

“To be sold by retail on the prescription of Psychiatrist only”

ARIP MT 2

INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS and SUICIDAL THOUGHTS AND BEHAVIORS WITH ANTIDEPRESSANT DRUGS Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. ARIP MT 2 is not approved for the treatment of patients with dementia-related psychosis. Antidepressants increased the risk of suicidal thoughts and behavior in children, adolescents, and young adults in short-term studies. These studies did not show an increase in the risk of suicidal thoughts and behavior with antidepressant use in patients over age 24; there was a reduction in risk with antidepressant use in patients aged 65 and older [see WARNINGS AND PRECAUTIONS]. In patients of all ages who are started on antidepressant therapy, monitor closely for worsening, and for emergence of suicidal thoughts and behaviours. Advise families and caregivers of the need for close observation and communication with the prescriber.

1. Generic Name

Aripiprazole Tablets I.P.

2. Qualitative and quantitative Composition:

Each uncoated tablet contains:

Aripiprazole I.P.....2 mg

Excipients.....q.s.

The other ingredients are Mannitol-25, Crospovidone, Colloidal silicon Dioxide, Hydroxypropylcellulose, Purified Water, Microcrystalline Cellulose, Colloidal Silicon Dioxide, Magnesium Stearate

3. Dosage form and strength

Dosage form: Uncoated Tablet

Strength: Aripiprazole 2 mg

4. Clinical particulars

4.1 Therapeutic indication

For the treatment of Schizophrenia in adolescent patients (13 to 17 years of age).

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4.2 Posology and method of administration

Posology

Adults

Schizophrenia: the recommended starting dose for Aripiprazole is 10 or 15 mg/day with a maintenance dose of 15 mg/day administered on a once-a-day schedule without regard to meals.

Aripiprazole is effective in a dose range of 10 to 30 mg/day. Enhanced efficacy at doses higher than a daily dose of 15 mg has not been demonstrated although individual patients may benefit from a higher dose. The maximum daily dose should not exceed 30 mg.

Manic episodes in Bipolar I Disorder: the recommended starting dose for aripiprazole is 15 mg administered on a once-a-day schedule without regard to meals. Some patients may benefit from a higher dose. The maximum daily dose should not exceed 30 mg.

Recurrence prevention of manic episodes in Bipolar I Disorder: for preventing recurrence of manic episodes in patients who have been receiving, continue therapy at the same dose. Adjustments of daily dosage, including dose reduction should be considered on the basis of clinical status.

Special populations

Paediatric population

Other pharmaceutical formulations containing aripiprazole are available and may be more suitable to perform any initial titration in paediatric population.

Schizophrenia in adolescents aged 15 years and older: the recommended dose for aripiprazole is 10 mg/day administered on a once-a-day schedule without regard to meals. Treatment should be initiated at 2 mg (using aripiprazole oral solution 1 mg/ml) for 2 days, titrated to 5 mg for 2 additional days to reach the recommended daily dose of 10 mg. When appropriate, subsequent dose increases should be administered in 5 mg increments without exceeding the maximum daily dose of 30 mg.

Aripiprazole is effective in a dose range of 10 to 30 mg/day. Enhanced efficacy at doses higher than a daily dose of 10 mg has not been demonstrated although individual patients may benefit from a higher dose.

Aripiprazole is not recommended for use in patients with schizophrenia below 15 years of age due to insufficient data on safety and efficacy.

Manic episodes in Bipolar I Disorder in adolescents aged 13 years and older: the recommended dose for aripiprazole is 10 mg/day administered on a once-a-day schedule without regard to meals. Treatment should be initiated at 2 mg (using aripiprazole oral solution 1 mg/ml) for 2 days, titrated to 5 mg for 2 additional days to reach the recommended daily dose of 10 mg.

The treatment duration should be the minimum necessary for symptom control and must not exceed 12 weeks. Enhanced efficacy at doses higher than a daily dose of 10 mg has not been demonstrated, and a daily dose of 30 mg is associated with a substantially higher incidence of significant undesirable effects including EPS related events, somnolence, fatigue and weight gain. Doses higher than 10 mg/day should therefore only be used in exceptional cases and with close clinical monitoring.

Younger patients are at increased risk of experiencing adverse events associated with aripiprazole. Therefore, aripiprazole is not recommended for use in patients below 13 years of age.

Irritability associated with autistic disorder: the safety and efficacy of aripiprazole in children and adolescents aged below 18 years have not yet been established. Currently available data are described in but no recommendation on a posology can be made.

Tics associated with Tourette's disorder: the safety and efficacy of aripiprazole in children and adolescents 6 to 18 years of age have not yet been established. Currently available data are described in but no recommendation on a posology can be made.

Hepatic impairment:

No dosage adjustment is required for patients with mild to moderate hepatic impairment. In patients with severe hepatic impairment, the data available are insufficient to establish recommendations. In these patients dosing should be managed cautiously. However, the maximum daily dose of 30 mg should be used with caution in patients with severe hepatic impairment.

Renal impairment:

No dosage adjustment is required in patients with renal impairment.

Elderly:

The effectiveness of aripiprazole in the treatment of schizophrenia and Bipolar I Disorder in patients aged 65 years and older has not been established. Owing to the greater sensitivity of this population, a lower starting dose should be considered when clinical factors warrant.

Gender:

No dosage adjustment is required for female patients as compared to male patients.

Smoking status:

According to the metabolic pathway of Aripiprazole no dosage adjustment is required for smokers.

Dose adjustments due to interactions:

When concomitant administration of potent CYP3A4 or CYP2D6 inhibitors with aripiprazole occurs, the aripiprazole dose should be reduced. When the CYP3A4 or CYP2D6 inhibitor is withdrawn from the combination therapy, aripiprazole dose should then be increased.

When concomitant administration of potent CYP3A4 inducers with aripiprazole occurs, the aripiprazole dose should be increased. When the CYP3A4 inducer is withdrawn from the combination therapy, the aripiprazole dose should then be reduced to the recommended dose.

Method of administration

Aripiprazole tablets are for oral use.

Orodispersible tablets or oral solution may be used as an alternative to Aripiprazole tablets for patients who have difficulty swallowing Aripiprazole tablets.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients.

4.4 Special warnings and precautions for use

During antipsychotic treatment, improvement in the patient's clinical condition may take several days to some weeks. Patients should be closely monitored throughout this period.

Suicidality

The occurrence of suicidal behaviour is inherent in psychotic illnesses and mood disorders and in some cases has been reported early after initiation or switch of antipsychotic treatment, including treatment with aripiprazole. Close supervision of high-risk patients should accompany antipsychotic treatment.

Cardiovascular disorders

Aripiprazole should be used with caution in patients with known cardiovascular disease (history of myocardial infarction or ischaemic heart disease, heart failure, or conduction abnormalities), cerebrovascular disease, conditions which would predispose patients to hypotension (dehydration, hypovolemia, and treatment with antihypertensive medicinal products) or hypertension, including accelerated or malignant. Cases of venous thromboembolism (VTE) have been reported with antipsychotic medicinal products. Since patients treated with antipsychotics often present with acquired risk factors for VTE, all possible risk factors for VTE should be identified before and during treatment with aripiprazole and preventive measures undertaken.

QT prolongation

In reported clinical trials of aripiprazole, the incidence of QT prolongation was comparable to placebo. Aripiprazole should be used with caution in patients with a family history of QT prolongation.

Tardive dyskinesia

In reported clinical trials of one year or less duration, there were uncommon reports of treatment emergent dyskinesia during treatment with aripiprazole. If signs and symptoms of tardive dyskinesia appear in a patient on aripiprazole, dose reduction or discontinuation should be considered. These symptoms can temporally deteriorate or can even arise after discontinuation of treatment.

Other extrapyramidal symptoms

In reported paediatric clinical trials of aripiprazole akathisia and Parkinsonism were observed. If signs and symptoms of other EPS appear in a patient taking aripiprazole, dose reduction and close clinical monitoring should be considered.

