

**PREGABALIN SUSTAINED RELEASE CAPSULES**  
**100mg/150mg**

**1. Name of the medicinal product**

Pregabalin Sustained Release Capsules 100mg Taj Pharma  
Pregabalin Sustained Release Capsules 150mg Taj Pharma

**2. Qualitative and quantitative composition**

Each hard gelatin capsule contains:

Pregabalin 100mg

Excipients q.s

Approved colour used in empty capsule shells.

Each hard gelatin capsule contains:

Pregabalin 150mg

Excipients q.s

Approved colour used in empty capsule shells.

For the full list of excipients, see section 6.1.

**3. Pharmaceutical form**

Capsule, hard.

**4. Clinical particulars**

**4.1 Therapeutic indications**

*Neuropathic pain*

Pregabalin is indicated for the treatment of peripheral and central neuropathic pain in adults.

*Epilepsy*

Pregabalin is indicated as adjunctive therapy in adults with partial seizures with or without secondary generalisation.

*Generalised Anxiety Disorder*

Pregabalin is indicated for the treatment of Generalised Anxiety Disorder (GAD) in adults.

**4.2 Posology and method of administration**

Posology

The dose range is 150 to 600mg per day given in either two or three divided doses.

*Neuropathic pain*

Pregabalin treatment can be started at a dose of 150mg per day given as two or three divided doses. Based on individual patient response and tolerability, the dose may be increased to 300mg per day after an interval of 3 to 7 days, and if needed, to a maximum dose of 600mg per day after an additional 7-day interval.

*Epilepsy*

Pregabalin treatment can be started with a dose of 150mg per day given as two or three divided doses. Based on individual patient response and tolerability, the dose may be increased to 300mg per

day after 1 week. The maximum dose of 600mg per day may be achieved after an additional week.

#### *Generalised Anxiety Disorder*

The dose range is 150 to 600mg per day given as two or three divided doses. The need for treatment should be reassessed regularly.

Pregabalin treatment can be started with a dose of 150mg per day. Based on individual patient response and tolerability, the dose may be increased to 300mg per day after 1 week. Following an additional week the dose may be increased to 450mg per day. The maximum dose of 600mg per day may be achieved after an additional week.

#### *Discontinuation of pregabalin*

In accordance with current clinical practice, if pregabalin has to be discontinued it is recommended this should be done gradually over a minimum of 1 week independent of the indication (see sections 4.4 and 4.8).

#### *Patients with renal impairment*

Pregabalin is eliminated from the systemic circulation primarily by renal excretion as unchanged drug. As pregabalin clearance is directly proportional to creatinine clearance (see section 5.2), dose reduction in patients with compromised renal function must be individualised according to creatinine clearance (CL<sub>cr</sub>), as indicated in Table 1 determined using the following formula:

$$CL_{cr}(\text{ml/min}) = \left[ \frac{1.23 \times [140 - \text{age (years)}] \times \text{weight (kg)}}{\text{serum creatinine } (\mu\text{mol/l})} \right] (\times 0.85 \text{ for female patients})$$

Pregabalin is removed effectively from plasma by haemodialysis (50 % of drug in 4 hours). For patients receiving haemodialysis, the pregabalin daily dose should be adjusted based on renal function. In addition to the daily dose, a supplementary dose should be given immediately following every 4 hour haemodialysis treatment (see Table 1).

*Table 1.* Pregabalin dose adjustment based on renal function

Creatinine clearance (CL <sub>cr</sub> ) (mL/min)	Total pregabalin daily dose *		Dose regimen
	Starting dose (mg/day)	Maximum dose (mg/day)	
≥ 60	150	600	BID or TID
≥30 - <60	75	300	BID or TID
≥15 - <30	25 – 50	150	Once Daily or BID
< 15	25	75	Once Daily
Supplementary dosage following haemodialysis (mg)			
	25	100	Single dose <sup>+</sup>

TID = Three divided doses

BID = Two divided doses

\* Total daily dose (mg/day) should be divided as indicated by dose regimen to provide mg/dose

<sup>+</sup> Supplementary dose is a single additional dose

#### *Patients with hepatic impairment*

No dose adjustment is required for patients with hepatic impairment (see section 5.2).

