients 12 to 17 Years of Age

The effectiveness of immediate-release topiramate as prophylaxis for migraine headache in pediatric patients 12 to 17 years of age was established in a multicenter, randomized, double-blind, parallel-group trial (Study 13). The study enrolled 103 patients (40 male, 63 female) 12 to 17 years of age with episodic migraine headaches with or without aura. Patient selection was based on IHS criteria for migraines (using proposed revisions to the 1988 IHS pediatric migraine criteria [IHS-R criteria]).

Patients who experienced 3 to 12 migraine attacks (according to migraines classified by patient reported diaries) and ≤14 headache days (migraine and non-migraine) during the 4-week prospective baseline period were randomized to either immediate-release topiramate 50 mg/day, 100 mg/day, or placebo and treated for a total of 16 weeks (4-week titration period followed by a 12 week maintenance period). Treatment was initiated at 25 mg/day for one week, and then the daily dosage was increased by 25 mg increments each week until reaching the assigned target dose or maximum tolerated dose (administered twice daily). Approximately 80% or more patients in each treatment group completed the study. The median average daily dosages were 45 and 79 mg/day in the target dose groups of immediate-release topiramate 50 and 100 mg/day, respectively.

Effectiveness of treatment was assessed by comparing each immediate-release topiramate treatment group to placebo (ITT population) for the percent reduction from baseline to the last 12 weeks of the double-blind phase in the monthly migraine attack rate (primary endpoint). The percent reduction from baseline to the last 12 weeks of the double-blind phase in average monthly migraine attack rate is shown in Table 11. The 100 mg immediate-release topiramate dose produced a statistically significant treatment difference relative to placebo of 28% reduction from baseline in the monthly migraine attack rate.

The mean reduction from baseline to the last 12 weeks of the double-blind phase in average monthly attack rate, a key secondary efficacy endpoint in Study 13 (and the primary efficacy endpoint in Studies 11 and 12, of adults) was 3.0 for 100 mg immediate- release topiramate dose and 1.7 for placebo. This 1.3 treatment difference in mean reduction from baseline of montly migraine rate was statistically significant (p=0.0087).

Table 11: Percent Reduction from Baseline to the Last 12 Weeks of Double-Blind Phase in Average Monthly Attack Rate: Study 13 (Intent-to-Treat Analysis Set)

Category	Placebo (N=33)	Immediate-Release Topiramate 50 g/day (N=35)	Immediate-Release Topiramate 100 mg/day (N=35)
Baseline			
Median	3.6	4.0	4.0
Last 12 Weeks of Double-Blind Phase			
Median	2.3	2.3	1.0
Percent Reduction (%)			
Median	44.4	44.6	72.2
P-value versus Placebo [a,b]		0.7975	0.0164[c]

[a]P-values (two-sided) for comparisons relative to placebo are generated by applying an ANCOVA model on ranks that includes subject's stratified age at baseline, treatment group, and analysis center as factors and monthly migraine attack rate during baseline period as a covariate.
[b]P-values for the dose groups are the adjusted p-value according to the Hochberg multiple comparison procedure.
[c]Indicates p-value is <0.05 (two-sided).

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 AVAILABILITY

Topiramate (Trokendi XR) extended-release capsules are available in the following strengths and colors:
25 mg (light green opaque body/yellow opaque cap) topiramate extended-release capsules (with black print "SPN" and "25") – blister pack of 7's; box of 28's
50 mg (light green opaque body/orange opaque cap) topiramate extended-release capsules (with black print "SPN" and "50") – blister pack of 7's; box of 28's
100 mg (green opaque body/blue opaque cap) topiramate extended-release capsules (with black print "SPN" and "100") – blister pack of 7's; box of 28's

16.2 Storage and Handling

Store at temperatures not exceeding 30°C. Protect from moisture and light.

17 PATIENT COUNSELING INFORMATION

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

Administration Instructions

Counsel patients to swallow TROKENDI XR® capsules whole and intact. TROKENDI XR® should not be sprinkled on food, chewed or crushed *[see Dosage and Administration (2.7)]*.

Consumption of Alcohol

Advise patients to completely avoid consumption of alcohol at least 6 hours prior to and 6 hours after taking TROKENDI XR® *[see Warnings and Precautions (5.5)]*.

Eye Disorders

Advise patients taking TROKENDI XR® to seek immediate medical attention if they experience blurred vision, visual disturbances or periorbital pain *[see Warnings and Precautions (5.1, 5.2)]*.

Oligohydrosis and Hyperthermia

Counsel patients that TROKENDI XR®, especially pediatric patients, can cause decreased sweating and increased body temperature, especially in hot weather, and they should seek medical attention if this is noticed *[see Warnings and Precautions (5.3)]*.

