

AUSTRALIAN PI – GAPENTIN (GABAPENTIN)

1 NAME OF THE MEDICINE

Gabapentin

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

GAPENTIN 600 mg tablets contain 600mg of gabapentin.

GAPENTIN 800 mg tablets contain 800mg of gabapentin.

Physical and Chemical characteristics:

Gabapentin is a white to off-white crystalline solid. It is freely soluble in water and both basic and acidic aqueous solutions.

Excipients:

For the full list of excipients, see **Section 6.1 List of Excipients**.

3 PHARMACEUTICAL FORM

GAPENTIN 600 mg tablets white to off white, oval shaped, film coated tablets plain on both sides.

GAPENTIN 800 mg tablets are white to off white, capsule shaped, film coated tablets plain on both sides.

4 CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Treatment of partial seizures, including secondarily generalised tonic-clonic seizures, initially as add-on therapy in adults who have not achieved adequate control with standard antiepileptic drugs.

Treatment of neuropathic pain.

4.2 DOSE AND METHOD OF ADMINISTRATION

Note :- Gapentin is available as 600mg and 800 mg unscored tablets and should not be broken into half to achieve gabapentin dosages of 300mg or 400 mg.

Gapentin 600 mg unscored tablets and Gapentin 800 mg unscored Tablets cannot be used for initiation of treatment, dose titration or to achieve lower daily dose regimens. Gapentin can only be used in stabilised patients.

Epilepsy Dosage for Adults and children over 12 years of age

Gapentin can be only used in stabilised patients. Alternative brands of gabapentin must be used for initiation of treatment. Gabapentin can be given orally with or without food.

In controlled clinical trials, the effective dose range was 900 to 1,800 mg/day given in divided doses (three times a day).

Therapy may be initiated by administering gabapentin 300 mg three times daily on day 1, (or by titrating the dose as described below.

Titration to an effective dose can take place rapidly, over a few days, giving gabapentin 300 mg on day 1, gabapentin 300 mg twice a day on day 2 and gabapentin 300 mg three times a day on day 3. Titration may be preferable for patients with renal impairment, patients with encephalopathy, patients on more than two other antiepileptic drugs and patients with multiple other medical problems.

To minimise potential side effects, especially somnolence, dizziness, fatigue and ataxia, the first dose on day 1 may be administered at bedtime. If necessary, the dose may be increased up to 2,400 mg/day. Dosages up to 2,400 mg/day have been well tolerated in long-term, open label clinical studies. The maximum time between doses in the TID schedule should not exceed 12 hours.

Neuropathic pain in Adults (over 18 years of age):

The starting dose is 900 mg/day given as three daily divided doses, and titrated if necessary, based on response, up to a maximum dose of 3,600 mg/day. Alternative brands must be used for dose titration of treatment

Dosage adjustment in impaired renal function for Patients with Neuropathic Pain or Epilepsy:

Dosage adjustment is recommended in patients with neuropathic pain or epilepsy who have compromised renal function or who are undergoing haemodialysis. (See Table 1)

Table 1: Maintenance dosage of Gabapentin in adults with reduced renal function

Creatinine clearance (mL/minute)	Total daily dose^a (mg/day)			
≥ 80	900	1200	2400	3600
50-79	600	600	1200	1800
30-49	300	300	600	900
15-29	150 ^b	300	300	600
<15	150 ^b	150 ^b	150 ^b	300

^a Total daily dose should be administered as a three times daily regimen. Doses should be used to treat patients with normal renal function (creatinine clearance ≥80 mL/min) range from 900 to 3600 mg/day. Reduced dosages are for patients with renal impairment (creatinine clearance <79 mL/min).

^b To be administered as 300 mg every other day.

For patients undergoing haemodialysis who have never received gabapentin, a loading dose of 300 to 400 mg is recommended, then gabapentin 200 to 300 mg following each four hours of haemodialysis.

Alternative brands of gabapentin may be needed for dose reduction of treatment in adults with reduced renal function.

4.3 CONTRAINDICATIONS

Demonstrated hypersensitivity to gabapentin or the inactive ingredients in the tablets.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

General

Although there is no evidence of rebound seizures with gabapentin, abrupt withdrawal of anticonvulsants in epileptic patients may precipitate status epilepticus. When, in the judgment of the doctor, there is a need for dose reduction, discontinuation or substitution of alternative anticonvulsant medication, this should be done gradually over a minimum of one week.