#### *Paediatric population*

The safety and efficacy of Pregabalin in children below the age of 12 years and in adolescents (12-17 years of age) have not been established. Currently available data are described in sections 4.8, 5.1 and 5.2 but no recommendation on a posology can be made.

#### *Elderly (over 65 years of age) population*

Elderly patients may require a dose reduction of pregabalin due to a decreased renal function (see patients with renal impairment).

#### Method of administration

Pregabalin may be taken with or without food.

Pregabalin is for oral use only.

### **4.3 Contraindications**

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

### **4.4 Special warnings and precautions for use**

#### *Diabetic patients*

In accordance with current clinical practice, some diabetic patients who gain weight on pregabalin treatment may need to adjust hypoglycaemic medicinal products.

#### *Hypersensitivity reactions*

There have been reports in the postmarketing experience of hypersensitivity reactions, including cases of angioedema. Pregabalin should be discontinued immediately if symptoms of angioedema, such as facial, perioral, or upper airway swelling occur.

#### *Dizziness, somnolence, loss of consciousness, confusion, and mental impairment*

Pregabalin treatment has been associated with dizziness and somnolence, which could increase the occurrence of accidental injury (fall) in the elderly population. There have also been post-marketing reports of loss of consciousness, confusion and mental impairment. Therefore, patients should be advised to exercise caution until they are familiar with the potential effects of the medicinal product.

#### *Vision-related effects*

In controlled trials, a higher proportion of patients treated with pregabalin reported blurred vision than did patients treated with placebo which resolved in a majority of cases with continued dosing. In the clinical studies where ophthalmologic testing was conducted, the incidence of visual acuity reduction and visual field changes was greater in pregabalin-treated patients than in placebo-treated patients; the incidence of fundoscopic changes was greater in placebo-treated patients (see section 5.1).

In the post-marketing experience, visual adverse reactions have also been reported, including loss of vision, visual blurring or other

changes of visual acuity, many of which were transient. Discontinuation of pregabalin may result in resolution or improvement of these visual symptoms.

#### *Renal failure*

Cases of renal failure have been reported and in some cases discontinuation of pregabalin did show reversibility of this adverse reaction.

#### *Withdrawal of concomitant antiepileptic medicinal products*

There are insufficient data for the withdrawal of concomitant antiepileptic medicinal products, once seizure control with pregabalin in the add-on situation has been reached, in order to reach monotherapy on pregabalin.

#### *Withdrawal symptoms*

After discontinuation of short-term and long-term treatment with pregabalin withdrawal symptoms have been observed in some patients. The following events have been mentioned: insomnia, headache, nausea, anxiety, diarrhoea, flu syndrome, nervousness, depression, pain, convulsion, hyperhidrosis and dizziness, suggestive of physical dependence. The patient should be informed about this at the start of the treatment.

Convulsions, including status epilepticus and grand mal convulsions, may occur during pregabalin use or shortly after discontinuing pregabalin.

Concerning discontinuation of long-term treatment of pregabalin, data suggest that the incidence and severity of withdrawal symptoms may be dose-related.

#### *Congestive heart failure*

There have been post-marketing reports of congestive heart failure in some patients receiving pregabalin. These reactions are mostly seen in elderly cardiovascular compromised patients during pregabalin treatment for a neuropathic indication. Pregabalin should be used with caution in these patients. Discontinuation of pregabalin may resolve the reaction.

#### *Treatment of central neuropathic pain due to spinal cord injury*

In the treatment of central neuropathic pain due to spinal cord injury the incidence of adverse reactions in general, central nervous system adverse reactions and especially somnolence was increased. This may be attributed to an additive effect due to concomitant medicinal products (e.g. anti-spasticity agents) needed for this condition. This should be considered when prescribing pregabalin in this condition.

#### *Suicidal ideation and behaviour*

Suicidal ideation and behaviour have been reported in patients treated with anti-epileptic agents in several indications. A meta-analysis of randomised placebo controlled studies of anti-epileptic drugs has also shown a small increased risk of suicidal ideation and behaviour. The mechanism of this risk is not known and the available data do not exclude the possibility of an increased risk for pregabalin.