Neuroleptic Malignant Syndrome (NMS)

NMS is a potentially fatal symptom complex associated with antipsychotics. In reported clinical trials, rare cases of NMS were reported during treatment with aripiprazole. Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. However, elevated creatine phosphokinase and rhabdomyolysis, not necessarily in association with

NMS, have also been reported. If a patient develops signs and symptoms indicative of NMS, or presents with unexplained high fever without additional clinical manifestations of NMS, all antipsychotics, including aripiprazole, must be discontinued.

Seizure

In reported clinical trials, uncommon cases of seizure were reported during treatment with aripiprazole. Therefore, aripiprazole should be used with caution in patients who have a history of seizure disorder or have conditions associated with seizures.

Elderly patients with dementia-related psychosis

Increased mortality

In three placebo-controlled trials (n = 938; mean age: 82.4 years; range: 56-99 years) of aripiprazole in elderly patients with psychosis associated with Alzheimer's disease, patients treated with aripiprazole were at increased risk of death compared to placebo. The rate of death in aripiprazole-treated patients was 3.5 % compared to 1.7 % in the placebo group. Although the causes of deaths were varied, most of the deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature.

Cerebrovascular adverse reactions

In the same trials, cerebrovascular adverse reactions (e.g. stroke, transient ischaemic attack), including fatalities, were reported in patients (mean age: 84 years; range: 78-88 years). Overall, 1.3 % of aripiprazole-treated patients reported cerebrovascular adverse reactions compared with 0.6 % of placebo-treated patients in these trials. This difference was not statistically significant. However, in one of these trials, a fixed-dose trial, there was a significant dose response relationship for cerebrovascular adverse reactions in patients treated with aripiprazole.

Aripiprazole is not indicated for the treatment of patients with dementia-related psychosis.

Hyperglycaemia and diabetes mellitus

Hyperglycaemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics, including aripiprazole. Risk factors that may predispose patients to severe complications include obesity and family history of diabetes. In reported clinical trials with aripiprazole, there were no significant differences in the incidence rates of hyperglycaemia-related adverse reactions (including diabetes) or in abnormal glycaemia laboratory values compared to placebo. Precise risk estimates for hyperglycaemia-related adverse reactions in patients treated with aripiprazole and with other atypical antipsychotics are not available to allow direct comparisons. Patients treated with any antipsychotics, including aripiprazole, should be observed for signs and symptoms of hyperglycaemia (such as polydipsia, polyuria, polyphagia and weakness) and patients with diabetes mellitus or with risk factors for diabetes mellitus should be monitored regularly for worsening of glucose control.

Hypersensitivity

Hypersensitivity reactions, characterised by allergic symptoms, may occur with aripiprazole.

Weight gain

Weight gain is commonly seen in schizophrenic and bipolar mania patients due to comorbidities, use of antipsychotics known to cause weight gain, poorly managed life-style, and might lead to severe complications. Weight gain has been reported post-marketing among patients prescribed aripiprazole. When seen, it is usually in those with significant risk factors such as history of diabetes, thyroid disorder or pituitary adenoma. In reported clinical trials aripiprazole has not been shown to induce clinically relevant weight gain in adults. In reported clinical trials of

adolescent patients with bipolar mania, aripiprazole has been shown to be associated with weight gain after 4 weeks of treatment. Weight gain should be monitored in adolescent patients with bipolar mania. If weight gain is clinically significant, dose reduction should be considered.

Dysphagia

Oesophageal dysmotility and aspiration have been associated with the use of antipsychotics, including aripiprazole. Aripiprazole should be used cautiously in patients at risk for aspiration pneumonia.

Pathological gambling and other impulse control disorders

Patients can experience increased urges, particularly for gambling, and the inability to control these urges while taking aripiprazole. Other urges, reported, include: increased sexual urges, compulsive shopping, binge or compulsive eating, and other impulsive and compulsive behaviours. It is important for prescribers to ask patients or their caregivers specifically about the development of new or increased gambling urges, sexual urges, compulsive shopping, binge or compulsive eating, or other urges while being treated with aripiprazole. It should be noted that impulse-control symptoms can be associated with the underlying disorder; however, in some cases, urges were reported to have stopped when the dose was reduced or the medication was discontinued. Impulse control disorders may result in harm to the patient and others if not recognised. Consider dose reduction or stopping the medication if a patient develops such urges while taking aripiprazole.

Patients with ADHD comorbidity

Despite the high comorbidity frequency of Bipolar I Disorder and ADHD, very limited safety data are available on concomitant use of aripiprazole and stimulants; therefore, extreme caution should be taken when these medicinal products are co-administered.

Falls

Aripiprazole may cause somnolence, postural hypotension, motor and sensory instability, which may lead to falls. Caution should be taken when treating patients at higher risk, and a lower starting dose should be considered (e.g., elderly or debilitated patients).

4.5 Drugs interactions

Due to its α_1 -adrenergic receptor antagonism, aripiprazole has the potential to enhance the effect of certain antihypertensive medicinal products.

Given the primary CNS effects of aripiprazole, caution should be used when aripiprazole is administered in combination with alcohol or other CNS medicinal products with overlapping adverse reactions such as sedation.

If aripiprazole is administered concomitantly with medicinal products known to cause QT prolongation or electrolyte imbalance, caution should be used.

Potential for other medicinal products to affect aripiprazole

A gastric acid blocker, the H₂ antagonist famotidine, reduces aripiprazole rate of absorption but this effect is deemed not clinically relevant. Aripiprazole is metabolised by multiple pathways involving the CYP2D6 and CYP3A4 enzymes but not CYP1A enzymes. Thus, no dosage adjustment is required for smokers.

Quinidine and other CYP2D6 inhibitors

In a clinical trial in healthy subjects, a strong inhibitor of CYP2D6 (quinidine) increased aripiprazole AUC by 107 %, while C_{max} was unchanged. The AUC and C_{max} of dehydro-aripiprazole, the active metabolite, decreased by 32 % and 47 %, respectively. Aripiprazole dose should be reduced to approximately one-half of its prescribed dose when concomitant administration of aripiprazole with quinidine occurs. Other strong inhibitors of CYP2D6, such as fluoxetine and paroxetine, may be expected to have similar effects and similar dose reductions should therefore be applied.

Ketoconazole and other CYP3A4 inhibitors

In a clinical trial in healthy subjects, a strong inhibitor of CYP3A4 (ketoconazole) increased aripiprazole AUC and C_{max} by 63 % and 37 %, respectively. The AUC and C_{max} of dehydro-aripiprazole increased by 77 % and 43 %, respectively. In CYP2D6 poor metabolisers, concomitant use of strong inhibitors of CYP3A4 may result in higher plasma concentrations of aripiprazole compared to that in CYP2D6 extensive metabolizers. When considering concomitant administration of ketoconazole or other strong CYP3A4 inhibitors with aripiprazole, potential benefits should outweigh the potential risks to the patient. When concomitant administration of ketoconazole with aripiprazole occurs, aripiprazole dose should be reduced to approximately one-half of its prescribed dose. Other strong inhibitors of CYP3A4, such as itraconazole and HIV protease inhibitors may be expected to have similar effects and similar dose reductions should therefore be applied. Upon discontinuation of the CYP2D6 or CYP3A4 inhibitor, the dosage of aripiprazole should be increased to the level prior to the initiation of the concomitant therapy. When weak inhibitors of CYP3A4 (e.g. diltiazem) or CYP2D6 (e.g. escitalopram) are used concomitantly with aripiprazole, modest increases in plasma aripiprazole concentrations may be expected.