Gabapentin is not generally considered effective in the treatment of absence seizures and may exacerbate these seizures in some patients. Consequently, gabapentin should be used with caution in patients who have mixed seizure disorders that include absence seizures.

Central Nervous System Depression

Respiratory Depression

Gabapentin has been associated with central nervous system (CNS) depression including sedation, somnolence, loss of consciousness as well as serious cases of respiratory depression. This may occur without concomitant opioid use. Patients with compromised respiratory function, respiratory or neurological disease, renal impairment and the elderly are at higher risk of experiencing these severe adverse effects. Concomitant use of CNS depressants with gabapentin increases the risk of respiratory depression.

Concomitant Use with Opioids

Patients who require concomitant treatment with morphine may experience increases in gabapentin concentrations. Patients should be carefully observed for signs of CNS depression, e.g. somnolence, and the dose of Gabapentin or morphine should be reduced appropriately (see **Section 4.5 Interactions with other medicines and other forms of interactions**).

Suicidal Behaviour and Ideation

Antiepileptic drugs (AED), including gabapentin, increase the risk of suicidal thoughts or behaviour in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behaviour, and/or any unusual changes in mood or behaviour.

Pooled analyses of 199 placebo-controlled clinical trials (mono- and adjunctive therapy) of 11 different AEDs showed that patients randomised to one of the AEDs had approximately twice the risk (adjusted Relative Risk 1.8, 95% CI:1.2, 2.7) of suicidal thinking or behaviour compared to patients randomized to placebo. In these trials, which had a median treatment duration of 12 weeks, the estimated incidence rate of suicidal behaviour or ideation among 27,863 AED-treated patients was 0.43%, compared to 0.24% among 16,029 placebo-treated patients, representing an increase of approximately one case of suicidal thinking or behaviour for every 530 patients treated. There were four suicides in drug-treated patients in the trials and none in placebo-treated patients, but the number is too small to allow any conclusion about drug effect on suicide.

The increased risk of suicidal thoughts or behaviour with AEDs was observed as early as one week after starting drug treatment with AEDs and persisted for the duration of treatment assessed. Because most trials included in the analysis did not extend beyond 24 weeks, the risk of suicidal thoughts or behaviour beyond 24 weeks could not be assessed.

The risk of suicidal thoughts or behaviour was generally consistent among drugs in the data analysed. The finding of increased risk with AEDs of varying mechanisms of action and across a range of indications suggests that the risk applies to all AEDs used for any indication. The risk did not vary substantially by age (5-100 years) in the clinical trials analysed. Table 2 shows absolute and relative risk by indication for all evaluated AEDs.

Table 2 Risk by indication for antiepileptic drugs in the pooled analysis

Indication	Placebo Patients with Events Per 1000 Patients	Drug Patients with Events Per 1000 Patients	Relative Risk: Incidence of Events in Drug Patients/Incidence in Placebo Patients	Risk Difference: Additional Drug Patients with Events Per 1000 Patients
Epilepsy	1.0	3.4	3.5	2.4
Psychiatric	5.7	8.5	1.5	2.9
Other	1.0	1.8	1.9	0.9
Total	2.4	4.3	1.8	1.9

The relative risk for suicidal thoughts or behaviour was higher in clinical trials for epilepsy than in clinical trials for psychiatric or other conditions, but the absolute risk differences were similar for the epilepsy and psychiatric indications.

Anyone considering prescribing gabapentin or any other AED must balance this risk with the risk of untreated illness. Epilepsy and many other illnesses for which AEDs are prescribed are themselves associated with morbidity and mortality and an increased risk of suicidal thoughts and behaviour. Should suicidal thoughts and behaviour emerge during treatment, the prescriber needs to consider whether the emergence of these symptoms in any given patient may be related to the illness being treated.

Patients, their caregivers, and families should be informed that AEDs increase the risk of suicidal thoughts and behaviour and should be advised of the need to be alert for the emergence or worsening of the signs and symptoms of depression, any unusual changes in mood or behaviour, or the emergence of suicidal thoughts, behaviour, or thoughts about self-harm. Behaviours of concern should be reported immediately to the treating doctor.