Therefore patients should be monitored for signs of suicidal ideation and behaviours and appropriate treatment should be considered. Patients (and caregivers of patients) should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge.

#### *Reduced lower gastrointestinal tract function*

There are post-marketing reports of events related to reduced lower gastrointestinal tract function (e.g., intestinal obstruction, paralytic ileus, constipation) when pregabalin was co-administered with medications that have the potential to produce constipation, such as opioid analgesics. When pregabalin and opioids will be used in combination, measures to prevent constipation may be considered (especially in female patients and elderly).

#### *Misuse, abuse potential or dependence*

Cases of misuse, abuse and dependence have been reported. Caution should be exercised in patients with a history of substance abuse and the patient should be monitored for symptoms of pregabalin misuse, abuse or dependence (development of tolerance, dose escalation, drug-seeking behaviour have been reported).

#### *Encephalopathy*

Cases of encephalopathy have been reported, mostly in patients with underlying conditions that may precipitate encephalopathy.

#### **4.5 Interaction with other medicinal products and other forms of interaction**

Since pregabalin is predominantly excreted unchanged in the urine, undergoes negligible metabolism in humans (<2 % of a dose recovered in urine as metabolites), does not inhibit drug metabolism *in vitro*, and is not bound to plasma proteins, it is unlikely to produce, or be subject to, pharmacokinetic interactions.

#### *In vivo studies and population pharmacokinetic analysis*

Accordingly, in *in vivo* studies no clinically relevant pharmacokinetic interactions were observed between pregabalin and phenytoin, carbamazepine, valproic acid, lamotrigine, gabapentin, lorazepam, oxycodone or ethanol. Population pharmacokinetic analysis indicated that oral antidiabetics, diuretics, insulin, phenobarbital, tiagabine and topiramate had no clinically significant effect on pregabalin clearance.

#### *Oral contraceptives, norethisterone and/or ethinyl oestradiol*

Co-administration of pregabalin with the oral contraceptives norethisterone and/or ethinyl oestradiol does not influence the steady-state pharmacokinetics of either substance.

#### *Central nervous system influencing medical products*

Pregabalin may potentiate the effects of ethanol and lorazepam. In controlled clinical trials, multiple oral doses of pregabalin co-administered with oxycodone, lorazepam, or ethanol did not result in clinically important effects on respiration. In the postmarketing experience, there are reports of respiratory failure and coma in patients taking pregabalin and other CNS depressant medicinal

products. Pregabalin appears to be additive in the impairment of cognitive and gross motor function caused by oxycodone.

#### *Interactions and the elderly*

No specific pharmacodynamic interaction studies were conducted in elderly volunteers. Interaction studies have only been performed in adults.

### **4.6 Fertility, pregnancy and lactation**

#### Women of childbearing potential/Contraception in males and females

As the potential risk for humans is unknown, effective contraception must be used in women of child bearing potential.

#### Pregnancy

There are no adequate data from the use of pregabalin in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3). The potential risk for humans is unknown.

Pregabalin should not be used during pregnancy unless clearly necessary (if the benefit to the mother clearly outweighs the potential risk to the foetus).

#### Breast-feeding

Pregabalin is excreted in human milk (see section 5.2). The effect of pregabalin on newborns/infants is unknown. A decision must be made whether to discontinue breast-feeding or to discontinue

pregabalin therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman.

#### Fertility

There are no clinical data on the effects of pregabalin on female fertility.

In a clinical trial to assess the effect of pregabalin on sperm motility, healthy male subjects were exposed to pregabalin at a dose of 600mg/day. After 3 months of treatment, there were no effects on sperm motility.

A fertility study in female rats has shown adverse reproductive effects. Fertility studies in male rats have shown adverse reproductive and developmental effects. The clinical relevance of these findings is unknown (see section 5.3).

### **4.7 Effects on ability to drive and use machines**

Pregabalin may have minor or moderate influence on the ability to drive and use machines. Pregabalin may cause dizziness and somnolence and therefore may influence the ability to drive or use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities.