Carbamazepine and other CYP3A4 inducers

Following concomitant administration of carbamazepine, a strong inducer of CYP3A4, and oral aripiprazole to patients with schizophrenia or schizoaffective disorder, the geometric means of C_{max} and AUC for aripiprazole were 68 % and 73 % lower, respectively, compared to when aripiprazole (30 mg) was administered alone. Similarly, for dehydro-aripiprazole the geometric means of C_{max} and AUC after carbamazepine co-administration were 69 % and 71 % lower, respectively, than those following treatment with aripiprazole alone. Aripiprazole dose should be doubled when concomitant administration of aripiprazole occurs with carbamazepine. Concomitant administration of aripiprazole and other inducers of CYP3A4 (such as rifampicin, rifabutin, phenytoin, phenobarbital, primidone, efavirenz, nevirapine and St. John's Wort) may be expected to have similar effects and similar dose increases should therefore be applied. Upon discontinuation of

strong CYP3A4 inducers, the dosage of aripiprazole should be reduced to the recommended dose.

Valproate and lithium

When either valproate or lithium was administered concomitantly with aripiprazole, there was no clinically significant change in aripiprazole concentrations and therefore no dose adjustment is necessary when either valproate or lithium is administered with aripiprazole.

Potential for aripiprazole to affect other medicinal products

In clinical studies, 10-30 mg/day doses of aripiprazole had no significant effect on the metabolism of substrates of CYP2D6 (dextromethorphan/3-methoxymorphinan ratio),

CYP2C9 (warfarin), CYP2C19 (omeprazole), and CYP3A4 (dextromethorphan). Additionally, aripiprazole and dehydro-aripiprazole did not show potential for altering CYP1A2-mediated metabolism in vitro. Thus, aripiprazole is unlikely to cause clinically important medicinal product interactions mediated by these enzymes.

When aripiprazole was administered concomitantly with either valproate, lithium or lamotrigine, there was no clinically important change in valproate, lithium or lamotrigine concentrations.

Serotonin syndrome

Cases of serotonin syndrome have been reported in patients taking aripiprazole, and possible signs and symptoms for this condition can occur especially in cases of concomitant use with other serotonergic medicinal products, such as SSRI/SNRI, or with medicinal products that are known to increase aripiprazole concentrations.

4.6 Use in special populations (such as pregnant women, lactating women, paediatric patients, geriatric patients etc.)

Pregnancy

There are no adequate and well-controlled trials of aripiprazole in pregnant women. Congenital anomalies have been reported; however, causal relationship with aripiprazole could not be established. Animal studies could not exclude potential developmental toxicity. Patients must be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with aripiprazole. Due to insufficient safety information in humans and concerns raised by animal reproductive studies, this medicinal product should not be used in pregnancy unless the expected benefit clearly justifies the potential risk to the foetus.

Newborn infants exposed to antipsychotics (including aripiprazole) during the third trimester of pregnancy are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, or feeding disorder. Consequently, newborn infants should be monitored carefully.

Breast-feeding

Aripiprazole is excreted in human milk. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from aripiprazole therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman.

Fertility

Aripiprazole did not impair fertility based on data from reproductive toxicity studies.

4.7 Effects on ability to drive and use machines

Aripiprazole has minor to moderate influence on the ability to drive and use machines due to potential nervous system and visual effects, such as sedation, somnolence, syncope, vision blurred, diplopia.

4.8 Undesirable effects

Summary of the safety profile

The most commonly reported adverse reactions in placebo-controlled trials were akathisia and nausea each occurring in more than 3 % of patients treated with oral aripiprazole.

Tabulated list of adverse reactions

The incidences of the Adverse Drug Reactions (ADRs) associated with aripiprazole therapy are tabulated below. The table is based on adverse events reported during reported clinical trials and/or post-marketing use.

All ADRs are listed by system organ class and frequency; very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$) and not known (cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

The frequency of adverse reactions reported during post-marketing use cannot be determined as they are derived from spontaneous reports. Consequently, the frequency of these adverse events is qualified as "not known".

	Common	Uncommon	Not known
Blood and lymphatic system disorders			Leukopenia Neutropenia Thrombocytopenia
Immune system disorders			Allergic reaction (e.g. anaphylactic reaction, angioedema including swollen tongue, tongue oedema, face

			oedema, pruritus, or urticaria)
Endocrine disorders		Hyperprolactinaemia	Diabetic hyperosmolar coma Diabetic ketoacidosis
Metabolism and nutrition disorders	Diabetes mellitus	Hyperglycaemia	Hyponatremia Anorexia Weight decreased Weight gain
Psychiatric disorders	Insomnia Anxiety Restlessness	Depression, Hypersexuality	Suicide attempt, suicidal ideation and completed suicide Pathological gambling Impulse-control disorders Binge eating Compulsive shopping Poriomania Aggression Agitation Nervousness
Nervous system disorders	Akathisia Extrapyramidal disorder Tremor Headache Sedation Somnolence Dizziness	Tardive dyskinesia Dystonia	Neuroleptic Malignant Syndrome (NMS) Grand mal convulsion Serotonin syndrome Speech disorder
Eye disorders	Vision blurred	Diplopia Photophobia	Oculogyric crisis
Cardiac disorders		Tachycardia	Sudden unexplained death Torsades de pointes QT prolongation Ventricular arrhythmias Cardiac arrest

			Bradycardia
Respiratory, thoracic and mediastinal disorders		Hiccups	Aspiration pneumonia Laryngospasm Oropharyngeal spasm
Gastrointestinal disorders	Constipation Dyspepsia Nausea Salivary hypersecretion Vomiting		Pancreatitis Dysphagia Diarrhoea Abdominal discomfort Stomach discomfort
Hepatobiliary disorders			Hepatic failure Hepatitis Jaundice Increased Alanine Aminotransferase (ALT) Increased Aspartate Aminotransferase (AST) Increased Gamma Glutamyl Transferase (GGT) Increased alkaline phosphatase
Skin and subcutaneous tissue disorders			Rash Photosensitivity reaction Alopecia Hyperhidrosis
Musculoskeletal and connective tissue disorders			Rhabdomyolysis Myalgia Stiffness
Renal and urinary disorders			Urinary incontinence Urinary retention

Pregnancy, puerperium and perinatal conditions			Drug withdrawal syndrome neonatal
Reproductive system and breast disorders			Priapism
General disorders and administration site conditions	Fatigue		Temperature regulation disorder (e.g. hypothermia, pyrexia) Chest pain Peripheral oedema
Investigations			Blood glucose increased Glycosylated haemoglobin increased Blood glucose fluctuation Increased creatine phosphokinase

Description of adverse reactions:

Adults

Extrapyramidal symptoms (EPS)

Schizophrenia: in a long term 52-week controlled trial, aripiprazole-treated patients had an overall-lower incidence (25.8 %) of EPS including Parkinsonism, akathisia, dystonia and dyskinesia compared with those treated with haloperidol (57.3 %). In a long term 26-week placebo-controlled trial, the incidence of EPS was 19 % for aripiprazoletreated patients and 13.1 % for placebo-treated patients. In another long-term 26-week controlled trial, the incidence of EPS was 14.8 % for aripiprazole-treated patients and 15.1 % for olanzapine-treated patients.

Manic episodes in Bipolar I Disorder: in a 12-week controlled trial, the incidence of EPS was 23.5 % for aripiprazole-treated patients and 53.3 % for haloperidol-treated patients. In another 12-week trial, the incidence of EPS was 26.6 % for patients treated with aripiprazole and 17.6 % for those treated with lithium. In the long term 26-week maintenance phase of a placebo-controlled trial, the incidence of EPS was 18.2 % for aripiprazole-treated patients and 15.7 % for placebo-treated patients.

Akathisia

In placebo-controlled trials, the incidence of akathisia in bipolar patients was 12.1 % with aripiprazole and 3.2 % with placebo. In schizophrenia patients the incidence of akathisia was 6.2 % with aripiprazole and 3.0 % with placebo.