Drug Rash with Eosinophilia and Systemic Symptoms (DRESS)

Severe, life-threatening, systemic hypersensitivity reactions such as drug rash with eosinophilia and systemic symptoms (DRESS) have been reported in patients taking anti-epileptic drugs including gabapentin.

It is important to note that early manifestations of hypersensitivity, such as fever or lymphadenopathy, may be present even though rash is not evident. If such signs or symptoms are present, the patient should be evaluated immediately. Gabapentin should be discontinued if an alternative aetiology for the signs or symptoms cannot be established.

Anaphylaxis

Gabapentin can cause anaphylaxis. Signs and symptoms in reported cases have included difficulty breathing, swelling of the lips, throat, and tongue, and hypotension requiring emergency treatment. Patients should be instructed to discontinue gabapentin and seek immediate medical care should they experience signs or symptoms of anaphylaxis.

Abuse and Dependence

Post-marketing cases of abuse and dependence have been reported with gabapentin. As with other CNS drugs, patients should be carefully evaluated for a history of drug abuse and observed for possible signs of gabapentin abuse.

Information for Patients

To assure safe and effective use of gabapentin, the following information and instructions should be given to patients:

1. Inform your physician about any prescription or non-prescription medications, alcohol, or drugs you are now taking or plan to take during your treatment with gabapentin.
2. No teratogenic effects have been found in animals. However, the risk to the human foetus cannot be dismissed. Therefore you should inform your physician if you are pregnant, or if you are planning to become pregnant, or if you become pregnant while you are taking gabapentin.
3. Gabapentin is excreted in human milk, and the effect on the nursing infant is unknown. You should inform your physician if you are breast feeding an infant.
4. Gabapentin may impair your ability to drive a car or operate potentially dangerous machinery. Until it is known that this medication does not affect your ability to engage in these activities, do not drive a car or operate potentially dangerous machinery.

5. You should not allow more than 12 hours between gabapentin doses. If you have missed a dose by not more than 4 hours, take the dose as soon as you remember. However, if you have missed a dose by more than 4 hours, you should skip the dose and continue taking following doses as usual.
6. Prior to initiation of treatment with gabapentin, the patient should be instructed that a rash or other signs or symptoms of hypersensitivity such as fever or lymphadenopathy may herald a serious medical event and that the patient should report any such occurrence to a physician immediately.

Use in the elderly

No data available.

Paediatric use

Epilepsy

Safety and effectiveness in children below the age of 3 years have not been established.

Neuropathic pain

Safety and effectiveness in children below the age of 18 years have not been established.

Effects on laboratory tests

False positive readings were reported with the Ames N-Multistix SG® dipstick test when gabapentin was added to other anticonvulsant drugs. To determine urinary protein, the more specific sulfosalicylic acid precipitation procedure is recommended.

4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS

There are spontaneous and literature case reports of respiratory depression and/or sedation associated with gabapentin and opioid use. These effects would be of particular concern in elderly patients.

Anticonvulsivants

In pharmacokinetic studies, no interactions were observed between gabapentin and phenobarbital (number of subjects, N = 12), phenytoin (N = 8), valproic acid (N = 17), or carbamazepine (N = 12).

Oral Contraceptives

Gabapentin did not influence the steady-state pharmacokinetics of norethindrone and ethinyl estradiol when administered concomitantly with an oral contraceptive containing these two drugs (N = 13).

Antiacid

Coadministration of gabapentin with large dose antacid (aluminium hydroxide 3600 mg, magnesium hydroxide 1800 mg) reduced gabapentin bioavailability by about 20% (N = 16). Although the difference was not expected to be clinically significant, it is recommended that gabapentin should be

taken about 2 hours following antacid administration, when the interaction has been shown to be diminished.

Cimetidine

In the presence of cimetidine at 300 mg QID, the mean apparent oral clearance of gabapentin fell by 14% and creatinine clearance by 10% (N = 12). Thus cimetidine appeared to alter the renal excretion of both gabapentin and creatinine, an endogenous marker of renal function.

Probenecid

Renal excretion of gabapentin was unaltered by probenecid, a blocker of renal tubular secretion.