### **4.8 Undesirable effects**

The pregabalin clinical programme involved over 8900 patients who were exposed to pregabalin, of whom over 5600 were in double-

blind placebo controlled trials. The most commonly reported adverse reactions were dizziness and somnolence. Adverse reactions were usually mild to moderate in intensity. In all controlled studies, the discontinuation rate due to adverse reactions was 12 % for patients receiving pregabalin and 5 % for patients receiving placebo. The most common adverse reactions resulting in discontinuation from pregabalin treatment groups were dizziness and somnolence.

In table 2 below all adverse reactions, which occurred at an incidence greater than placebo and in more than one patient, are listed by 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 ( $< 1/10,000$ ), not known (cannot be estimated from the available data). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

The adverse reactions listed may also be associated with the underlying disease and/or concomitant medicinal products.

In the treatment of central neuropathic pain due to spinal cord injury the incidence of adverse reactions in general, CNS adverse reactions and especially somnolence was increased (see section 4.4).

Additional reactions reported from post-marketing experience are included in italics in the list below.

**Table 2. Pregabalin Adverse Drug Reactions**

System Organ Class	Adverse drug reactions
Infections and infestations Common	Nasopharyngitis

<b>Blood and lymphatic system disorders</b> Uncommon	Neutropenia
<b>Immune system disorders</b> Uncommon Rare	<i>Hypersensitivity</i> <i>Angioedema, allergic reaction</i>
<b>Metabolism and nutrition disorders</b> Common Uncommon	Appetite increased Anorexia, hypoglycaemia
<b>Psychiatric disorders</b> Common Uncommon Rare	Euphoric mood, confusion, irritability, disorientation, insomnia, libido decreased Hallucination, panic attack, restlessness, agitation, depression, depressed mood, elevated mood, <i>aggression</i> , mood swings, depersonalisation, word finding difficulty, abnormal dreams, libido increased, anorgasmia, apathy Disinhibition
<b>Nervous system disorders</b> Very Common Common  Uncommon Rare	Dizziness, somnolence, headache Ataxia, coordination abnormal, tremor, dysarthria, amnesia, memory impairment, disturbance in attention, paraesthesia, hypoaesthesia, sedation, balance disorder, lethargy Syncope, stupor, myoclonus, <i>loss of consciousness</i> , psychomotor hyperactivity, dyskinesia, dizziness postural, intention tremor, nystagmus, cognitive disorder, <i>mental impairment</i> , speech disorder, hyporeflexia, hyperaesthesia, burning sensation, ageusia, <i>malaise</i> <i>Convulsions</i> , parosmia, hypokinesia, dysgraphia
<b>Eye disorders</b> Common	Vision blurred, diplopia

Uncommon  Rare	Peripheral vision loss, visual disturbance, eye swelling, visual field defect, visual acuity reduced, eye pain, asthenopia, photopsia, dry eye, lacrimation increased, eye irritation <i>Vision loss, keratitis, oscillopsia, altered visual depth perception, mydriasis, strabismus, visual brightness</i>
<b>Ear and labyrinth disorders</b> Common Uncommon	Vertigo Hyperacusis
<b>Cardiac disorders</b> Uncommon Rare	Tachycardia, atrioventricular block first degree, sinus bradycardia, <i>congestive heart failure QT prolongation</i> , sinus tachycardia, sinus arrhythmia
<b>Vascular disorders</b> Uncommon	Hypotension, hypertension, hot flushes, flushing, peripheral coldness
<b>Respiratory, thoracic and mediastinal disorders</b> Uncommon Rare	Dyspnoea, epistaxis, cough, nasal congestion, rhinitis, snoring, nasal dryness <i>Pulmonary oedema</i> , throat tightness
<b>Hepatobiliary disorders</b> Uncommon Rare Very rare	Elevated liver enzymes* Jaundice Hepatic failure, hepatitis
<b>Gastrointestinal disorders</b> Common Uncommon Rare	Vomiting, <i>nausea</i> , constipation, <i>diarrhoea</i> , flatulence, abdominal distension, dry mouth Gastroesophageal reflux disease, salivary hypersecretion, hypoaesthesia oral <i>Ascites, pancreatitis, swollen tongue</i> , dysphagia
<b>Skin and subcutaneous tissue disorders</b>	Rash papular, urticaria, hyperhidrosis, <i>pruritus</i>