Dystonia

Class effect: Symptoms of dystonia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during the first few days of treatment. Dystonic symptoms include: spasm of the neck muscles, sometimes progressing to tightness of the throat, swallowing difficulty, difficulty breathing, and/or protrusion of the tongue. While these symptoms can occur at low doses, they occur more frequently and with greater severity with high potency and at higher doses of first generation antipsychotic medicinal products. An elevated risk of acute dystonia is observed in males and younger age groups.

Prolactin

In reported clinical trials for the approved indications and post-marketing, both increase and decrease in serum prolactin as compared to baseline was observed with aripiprazole.

Laboratory parameters

Comparisons between aripiprazole and placebo in the proportions of patients experiencing potentially clinically significant changes in routine laboratory and lipid parameters revealed no medically important differences. Elevations of CPK (Creatine Phosphokinase), generally transient and asymptomatic, were observed in 3.5 % of aripiprazole treated patients as compared to 2.0 % of patients who received placebo.

Paediatric population

Schizophrenia in adolescents aged 15 years and older

In a short-term placebo-controlled clinical trial involving 302 adolescents (13-17 years) with schizophrenia, the frequency and type of adverse reactions were similar to those in adults except for the following reactions that were reported more frequently in adolescents receiving aripiprazole than in adults receiving aripiprazole (and more frequently than placebo):

Somnolence/sedation and extrapyramidal disorder were reported very commonly ($\geq 1/10$), and dry mouth, increased appetite, and orthostatic hypotension were reported commonly ($\geq 1/100$, $< 1/10$). The safety profile in a 26-week open-label extension trial was similar to that observed in the short-term, placebo-controlled trial.

The safety profile of a long-term, double-blind placebo controlled trial was also similar except for the following reactions that were reported more frequently than paediatric patients taking placebo: weight decreased, blood insulin increased, arrhythmia, and leukopenia were reported commonly ($\geq 1/100$, $< 1/10$).

In the pooled adolescent schizophrenia population (13-17 years) with exposure up to 2 years, incidence of low serum prolactin levels in females (< 3 ng/ml) and males (< 2 ng/ml) was 29.5 % and 48.3 %, respectively. In the adolescent (13-17 years) schizophrenia population with aripiprazole exposure of 5 to 30 mg up to 72 months, incidence of low serum prolactin levels in females (< 3 ng/ml) and males (< 2 ng/ml) was 25.6 % and 45.0 %, respectively.

In two long term trials with adolescent (13-17 years) schizophrenia and bipolar patients treated with aripiprazole, incidence of low serum prolactin levels in females (< 3 ng/ml) and males (< 2 ng/ml) was 37.0 % and 59.4 %, respectively.

Manic episodes in Bipolar I Disorder in adolescents aged 13 years and older

The frequency and type of adverse reactions in adolescents with Bipolar I Disorder were similar to those in adults except for the following reactions: very commonly ($\geq 1/10$) somnolence (23.0 %), extrapyramidal disorder (18.4 %), akathisia (16.0 %), and fatigue (11.8 %); and commonly ($\geq 1/100$, $< 1/10$) abdominal pain upper, heart rate increased, weight increased, increased appetite, muscle twitching, and dyskinesia.

The following adverse reactions had a possible dose response relationship; extrapyramidal disorder (incidences were 10 mg, 9.1 %, 30 mg, 28.8 %, placebo, 1.7 %); and akathisia (incidences were 10 mg, 12.1 %, 30 mg, 20.3 %, placebo, 1.7 %).

Mean changes in body weight in adolescents with Bipolar I Disorder at 12 and 30 weeks for aripiprazole were 2.4 kg and 5.8 kg, and for placebo 0.2 kg and 2.3 kg, respectively.

In the paediatric population somnolence and fatigue were observed more frequently in patients with bipolar disorder compared to patients with schizophrenia.

In the paediatric bipolar population (10-17 years) with exposure up to 30 weeks, incidence of low serum prolactin levels in females (< 3 ng/ml) and males (< 2 ng/ml) was 28.0 % and 53.3 %, respectively.

Pathological gambling and other impulse control disorders

Pathological gambling, hypersexuality, compulsive shopping and binge or compulsive eating can occur in patients treated with aripiprazole.

Reporting of suspected adverse reactions

If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via any point of contact of Torrent Pharma available at: https://torrentpharma.com/index.php/site/info/adverse_event_reporting

By reporting side effects, you can help provide more information on the safety of this medicine.

4.9 Overdose

Signs and symptoms

In reported clinical trials and post-marketing experience, accidental or intentional acute overdose of aripiprazole alone was identified in adult patients with reported estimated doses up to 1,260 mg with no fatalities. The potentially medically important signs and symptoms observed included lethargy, increased blood pressure, somnolence, tachycardia, nausea, vomiting and diarrhoea. In addition, reports of accidental overdose with aripiprazole alone (up to 195 mg) in children have been received with no fatalities. The potentially medically serious signs and symptoms reported included somnolence, transient loss of consciousness and extrapyramidal symptoms.

Management of overdose

Management of overdose should concentrate on supportive therapy, maintaining an adequate airway, oxygenation and ventilation, and management of symptoms. The

possibility of multiple medicinal product involvement should be considered. Therefore cardiovascular monitoring should be started immediately and should include continuous electrocardiographic monitoring to detect possible arrhythmias. Following any confirmed or suspected overdose with aripiprazole, close medical supervision and monitoring should continue until the patient recovers.

Activated charcoal (50 g), administered one hour after aripiprazole, decreased aripiprazole C_{max} by about 41 % and AUC by about 51 %, suggesting that charcoal may be effective in the treatment of overdose.

Haemodialysis

Although there is no information on the effect of haemodialysis in treating an overdose with aripiprazole, haemodialysis is unlikely to be useful in overdose management since aripiprazole is highly bound to plasma proteins.

5 Pharmacological properties

5.1 Mechanism of Action

Pharmacotherapeutic group: other antipsychotics, ATC code: N05AX12

It has been proposed that aripiprazole's efficacy in schizophrenia and Bipolar I Disorder is mediated through a combination of partial agonism at dopamine D₂ and serotonin 5-HT_{1A} receptors and antagonism of serotonin 5-HT_{2A} receptors. Aripiprazole exhibited antagonist properties in animal models of dopaminergic hyperactivity and agonist properties in animal models of dopaminergic hypoactivity. Aripiprazole exhibited high binding affinity in vitro for dopamine D₂ and D₃, serotonin 5-HT_{1A} and 5-HT_{2A} receptors and moderate affinity for dopamine D₄, serotonin 5-HT_{2C} and 5-HT₇, alpha-1 adrenergic and histamine H₁ receptors. Aripiprazole also exhibited moderate binding affinity for the serotonin reuptake site and no appreciable affinity for muscarinic receptors. Interaction with receptors other than dopamine and serotonin subtypes may explain some of the other clinical effects of aripiprazole.

5.2 Pharmacodynamic properties

Pharmacotherapeutic group: Psycholeptics, other antipsychotics, ATC code: N05AX12.

Aripiprazole doses ranging from 0.5 to 30 mg administered once a day to healthy subjects for 2 weeks produced a dose-dependent reduction in the binding of [¹¹C]raclopride, a D₂/D₃ receptor ligand, to the caudate and putamen detected by positron emission tomography.

Clinical efficacy and safety

Adults

Schizophrenia

In three short-term (4 to 6 weeks) placebo-controlled trials involving 1,228 schizophrenic adult patients, presenting with positive or negative symptoms, aripiprazole was associated with statistically significantly greater improvements in psychotic symptoms compared to placebo.

Aripiprazole is effective in maintaining the clinical improvement during continuation therapy in adult patients who have shown an initial treatment response. In a

haloperidol-controlled trial, the proportion of responder patients maintaining response to medicinal product at 52-weeks was similar in both groups (aripiprazole 77 % and haloperidol 73 %). The overall completion rate was significantly higher for patients on aripiprazole (43 %) than for haloperidol (30 %). Actual scores in rating scales used as secondary endpoints, including PANSS and the Montgomery-Asberg Depression Rating Scale showed a significant improvement over haloperidol.