Metabolic Acidosis

Inform patients about the potentially significant risk for metabolic acidosis that may be asymptomatic and may be associated with adverse effects on kidneys (e.g., kidney stones, nephrocalcinosis), bones (e.g., osteoporosis, osteomalacia, and/or rickets in children), and growth (e.g., growth delay/retardation) in pediatric patients, and on the fetus *[see Warnings and Precautions (5.4)]*.

Suicidal Behavior and Ideation

Counsel patients, their caregivers, and families that AEDs, including TROKENDI XR®, may increase the risk of suicidal thoughts and behavior and they should be advised of the need to be alert for the emergence or worsening of the signs and symptoms of depression, any unusual changes in mood or behavior or the emergence of suicidal thoughts, behavior or thoughts about self- harm. Behaviors of concern should be reported immediately to healthcare providers *[see Warnings and Precautions (5.6)]*.

Interference With Cognitive and Motor Performance

Warn patients about the potential for somnolence, dizziness, confusion, difficulty concentrating, or visual effects and advise them not to drive or operate machinery until they have gained sufficient experience on TROKENDI XR® to gauge whether it adversely affects their mental performance, motor performance, and/or vision *[see Warnings and Precautions (5.7)]*.

Advise patients that even when taking TROKENDI XR® or other anticonvulsants, some patients with epilepsy will continue to have unpredictable seizures. Therefore, counsel all patients taking TROKENDI XR® for epilepsy to exercise appropriate caution whe engaging in any activities where loss of consciousness could result in serious danger to themselves or those around them (including swimming, driving a car, climbing in high places, etc.). Some patients with refractory epilepsy will need to avoid such activities altogether.

Physicians should discuss the appropriate level of caution with their patients, before patients with epilepsy engage in such activities.

Fetal Toxicity

Counsel pregnant women and women of childbearing potential that use of TROKENDI XR during pregnancy can cause fetal harm, including an increased risk for cleft lip and/or cleft palate (oral clefts), which occur early in pregnancy before many women know they are pregnant. Also inform patients that infants exposed to topiramate monotherapy *in utero* may be small for their gestational age *[see Use in Specific Populations (8.1)]*. There may also be risks to the fetus from chronic metabolic acidosis with use o TROKENDI XR during pregnancy *[see Warnings and Precautions (5.4, 5.8)]*. When appropriate, prescribers should counsel pregnant women and women of childbearing potential about alternative therapeutic options.
Advise women of childbearing potential who are not planning a pregnancy to use effective contraception while using topiramate, keeping in mind that there is a potential for decreased contraceptive efficacy when using estrogen-containing birth control with topiramate *[see Warnings and Precautions (5.8) and Drug Interactions (7.5)]*.

Encourage pregnant women using TROKENDI XR to enroll in the North American Antiepileptic Drug (NAAED) Pregnancy Registry. The registry is collecting information about the safety of antiepileptic drugs during pregnancy *[see Use in Specific Populations (8.1)]*.

Hyperammonemia and Encephalopathy

Warn patients about the possible development of hyperammonemia with or without encephalopathy. Although hyperammonemia may be asymptomatic, clinical symptoms of hyperammonemic encephalopathy often include acute alterations in level consciousness and/or cognitive function with lethargy or vomiting. This hyperammonemia and encephalopathy can develop with topiramate treatment alone or with topiramate treatment with concomitant valproic acid (VPA). Patients should be instructed to contact their physician if they develop unexplained lethargy, vomiting, or changes in mental status *[see Warnings and Precautions (5.10)]*.

Kidney Stones

Instruct patients, particularly those with predisposing factors, to maintain an adequate fluid intake in order to minimize the risk of kidney stone formation *[see Warnings and Precautions (5.11)]*.

Hypothermia

Counsel patients that TROKENDI XR® can cause a reduction in body temperature, which can lead to alterations in mental status. If they note such changes, they should call their health care professional and measure their body temperature. Patients taking concomitant valproic acid should be specifically counseled on this potential adverse reaction *[see Warnings and Precautions (5.12)]*.

CAUTION

Foods, Drugs, Devices and Cosmetics Act prohibits dispensing without prescription.

ADR Statement

For suspected adverse reaction, report to the FDA: www.fda.gov.ph. Patient should seek medical attention immediately at the first sign of any adverse drug reaction.

Registration No.:

Topiramate 25 mg Extended-Release Capsule (Trokendi XR): DR-XY47058
Topiramate 50 mg Extended-Release Capsule (Trokendi XR): DR-XY47057
Topiramate 100 mg Extended-Release Capsule (Trokendi XR): DR-XY47056

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