Uncommon Rare	<i>Stevens Johnson syndrome, cold sweat</i>
<b>Musculoskeletal and connective tissue disorders</b> Common Uncommon Rare	Muscle cramp, arthralgia, back pain, pain in limb, cervical spasm Joint swelling, myalgia, muscle twitching, neck pain, muscle stiffness Rhabdomyolysis
<b>Renal and urinary disorders</b> Uncommon Rare	Urinary incontinence, dysuria Renal failure, oliguria, <i>urinary retention</i>
<b>Reproductive system and breast disorders</b> Common Uncommon Rare	Erectile dysfunction Sexual dysfunction, ejaculation delayed, dysmenorrhoea, breast pain Amenorrhoea, breast discharge, breast enlargement, <i>gynaecomastia</i>
<b>General disorders and administration site conditions</b> Common Uncommon	Oedema peripheral, oedema, gait abnormal, fall, feeling drunk, feeling abnormal, fatigue Generalised oedema, <i>face oedema</i> , chest tightness, pain, pyrexia, thirst, chills, asthenia
<b>Investigations</b> Common Uncommon Rare	Weight increased Blood creatine phosphokinase increased, blood glucose increased, platelet count decreased, blood creatinine increased, blood potassium decreased, weight decreased White blood cell count decreased

\* Alanine aminotransferase increased (ALT) and aspartate aminotransferase increased (AST).

After discontinuation of short-term and long-term treatment with pregabalin withdrawal symptoms have been observed in some



patients. The following reactions have been mentioned: insomnia, headache, nausea, anxiety, diarrhoea, flu syndrome, convulsions, nervousness, depression, pain, hyperhidrosis and dizziness, suggestive of physical dependence. The patient should be informed about this at the start of the treatment.

Concerning discontinuation of long-term treatment of pregabalin, data suggest that the incidence and severity of withdrawal symptoms may be dose-related.

#### Paediatric population

The pregabalin safety profile observed in three paediatric studies in patients with partial seizures with or without secondary generalization (12-week efficacy and safety study in patients with partial onset seizures, n=295; (pharmacokinetic and tolerability study, n=65; and 1 year open label follow on safety study, n=54) was similar to that observed in the adult studies of patients with epilepsy. The most common adverse events observed in the 12-week study with pregabalin treatment were somnolence, pyrexia, upper respiratory tract infection, increased appetite, weight increased, and nasopharyngitis (see sections 4.2, 5.1 and 5.2).

#### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product.

#### **4.9 Overdose**

In the post-marketing experience, the most commonly reported adverse reactions observed when pregabalin was taken in overdose included somnolence, confusional state, agitation, and restlessness. Seizures were also reported.

In rare occasions, cases of coma have been reported.

Treatment of pregabalin overdose should include general supportive measures and may include haemodialysis if necessary (see section 4.2 Table 1).

### **5. Pharmacological properties**

#### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Antiepileptics, other antiepileptics,

The active substance, pregabalin, is a gamma-aminobutyric acid analogue ((S)-3-(aminomethyl)-5-methylhexanoic acid).

#### Mechanism of action

Pregabalin binds to an auxiliary subunit ( $\alpha_2\text{-}\delta$  protein) of voltage-gated calcium channels in the central nervous system.

#### Clinical efficacy and safety

##### *Neuropathic pain*

Efficacy has been shown in trials in diabetic neuropathy, post herpetic neuralgia and spinal cord injury. Efficacy has not been studied in other models of neuropathic pain.

Pregabalin has been studied in 10 controlled clinical trials of up to 13 weeks with twice a day dosing (BID) and up to 8 weeks with three times a day (TID) dosing. Overall, the safety and efficacy profiles for BID and TID dosing regimens were similar.

In clinical trials up to 12 weeks for both peripheral and central neuropathic pain, a reduction in pain was seen by Week 1 and was maintained throughout the treatment period.