In a 26-week, placebo-controlled trial in adult stabilised patients with chronic schizophrenia, aripiprazole had significantly greater reduction in relapse rate, 34 % in aripiprazole group and 57 % in placebo.

Weight gain

In reported clinical trials, aripiprazole has not been shown to induce clinically relevant weight gain. In a reported 26-week, olanzapine-controlled, double-blind, multi-national study of schizophrenia which included 314 adult patients and where the primary end-point was weight gain, significantly less patients had at least 7 % weight gain over baseline (i.e. a gain of at least 5.6 kg for a mean baseline weight of ~80.5 kg) on aripiprazole (n = 18, or 13 % of evaluable patients), compared to olanzapine (n = 45, or 33 % of evaluable patients).

Lipid parameters

In a pooled analysis on lipid parameters from reported placebo controlled clinical trials in adults, aripiprazole has not been shown to induce clinically relevant alterations in levels of total cholesterol, triglycerides, HDL and LDL.

Prolactin

Prolactin levels were evaluated in all trials of all doses of aripiprazole (n = 28,242). The incidence of hyperprolactinaemia or increased serum prolactin in patients treated with aripiprazole (0.3 %) was similar to that of placebo (0.2 %). For patients receiving aripiprazole, the median time to onset was 42 days and median duration was 34 days.

The incidence of hypoprolactinaemia or decreased serum prolactin in patients treated with aripiprazole was 0.4 %, compared with 0.02 % for patients treated with placebo. For patients receiving aripiprazole, the median time to onset was 30 days and median duration was 194 days.

Manic episodes in Bipolar I Disorder

In two 3-week, flexible-dose, placebo-controlled monotherapy trials involving patients with a manic or mixed episode of Bipolar I Disorder, aripiprazole demonstrated superior efficacy to placebo in reduction of manic symptoms over 3 weeks. These trials included patients with or without psychotic features and with or without a rapidcycling course.

In one 3-week, fixed-dose, placebo-controlled monotherapy trial involving patients with a manic or mixed episode of Bipolar I Disorder, aripiprazole failed to demonstrate superior efficacy to placebo.

In two 12-week, placebo- and active-controlled monotherapy trials in patients with a manic or mixed episode of Bipolar I Disorder, with or without psychotic features, aripiprazole demonstrated superior efficacy to placebo at week 3 and a maintenance of effect comparable to lithium or haloperidol at week 12. Aripiprazole also demonstrated a comparable proportion of patients in symptomatic remission from mania as lithium or haloperidol at week 12.

In a 6-week, placebo-controlled trial involving patients with a manic or mixed episode of Bipolar I Disorder, with or without psychotic features, who were partially nonresponsive to lithium or valproate monotherapy for 2 weeks at therapeutic serum levels, the addition of aripiprazole as adjunctive therapy resulted in superior efficacy in reduction of manic symptoms than lithium or valproate monotherapy.

In a 26-week, placebo-controlled trial, followed by a 74-week extension, in manic patients who achieved remission on aripiprazole during a stabilization phase prior to randomisation, aripiprazole demonstrated superiority over placebo in preventing bipolar recurrence, primarily in preventing recurrence into mania but failed to demonstrate superiority over placebo in preventing recurrence into depression.

In a 52-week, placebo-controlled trial, in patients with a current manic or mixed episode of Bipolar I Disorder who achieved sustained remission (Y-MRS and MADRS total scores ≤ 12) on aripiprazole (10 mg/day to 30 mg/day) adjunctive to lithium or valproate for 12 consecutive weeks, adjunctive aripiprazole demonstrated superiority over placebo with a 46 % decreased risk (hazard ratio of 0.54) in preventing bipolar recurrence and a 65 % decreased risk (hazard ratio of 0.35) in preventing recurrence into mania over adjunctive placebo but failed to demonstrate superiority over placebo in preventing recurrence into depression. Adjunctive aripiprazole demonstrated superiority over placebo on the secondary outcome measure, CGI-BP Severity of Illness score (mania). In this trial, patients were assigned by investigators with either open-label lithium or valproate monotherapy to determine partial non-response. Patients were stabilised for at least 12 consecutive weeks with the combination of aripiprazole and the same mood stabilizer. Stabilized patients were then randomised to continue the same mood stabilizer with double-blind aripiprazole or placebo. Four mood stabilizer subgroups were assessed in the randomised phase: aripiprazole + lithium; aripiprazole + valproate; placebo + lithium; placebo + valproate. The KaplanMeier rates for recurrence to any mood episode for the adjunctive treatment arm were 16 % in aripiprazole + lithium and 18 % in aripiprazole + valproate compared to 45 % in placebo + lithium and 19 % in placebo + valproate.

Paediatric population

Schizophrenia in adolescents

In a 6-week placebo-controlled trial involving 302 schizophrenic adolescent patients (13-17 years), presenting with positive or negative symptoms, aripiprazole was associated with statistically significantly greater improvements in psychotic symptoms compared to placebo. In a sub-analysis of the adolescent patients between the ages of 15 to 17 years, representing 74 % of the total enrolled population, maintenance of effect was observed over the 26-week open-label extension trial.

In a 60- to 89-week, randomised, double-blind, placebo-controlled trial in adolescent subjects (n = 146; ages 13-17 years) with schizophrenia, there was a statistically significant difference in the rate of relapse of psychotic symptoms between the aripiprazole (19.39 %) and placebo (37.50 %) groups. The point estimate of the hazard ratio (HR) was 0.461 (95% confidence interval, 0.242-0.879) in the full population. In subgroup analyses the point estimate of the HR was 0.495 for subjects 13 to 14 years of age compared to 0.454 for subjects 15 to 17 years of age. However, the estimation of the HR for the younger (13-14 years) group was not precise, reflecting the smaller number of subjects in that group (aripiprazole, n = 29; placebo, n = 12), and the confidence interval for this estimation (ranging from 0.151 to 1.628) did not allow conclusions to be drawn on the presence of a treatment effect. In contrast the 95 % confidence interval for the HR in the older subgroup (aripiprazole, n = 69; placebo, n = 36) was 0.242 to 0.879 and hence a treatment effect could be concluded in the older patients.

Manic episodes in Bipolar I Disorder in children and adolescents

Aripiprazole was studied in a 30-week placebo-controlled trial involving 296 children and adolescents (10-17 years), who met DSM-IV criteria for Bipolar I Disorder with manic or mixed episodes with or without psychotic features and had a Y-MRS score ≥ 20 at baseline. Among the patients included in the primary efficacy analysis, 139 patients had a current co-morbid diagnosis of ADHD.

Aripiprazole was superior to placebo in change from baseline at week 4 and at week 12 on the Y-MRS total score. In a post-hoc analysis, the improvement over placebo was more pronounced in the patients with associated co-morbidity of ADHD compared to the group without ADHD, where there was no difference from placebo. Recurrence prevention was not established.

The most common treatment-emergent adverse events among patients receiving 30 mg were extrapyramidal disorder (28.3 %), somnolence (27.3 %), headache (23.2 %), and nausea (14.1 %). Mean weight gain in the 30 weeks treatment-interval was 2.9 kg as compared to 0.98 kg in patients treated with placebo.

Irritability associated with autistic disorder in paediatric patients

Aripiprazole was studied in patients aged 6 to 17 years in two 8-week, placebocontrolled trials [one flexible-dose (2-15 mg/day) and one fixed-dose (5, 10, or 15 mg/day)] and in one 52-week open-label trial. Dosing in these trials was initiated at 2 mg/day, increased to 5 mg/day after one week, and increased by 5 mg/day in weekly increments to the target dose. Over 75 % of patients were less than 13 years of age. Aripiprazole demonstrated statistically superior efficacy compared to placebo on the Aberrant Behaviour Checklist Irritability subscale. However, the clinical relevance of this finding has not been established. The safety profile included weight gain and changes in prolactin levels. The duration of the reported long-term safety study was limited to 52 weeks. In the pooled trials, the incidence of low serum prolactin levels in females (< 3 ng/ml) and males (< 2 ng/ml) in aripiprazole-treated patients was 27/46 (58.7 %) and 258/298 (86.6 %), respectively. In the placebo-controlled trials, the mean weight gain was 0.4 kg for placebo and 1.6 kg for aripiprazole.