In controlled clinical trials in peripheral neuropathic pain 35% of the pregabalin treated patients and 18% of the patients on placebo had a 50% improvement in pain score. For patients not experiencing somnolence, such an improvement was observed in 33% of patients treated with pregabalin and 18% of patients on placebo. For patients who experienced somnolence the responder rates were 48% on pregabalin and 16% on placebo.

In the controlled clinical trial in central neuropathic pain 22% of the pregabalin treated patients and 7% of the patients on placebo had a 50% improvement in pain score.

### *Epilepsy*

#### *Adjunctive Treatment*

Pregabalin has been studied in 3 controlled clinical trials of 12 week duration with either BID or TID dosing. Overall, the safety and efficacy profiles for BID and TID dosing regimens were similar.

A reduction in seizure frequency was observed by Week 1.

#### *Paediatric population*

The efficacy and safety of pregabalin as adjunctive treatment for epilepsy in paediatric patients below the age of 12 and adolescents has not been established. The adverse events observed in a pharmacokinetic and tolerability study that enrolled patients from 3 months to 16 years of age (n=65) with partial onset seizures were similar to those observed in adults. Results of a 12-week placebo-controlled study of 295 paediatric patients aged 4 to 16 years performed to evaluate the efficacy and safety of pregabalin as adjunctive therapy for the treatment of partial onset seizures and a 1 year open label safety study in 54 paediatric patients from 3 months to 16 years of age with epilepsy indicate that the adverse events of pyrexia and upper respiratory infections were observed more frequently than in adult studies of patients with epilepsy (see sections 4.2, 4.8 and 5.2).

In the 12-week placebo-controlled study, paediatric patients were assigned to pregabalin 2.5mg/kg/day (maximum, 150mg/day), pregabalin 10mg/kg/day (maximum, 600mg/day), or placebo. The percentage of subjects with at least a 50% reduction in partial onset seizures as compared to baseline was 40.6% of subjects treated with pregabalin 10mg/kg/day (p=0.0068 versus placebo), 29.1% of subjects treated with pregabalin 2.5mg/kg/day (p=0.2600 versus placebo) and 22.6% of those receiving placebo.

#### *Monotherapy (newly diagnosed patients)*

Pregabalin has been studied in 1 controlled clinical trial of 56 week duration with BID dosing. Pregabalin did not achieve non-inferiority to lamotrigine based on the 6-month seizure freedom endpoint. Pregabalin and lamotrigine were similarly safe and well tolerated.

### *Generalised Anxiety Disorder*

Pregabalin has been studied in 6 controlled trials of 4-6 week duration, an elderly study of 8 week duration and a long-term relapse prevention study with a double blind relapse prevention phase of 6 months duration.

Relief of the symptoms of GAD as reflected by the Hamilton Anxiety Rating Scale (HAM-A) was observed by Week 1.

In controlled clinical trials (4-8 week duration) 52 % of the pregabalin treated patients and 38 % of the patients on placebo had at least a 50 % improvement in HAM-A total score from baseline to endpoint.

In controlled trials, a higher proportion of patients treated with pregabalin reported blurred vision than did patients treated with placebo which resolved in a majority of cases with continued dosing. Ophthalmologic testing (including visual acuity testing, formal visual field testing and dilated fundoscopic examination) was conducted in over 3600 patients within controlled clinical trials. In these patients, visual acuity was reduced in 6.5 % of patients treated with pregabalin, and 4.8 % of placebo-treated patients. Visual field changes were detected in 12.4 % of pregabalin-treated, and 11.7 % of placebo-treated patients. Fundoscopic changes were observed in 1.7 % of pregabalin-treated and 2.1 % of placebo-treated patients.

### **5.2 Pharmacokinetic properties**

Pregabalin steady-state pharmacokinetics are similar in healthy volunteers, patients with epilepsy receiving anti-epileptic drugs and patients with chronic pain.