Aripiprazole was also studied in a placebo-controlled, long-term maintenance trial. After a 13-26 week stabilisation on aripiprazole (2-15 mg/day) patients with a stable response were either maintained on aripiprazole or substituted to placebo for further 16 weeks. Kaplan-Meier relapse rates at week 16 were 35 % for aripiprazole and 52 % for placebo; the hazard ratio for relapse within 16 weeks (aripiprazole/placebo) was 0.57 (non-statistically significant difference). The mean weight gain over the stabilisation phase (up to 26 weeks) on aripiprazole was 3.2 kg, and a further mean increase of 2.2 kg for aripiprazole as compared to 0.6 kg for placebo was observed in the second phase (16 weeks) of the trial. Extrapyramidal symptoms were mainly reported during the stabilisation phase in 17 % of patients, with tremor accounting for 6.5 %.

Tics associated with Tourette's disorder in paediatric patients

The efficacy of aripiprazole was studied in paediatric subjects with Tourette's disorder (aripiprazole: n = 99, placebo: n = 44) in a reported randomised, double-blind, placebo controlled, 8 week study using a fixed dose weight-based treatment group design over the dose range of 5 mg/day to 20 mg/day and a starting dose of 2 mg. Patients were 7 - 17 years of age and presented an average score of 30 on Total Tic Score on the Yale Global Tic Severity Scale (TTS-YGTSS) at baseline. Aripiprazole showed an improvement on TTS-YGTSS change from baseline to week 8 of 13.35, for the low dose group (5 mg or 10 mg) and 16.94 for the high dose group (10 mg or 20 mg) as compared with an improvement of 7.09 in the placebo group.

The efficacy of aripiprazole in paediatric subjects with Tourette's syndrome (aripiprazole: n = 32, placebo: n = 29) was also evaluated over a flexible dose range of 2 mg/day to 20 mg/day and a starting dose of 2 mg, in a 10 week, reported randomised, double blind, placebo-controlled study conducted in South-Korea. Patients were 6 - 18 years and presented an average score of 29 on TTS-YGTSS at baseline. Aripiprazole group showed an improvement of 14.97 on TTS-YGTSS change from baseline to week 10 as compared with an improvement of 9.62 in the placebo group.

In both of these short term trials, the clinical relevance of the efficacy findings has not been established, considering the magnitude of treatment effect compared to the large placebo effect and the unclear effects regarding psycho-social functioning. No long term data are available with regard to the efficacy and the safety of aripiprazole in this fluctuating disorder.

The European Medicines Agency has deferred the obligation to submit the results of studies with Aripiprazole in one or more subsets of the paediatric population in the treatment of schizophrenia and in the treatment of bipolar affective disorder.

5.3 Pharmacokinetic properties

Absorption

Aripiprazole is well absorbed, with peak plasma concentrations occurring within 3-5 hours after dosing. Aripiprazole undergoes minimal pre-systemic metabolism. The absolute oral bioavailability of the tablet formulation is 87 %. There is no effect of a high fat meal on the pharmacokinetics of aripiprazole.

Distribution

Aripiprazole is widely distributed throughout the body with an apparent volume of distribution of 4.9 l/kg, indicating extensive extravascular distribution. At therapeutic concentrations, aripiprazole and dehydro-aripiprazole are greater than 99 % bound to serum proteins, binding primarily to albumin.

Biotransformation

Aripiprazole is extensively metabolised by the liver primarily by three biotransformation pathways: dehydrogenation, hydroxylation, and N-dealkylation. Based on in vitro studies, CYP3A4 and CYP2D6 enzymes are responsible for dehydrogenation and hydroxylation of aripiprazole, and N-dealkylation is catalysed by CYP3A4. Aripiprazole is the predominant medicinal product moiety in systemic circulation. At steady state, dehydro-aripiprazole, the active metabolite, represents about 40 % of aripiprazole AUC in plasma.

Elimination

The mean elimination half-lives for aripiprazole are approximately 75 hours in extensive metabolisers of CYP2D6 and approximately 146 hours in poor metabolisers of CYP2D6.

The total body clearance of aripiprazole is 0.7 ml/min/kg, which is primarily hepatic.

Following a single oral dose of [14C]-labelled aripiprazole, approximately 27 % of the administered radioactivity was recovered in the urine and approximately 60 % in the faeces. Less than 1 % of unchanged aripiprazole was excreted in the urine and approximately 18 % was recovered unchanged in the faeces.

Paediatric population

The pharmacokinetics of aripiprazole and dehydro-aripiprazole in paediatric patients 10 to 17 years of age were similar to those in adults after correcting for the differences in body weights.

Pharmacokinetics in special patient groups

Elderly

There are no differences in the pharmacokinetics of aripiprazole between healthy elderly and younger adult subjects, nor is there any detectable effect of age in a population pharmacokinetic analysis in schizophrenic patients.

Gender

There are no differences in the pharmacokinetics of aripiprazole between healthy male and female subjects nor is there any detectable effect of gender in a population pharmacokinetic analysis in schizophrenic patients.

Smoking

Population pharmacokinetic evaluation has revealed no evidence of clinically significant effects from smoking on the pharmacokinetics of aripiprazole.

Race

Population pharmacokinetic evaluation showed no evidence of race-related differences on the pharmacokinetics of aripiprazole.

Renal impairment

The pharmacokinetic characteristics of aripiprazole and dehydro-aripiprazole were found to be similar in patients with severe renal disease compared to young healthy subjects.

Hepatic impairment

A reported single-dose study in subjects with varying degrees of liver cirrhosis (Child-Pugh Classes A, B, and C) did not reveal a significant effect of hepatic impairment on the pharmacokinetics of aripiprazole and dehydro-aripiprazole, but the study included only 3 patients with Class C liver cirrhosis, which is insufficient to draw conclusions on their metabolic capacity.

6 Nonclinical properties

6.1 Animal Toxicology or Pharmacology

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, toxicity to reproduction and development.

Toxicologically significant effects were observed only at doses or exposures that were sufficiently in excess of the maximum human dose or exposure, indicating that these effects were limited or of no relevance to clinical use. These included: dose-dependent adrenocortical toxicity (lipofuscin pigment accumulation and/or parenchymal cell loss) in rats after 104 weeks at 20 to 60 mg/kg/day (3 to 10 times the mean steady-state AUC at the maximum recommended human dose) and increased adrenocortical carcinomas and combined adrenocortical adenomas/carcinomas in female rats at 60 mg/kg/day (10 times the mean steady-state AUC at the maximum recommended human dose). The highest nontumorigenic exposure in female rats was 7 times the human exposure at the recommended dose.

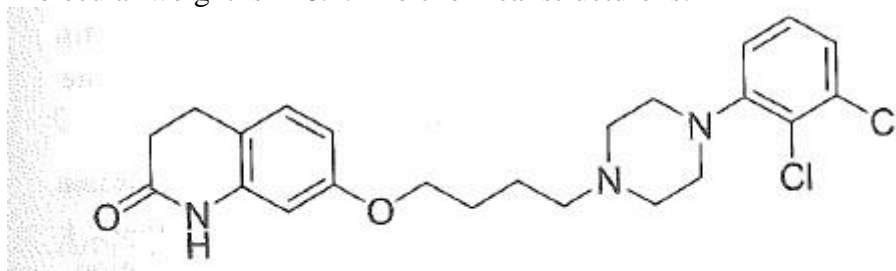
An additional finding was cholelithiasis as a consequence of precipitation of sulphate conjugates of hydroxy metabolites of aripiprazole in the bile of monkeys after repeated oral dosing at 25 to 125 mg/kg/day (1 to 3 times the mean steady-state AUC at the maximum recommended clinical dose or 16 to 81 times the maximum recommended human dose based on mg/m²). However, the concentrations of the sulphate conjugates of hydroxy aripiprazole in human bile at the highest dose proposed, 30 mg per day, were no more than 6 % of the bile concentrations found in the monkeys in the 39-week reported study and are well below (6 %) their limits of in vitro solubility.

In repeat-dose studies in juvenile rats and dogs, the toxicity profile of aripiprazole was comparable to that observed in adult animals, and there was no evidence of neurotoxicity or adverse reactions on development.

Based on results of a full range of standard genotoxicity tests, aripiprazole was considered non-genotoxic. Aripiprazole did not impair fertility in reproductive toxicity studies. Developmental toxicity, including dose-dependent delayed foetal ossification and possible teratogenic effects, were observed in rats at doses resulting in subtherapeutic exposures (based on AUC) and in rabbits at doses resulting in exposures 3 and 11 times the mean steady-state AUC at the maximum recommended clinical dose. Maternal toxicity occurred at doses similar to those eliciting developmental toxicity.

7 Description

The chemical name of Aripiprazole is 7-{4-[4-(2,3 Dichlorophenyl)piperazin-1-yl]butoxy}3,4-dihydroquinolin-2(1H)-one. Its molecular formula is $C_{23}H_{27}Cl_2N_3O_2$ and its molecular weight is 448.4. The chemical structure is:



Product Description:

White to off white coloured, round, flat, beveled edge uncoated tablet debossed with “2” on one side and plain on the other side.

8 Pharmaceutical particulars

8.1 Incompatibilities

Not applicable

8.2 Shelf-life

Do not use later than date of expiry.

8.3 Packaging information

Available in blister pack of 15 tablets

8.4 Storage and handing instructions

- Store at a temperature not exceeding 30°C, protected from Light and Moisture.
- Keep out of reach of children

9 Patient Counselling Information

Package leaflet: Information for the user

ARIP MT 2

Aripiprazole Tablets I.P.

Read all of this leaflet carefully before you start using this medicine because it contains important information for you.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet.

What is in this leaflet

- 9.1 What Arip MT 2 is and what it is used for
- 9.2 What you need to know before you take Arip MT 2
- 9.3 How to take Arip MT 2
- 9.4 Possible side effects
- 9.5 How to store Arip MT 2
- 9.6. Contents of the pack and other information

9.1 What Arip MT 2 is and what it is used for

Arip MT 2 contains the active substance aripiprazole and belong to a group of medicines called antipsychotics.

Arip MT is used for the treatment of Schizophrenia in adolescent patients (13 to 17 years of age). **With the condition:** to be sold by retail on the prescription of Psychiatrist only.

9.2 What you need to know before you take Arip MT 2

Do not take Arip MT 2

- if you are allergic to aripiprazole or any of the other ingredients of this medicine.

Warnings and precautions

Talk to your doctor before taking Arip MT 2.

Suicidal thoughts and behaviours have been reported during aripiprazole treatment. Tell your doctor immediately if you are having any thoughts or feelings about hurting yourself.

Before treatment with Aripiprazole, tell your doctor if you suffer from

- high blood sugar (characterised by symptoms such as excessive thirst, passing of large amounts of urine, increase in appetite and feeling weak) or family history of diabetes
- fits (seizures) since your doctor may want to monitor you more closely
- involuntary, irregular muscle movements, especially in the face
- cardiovascular diseases (diseases of the heart and circulation), family history of cardiovascular disease, stroke or "mini" stroke, abnormal blood pressure
- blood clots, or family history of blood clots, as antipsychotics have been associated with formation of blood clots
- past experience with excessive gambling

If you notice you are gaining weight, develop unusual movements, experience somnolence that interferes with normal daily activities, any difficulty in swallowing or allergic symptoms, please tell your doctor.

If you are an elderly patient suffering from dementia (loss of memory and other mental abilities), you or your carer/relative should tell your doctor if you have ever had a stroke or "mini" stroke.

Tell your doctor immediately if you are having any thoughts or feelings about hurting yourself. Suicidal thoughts and behaviours have been reported during aripiprazole treatment.

Tell your doctor immediately if you suffer from muscle stiffness or inflexibility with high fever, sweating, altered mental status, or very rapid or irregular heartbeat.

Tell your doctor if you or your family/carer notices that you are developing urges or cravings to behave in ways that are unusual for you and you cannot resist the impulse, drive or temptation to carry out certain activities that could harm yourself or others. These are called impulse control disorders and can include behaviours such as addictive gambling, excessive eating or spending, an abnormally high sex drive or preoccupation with an increase in sexual thoughts or feelings.

Your doctor may need to adjust or stop your dose.

Aripiprazole may cause sleepiness, fall in blood pressure when standing up, dizziness and changes in your ability to move and balance, which may lead to falls. Caution should be taken, particularly if you are an elderly patient or have some debility.

Children and adolescents

Do not use this medicine in children and adolescents under 13 years of age. It is not known if it is safe and effective in these patients.

Other medicines and Arip MT 2

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines, including medicines obtained without a prescription.

Blood pressure-lowering medicines: Aripiprazole may increase the effect of medicines used to lower the blood pressure. Be sure to tell your doctor if you take a medicine to keep your blood pressure under control.

Taking Aripiprazole with some medicines may mean the doctor will need to change your dose of Aripiprazole or the other medicines. It is especially important to mention the following to your doctor:

- medicines to correct heart rhythm (such as quinidine, amiodarone, flecainide)
- antidepressants or herbal remedy used to treat depression and anxiety (such as fluoxetine, paroxetine, venlafaxine, St. John's Wort)
- antifungal medicines (such as ketoconazole, itraconazole)
- certain medicines to treat HIV infection (such as efavirenz, nevirapine, an protease inhibitors e.g. indinavir, ritonavir)
- anticonvulsants used to treat epilepsy (such as carbamazepine, phenytoin, phenobarbital)
- certain antibiotics used to treat tuberculosis (rifabutin, rifampicin)

These medicines may increase the risk of side effects or reduce the effect of Aripiprazole; if you get any unusual symptom taking any of these medicines together with Aripiprazole you should see your doctor.

Medicines that increase the level of serotonin are typically used in conditions including depression, generalised anxiety disorder, obsessive-compulsive disorder (OCD) and social phobia as well as migraine and pain:

- triptans, tramadol and tryptophan used for conditions including depression, generalised anxiety disorder, obsessive compulsive disorder (OCD) and social phobia as well as migraine and pain
- SSRI s (such as paroxetine and fluoxetine) used for depression, OCD, panic and anxiety
- other anti-depressants (such as venlafaxine and tryptophan) used in major depression • tricyclic's (such as clomipramine and amitriptyline) used for depressive illness
- St John's Wort (*Hypericum perforatum*) used as a herbal remedy for mild depression
- pain killers (such as tramadol and pethidine) used for pain relief
- triptans (such as sumatriptan and zolmitriptan) used for treating migraine

These medicines may increase the risk of side effects; if you get any unusual symptom taking any of these medicines together with Aripiprazole, you should see your doctor.

Arip MT 2 with food, drink and alcohol This medicine can be taken regardless of meals.

Alcohol should be avoided.

Pregnancy, breast-feeding and fertility

If you are pregnant or breast-feeding, think you may be pregnant or are planning to have a baby, ask your doctor for advice before taking this medicine.

The following symptoms may occur in newborn babies, of mothers that have used Aripiprazole in the last trimester (last three months of their pregnancy): shaking, muscle stiffness and/or weakness, sleepiness, agitation, breathing problems, and difficulty in feeding. If your baby develops any of these symptoms you may need to contact your doctor.

If you are taking Aripiprazole, your doctor will discuss with you whether you should breastfeed considering the benefit to you of your therapy and the benefit to your baby of breastfeeding. You should not do both. Talk to your doctor about the best way to feed your baby if you are taking this medicine.