#### Absorption

Pregabalin is rapidly absorbed when administered in the fasted state, with peak plasma concentrations occurring within 1 hour following both single and multiple dose administration. Pregabalin oral bioavailability is estimated to be  $\geq 90$  % and is independent of dose. Following repeated administration, steady state is achieved within 24 to 48 hours. The rate of pregabalin absorption is decreased when given with food resulting in a decrease in  $C_{max}$  by approximately 25-30 % and a delay in  $t_{max}$  to approximately 2.5 hours. However, administration of pregabalin with food has no clinically significant effect on the extent of pregabalin absorption.

#### Distribution

In preclinical studies, pregabalin has been shown to cross the blood brain barrier in mice, rats, and monkeys. Pregabalin has been shown to cross the placenta in rats and is present in the milk of lactating rats. In humans, the apparent volume of distribution of pregabalin following oral administration is approximately 0.56 l/kg. Pregabalin is not bound to plasma proteins.

#### Biotransformation

Pregabalin undergoes negligible metabolism in humans. Following a dose of radiolabelled pregabalin, approximately 98 % of the radioactivity recovered in the urine was unchanged pregabalin. The

N-methylated derivative of pregabalin, the major metabolite of pregabalin found in urine, accounted for 0.9 % of the dose. In preclinical studies, there was no indication of racemisation of pregabalin S-enantiomer to the R-enantiomer.

#### Elimination

Pregabalin is eliminated from the systemic circulation primarily by renal excretion as unchanged drug. Pregabalin mean elimination half-life is 6.3 hours. Pregabalin plasma clearance and renal clearance are directly proportional to creatinine clearance (see section 5.2 Renal impairment). Dose adjustment in patients with reduced renal function or undergoing haemodialysis is necessary (see section 4.2 Table 1).

#### Linearity/non-linearity

Pregabalin pharmacokinetics are linear over the recommended daily dose range. Inter-subject pharmacokinetic variability for pregabalin is low (<20 %). Multiple dose pharmacokinetics are predictable from single-dose data. Therefore, there is no need for routine monitoring of plasma concentrations of pregabalin.

#### Gender

Clinical trials indicate that gender does not have a clinically significant influence on the plasma concentrations of pregabalin.

#### Renal impairment

Pregabalin clearance is directly proportional to creatinine clearance. In addition, pregabalin is effectively removed from plasma by

haemodialysis (following a 4 hour haemodialysis treatment plasma pregabalin concentrations are reduced by approximately 50 %). Because renal elimination is the major elimination pathway, dose reduction in patients with renal impairment and dose supplementation following haemodialysis is necessary (see section 4.2 Table 1).

#### Hepatic impairment

No specific pharmacokinetic studies were carried out in patients with impaired liver function. Since pregabalin does not undergo significant metabolism and is excreted predominantly as unchanged drug in the urine, impaired liver function would not be expected to significantly alter pregabalin plasma concentrations.

#### Paediatric population

Pregabalin pharmacokinetics were evaluated in paediatric patients with epilepsy (age groups: 1 to 23 months, 2 to 6 years, 7 to 11 years and 12 to 16 years) at dose levels of 2.5, 5, 10 and 15mg/kg/day in a pharmacokinetic and tolerability study.

After oral administration of pregabalin in paediatric patients in the fasted state, in general, time to reach peak plasma concentration was similar across the entire age group and occurred 0.5 hours to 2 hours postdose.

Pregabalin  $C_{max}$  and AUC parameters increased in a linear manner with increasing dose within each age group. The AUC was lower by 30% in paediatric patients below a weight of 30 kg due to an

increased body weight adjusted clearance of 43% for these patients in comparison to patients weighing  $\geq 30$  kg.

Pregabalin terminal half-life averaged about 3 to 4 hours in paediatric patients up to 6 years of age, and 4 to 6 hours in those 7 years of age and older.

Population pharmacokinetic analysis showed that creatinine clearance was a significant covariate of pregabalin oral clearance, body weight was a significant covariate of pregabalin apparent oral volume of distribution, and these relationships were similar in paediatric and adult patients.

Pregabalin pharmacokinetics in patients younger than 3 months old have not been studied (see sections 4.2, 4.8 and 5.1).