Driving and using machines

Dizziness and vision problems may occur during treatment with this medicine. This should be considered in cases where full alertness is required, e.g. when driving a car or handling machines.

9.3 How to take Arip MT 2

Always take this medicine exactly as your doctor or pharmacist has told you. Check with your doctor or pharmacist if you are not sure.

The recommended dose for adults is 15 mg once a day. However your doctor may prescribe a lower or higher dose to a maximum of 30 mg once a day.

Use in children and adolescents

This medicinal product may be started at a low dose with the oral solution (liquid) form. The dose may be gradually increased to **the recommended dose for adolescents of 10 mg once a day.** However your doctor may prescribe a lower or higher dose to a maximum of 30 mg once a day. If you have the impression that the effect of Aripiprazole is too strong or too weak, talk to your doctor or pharmacist

Try to take Arip MT 2 at the same time each day. It does not matter whether you take it with or without food. Always take the tablet with water and swallow it whole.

Even if you feel better, do not alter or discontinue the daily dose of Aripiprazole without first consulting your doctor.

If you take more Arip MT 2 than you should

If you realise you have taken more Arip MT 2 than your doctor has recommended (or if someone else has taken some of your Arip MT 2), contact your doctor right away. If you cannot reach your doctor, go to the nearest hospital and take the pack with you.

Patients who have taken too much aripiprazole have experienced the following symptoms: • rapid heartbeat, agitation/aggressiveness, problems with speech.

- unusual movements (especially of the face or tongue) and reduced level of consciousness.

Other symptoms may include:

- acute confusion, seizures (epilepsy), coma, a combination of fever, faster breathing, sweating,
- muscle stiffness, and drowsiness or sleepiness, slower breathing, choking, high or low blood pressure, abnormal rhythms of the heart.

Contact your doctor or hospital immediately if you experience any of the above.

If you forget to take Arip MT 2

If you miss a dose, take the missed dose as soon as you remember but do not take two doses in one day.

If you stop taking Arip MT 2

Do not stop your treatment just because you feel better. It is important that you carry on taking Arip MT 2 for as long as your doctor has told you to.

If you have any further questions on the use of this medicine, ask your doctor or pharmacist.

9.4 Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them.

Common side effects (may affect up to 1 in 10 people):

- diabetes mellitus,
- difficulty sleeping,
- feeling anxious,
- feeling restless and unable to keep still, difficulty sitting still,
- uncontrollable twitching, jerking or writhing movements, restless legs,
- trembling,
- headache,
- tiredness,
- sleepiness,
- light-headedness,
- shaking and blurred vision,
- decreased number of or difficulty making bowel movements,
- indigestion,
- feeling sick,
- more saliva in mouth than normal,
- vomiting,
- feeling tired.

Uncommon side effects (may affect up to 1 in 100 people):

- increased blood levels of the hormone prolactin,
- too much sugar in the blood,
- depression,
- altered or increased sexual interest,
- uncontrollable movements of mouth, tongue and limbs (tardive dyskinesia),
- muscle disorder causing twisting movements (dystonia),
- double vision,
- fast heartbeat,
- a fall in blood pressure on standing up which causes dizziness, light-headedness or fainting,
- hiccups.

The following side effects have been reported since the marketing of oral aripiprazole but the frequency for them to occur is not known:

- low levels of white blood cells,
- low levels of blood platelets,
- allergic reaction (e.g. swelling in the mouth, tongue, face and throat, itching, hives),
- onset or worsening of diabetes, ketoacidosis (ketones in the blood and urine) or coma,
- high blood sugar,
- not enough sodium in the blood,
- loss of appetite (anorexia),
- weight loss,
- weight gain,
- thoughts of suicide, suicide attempt and suicide,
- feeling aggressive,

- agitation,
- nervousness,
- combination of fever, muscle stiffness, faster breathing, sweating, reduced consciousness and sudden changes in blood pressure and heart rate, fainting (neuroleptic malignant syndrome),
- seizure,
- serotonin syndrome (a reaction which may cause feelings of great happiness, drowsiness, clumsiness, restlessness, feeling of being drunk, fever, sweating or rigid muscles),
- speech disorder,
- fixation of the eyeballs in one position,
- sudden unexplained death,
- life-threatening irregular heartbeat,
- heart attack,
- slower heartbeat,
- blood clots in the veins especially in the legs (symptoms include swelling, pain and redness in the leg), which may travel through blood vessels to the lungs causing chest pain and difficulty in breathing (if you notice any of these symptoms, seek medical advice immediately),
- high blood pressure,
- fainting,
- accidental inhalation of food with risk of pneumonia (lung infection),
- spasm of the muscles around the voice box,
- inflammation of the pancreas,
- difficulty swallowing,
- diarrhoea,
- abdominal discomfort,
- stomach discomfort,
- liver failure,
- inflammation of the liver,
- yellowing of the skin and white part of eyes,
- reports of abnormal liver tests values,
- skin rash,
- sensitivity to light,
- baldness,
- excessive sweating,
- abnormal muscle breakdown which can lead to kidney problems,
- muscle pain,
- stiffness,
- involuntary loss of urine (incontinence),
- difficulty in passing urine,
- withdrawal symptoms in newborn babies in case of exposure during pregnancy,
- prolonged and/or painful erection,
- difficulty controlling core body temperature or overheating,
- chest pain,
- swelling of hands, ankles or feet,
- in blood tests: increased or fluctuating blood sugar, increased glycosylated haemoglobin.

- Inability to resist the impulse, drive or temptation to perform an action that could be harmful to you or others, which may include:
 - strong impulse to gamble excessively despite serious personal or family consequences - altered or increased sexual interest and behaviour of significant concern to you or to others, for example, an increased sexual drive
 - uncontrollable excessive shopping
 - binge eating (eating large amounts of food in a short time period) or compulsive eating (eating more food than normal and more than is needed to satisfy your hunger) - a tendency to wander away.

Tell your doctor if you experience any of these behaviours; he/she will discuss ways of managing or reducing the symptoms.

In elderly patients with dementia, more fatal cases have been reported while taking aripiprazole. In addition, cases of stroke or "mini" stroke have been reported.

Additional side effects in children and adolescents

Adolescents aged 13 years and older experienced side effects that were similar in frequency and type to those in adults except that sleepiness, uncontrollable twitching or jerking movements, restlessness, and tiredness were very common (greater than 1 in 10 patients) and upper abdominal pain, dry mouth, increased heart rate, weight gain, increased appetite, muscle twitching, uncontrolled movements of the limbs, and feeling dizzy, especially when getting up from a lying or sitting position, were common (greater than 1 in 100 patients).

9.5 How to store Arip MT 2

- Store at a temperature not exceeding 30°C, protected from Light and Moisture.
- Keep this medicine out of the sight and reach of children.
- Do not use this medicine after the expiry date which is stated on the blister and on the carton after EXP. The expiry date refers to the last day of that month.
- Store in the original package in order to protect from moisture.
- Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

9.6. Contents of the pack and other information

Each uncoated tablet of Arip MT 2 consist of Aripiprazole I.P. 2 mg.

The other ingredients are Mannitol-25, Crospovidone, Colloidal silicon Dioxide, Hydroxypropylcellulose, Purified Water, Microcrystalline Cellulose, Colloidal Silicon Dioxide, Magnesium Stearate.

Arip MT 2 is available in blister pack of 15 tablets.

10 Details of manufacturer

TORRENT PHARMACEUTICALS LTD.

32 No. Middle Camp, NH-10,

East District, Gangtok

Sikkim - 737 135, INDIA

11 Details of permission or licence number with date

Mfg Lic. No.: M/563/2010

12. Date of revision

FEB 2022

MARKETED BY



TORRENT PHARMACEUTICALS LTD.

Torrent House, Off Ashram Road,
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IN/ARIP MT 2 mg/Feb-22/04/PI