#### Elderly

Pregabalin clearance tends to decrease with increasing age. This decrease in pregabalin oral clearance is consistent with decreases in creatinine clearance associated with increasing age. Reduction of pregabalin dose may be required in patients who have age related compromised renal function (see section 4.2 Table 1).

#### Breast-feeding mothers

The pharmacokinetics of 150mg pregabalin given every 12 hours (300mg daily dose) was evaluated in 10 lactating women who were at least 12 weeks postpartum. Lactation had little to no influence on pregabalin pharmacokinetics. Pregabalin was excreted into breast milk with average steady-state concentrations approximately 76% of those in maternal plasma. The estimated infant dose from breast milk

(assuming mean milk consumption of 150 ml/kg/day) of women receiving 300mg/day or the maximum dose of 600mg/day would be 0.31 or 0.62mg/kg/day, respectively. These estimated doses are approximately 7% of the total daily maternal dose on amg/kg basis.

#### **5.3 Preclinical safety data**

In conventional safety pharmacology studies in animals, pregabalin was well-tolerated at clinically relevant doses. In repeated dose toxicity studies in rats and monkeys CNS effects were observed, including hypoactivity, hyperactivity and ataxia. An increased incidence of retinal atrophy commonly observed in aged albino rats was seen after long term exposure to pregabalin at exposures  $\geq 5$  times the mean human exposure at the maximum recommended clinical dose.

Pregabalin was not teratogenic in mice, rats or rabbits. Foetal toxicity in rats and rabbits occurred only at exposures sufficiently above human exposure. In prenatal/postnatal toxicity studies, pregabalin induced offspring developmental toxicity in rats at exposures  $> 2$  times the maximum recommended human exposure.

Adverse effects on fertility in male and female rats were only observed at exposures sufficiently in excess of therapeutic exposure. Adverse effects on male reproductive organs and sperm parameters were reversible and occurred only at exposures sufficiently in excess of therapeutic exposure or were associated with spontaneous degenerative processes in male reproductive organs in the rat. Therefore the effects were considered of little or no clinical relevance.

Pregabalin is not genotoxic based on results of a battery of *in vitro* and *in vivo* tests.

Two-year carcinogenicity studies with pregabalin were conducted in rats and mice. No tumours were observed in rats at exposures up to 24 times the mean human exposure at the maximum recommended clinical dose of 600mg/day. In mice, no increased incidence of tumours was found at exposures similar to the mean human exposure, but an increased incidence of haemangiosarcoma was observed at higher exposures. The non-genotoxic mechanism of pregabalin-induced tumour formation in mice involves platelet changes and associated endothelial cell proliferation. These platelet changes were not present in rats or in humans based on short term and limited long term clinical data. There is no evidence to suggest an associated risk to humans.

In juvenile rats the types of toxicity do not differ qualitatively from those observed in adult rats. However, juvenile rats are more sensitive. At therapeutic exposures, there was evidence of CNS clinical signs of hyperactivity and bruxism and some changes in growth (transient body weight gain suppression). Effects on the oestrus cycle were observed at 5-fold the human therapeutic exposure. Reduced acoustic startle response was observed in juvenile rats 1-2 weeks after exposure at > 2 times the human therapeutic exposure. Nine weeks after exposure, this effect was no longer observable.

## 6. Pharmaceutical particulars

### 6.1 List of excipients

#### Capsules content

Mannitol

Co-processed corn starch, consisting of: Corn starch, Pregelatinised corn starch, Talc

#### Capsules shell

Gelatin, Titanium dioxide Printing Ink

Shellac, Black Iron Oxide, Potassium hydroxide

### 6.2 Incompatibilities

Not applicable.

### 6.3 Shelf life

2 years

### 6.4 Special precautions for storage

Do not store above 30°C

### 6.5 Nature and contents of container

Aluminium/PVC blisters containing 84 capsules, hard.

### 6.6 Special precautions for disposal and other handling

No special requirements for disposal.

## 7. Manufactured By:

### Taj Pharmaceuticals Ltd.

at: Plot. No. 220, Mahagujarat

Industrial Estate, At & Post-Moraiya,

Tal-Sanand, Dist- Ahmedabad Gujarat (India)