Morphine

A literature article reported that when a 60 mg controlled-release morphine capsule was administered 2 hours prior to a 600 mg Gabapentin capsule (N = 12), mean gabapentin AUC increased by 44% compared to gabapentin administered without morphine (see **Section 4.4 Special warnings and precautions for use**). Morphine pharmacokinetic parameter values were not affected by administration of gabapentin 2 hours after morphine. The magnitude of interaction at other doses is not known.

4.6 FERTILITY, PREGNANCY AND LACTATION

Effects on fertility

No adverse effects on fertility or reproduction were observed in rats at doses up to 2,000 mg/kg/day.

Use in pregnancy

Category B3

Gabapentin crosses the human placenta. Congenital malformations and adverse pregnancy outcomes have been reported with gabapentin use, however there are no adequate and well-controlled studies in pregnant women and no definite conclusions can be made as to whether gabapentin is causally associated with an increased risk of congenital malformations or other adverse developmental outcomes when taken during pregnancy. The risk of birth defects is increased by a factor of 2 – 3 in the offspring of mothers treated with an antiepileptic medicinal product.

Gabapentin should be used during pregnancy only if the potential benefit to the mother clearly outweighs the potential risk to the fetus. The risk of having a child with a congenital defect as a result of antiepileptic medication is far outweighed by the dangers to the mother and fetus of uncontrolled epilepsy.

It is recommended that:

- women on antiepileptic drugs (AEDs) receive pre-pregnancy counselling with regard to the risk of fetal abnormalities;

- AEDs should be continued during pregnancy and monotherapy should be used if possible at the lowest effective dose as risk of abnormality is greater in women taking combined medication;
- folic acid supplementation (5 mg) should be commenced four weeks prior to and continue for twelve weeks after conception;
- specialist prenatal diagnosis including detailed mid-trimester ultrasound should be offered.

Studies in animals have shown reproductive toxicity. The potential risk for humans is unknown.

Embryofetal development studies with gabapentin in mice at oral doses up to 3000 mg/kg/day and in rats at oral doses up to 1500 mg/kg/day revealed no evidence of fetal malformations. Delayed ossification in the skull, vertebrae and limbs, indicative of fetal growth retardation, was reported in the offspring of mice administered gabapentin at oral doses of 1000 and 3000 mg/kg/day during organogenesis, and rats administered gabapentin 2000 mg/kg/day in the diet during mating and throughout gestation. An increased incidence of hydroureter and/or hydronephrosis was observed in rats treated with dietary gabapentin from late gestation to weaning (see **Section 4.6 Fertility, pregnancy and lactation – Use in lactation**). In these studies, exposure to gabapentin (based on areas under the concentration time curve) was up to 5 times higher in the mouse, and up to 14 times higher in the rat, than in humans at the recommended maximum dose of 2400 mg/day.

In female rabbits given 60, 300 or 1500 mg/kg/day gabapentin orally during the period of organogenesis, maternal toxicity and abortion were observed at the high dose, but at the low and mid doses, no evidence of harm to the fetus was observed.

Use in lactation.

Gabapentin is excreted in human milk.

In a peri-postnatal study in rats administered gabapentin in the diet at doses of 500, 1000 and 2000 mg/kg/day from late gestation to weaning, there was a dose related reversible increase in the incidence of hydroureter and hydronephrosis in 21 day-old pups.

Because the effect on the nursing infant is unknown, and because of the potential for serious adverse reactions in nursing infants from Gabapentin, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Gabapentin should be used in nursing mothers only if the benefits clearly outweigh the risks.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Patients should be advised not to drive a car or operate potentially dangerous machinery until it is known that this medication does not affect their ability to engage in these activities.

4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)

Adults and children over 12 years of age

Gabapentin has been evaluated for safety in approximately 2,000 subjects and patients and was well tolerated. Of these, 543 patients participated in controlled clinical trials.

The most commonly observed adverse events associated with the use of gabapentin in combination with other antiepileptic drugs, not seen in an equivalent frequency among placebo treated patients, were somnolence, dizziness, ataxia, fatigue and nystagmus.

Approximately 7% of the 2,074 individuals who received gabapentin in the pre-marketing clinical trials discontinued treatment because of an adverse event. The adverse events most commonly associated with withdrawal were somnolence, ataxia, fatigue, nausea and/or vomiting and dizziness.

Incidence in controlled clinical trials

Listed below (see Table 3) are the treatment emergent signs and symptoms that occurred in at least 1% of gabapentin treated patients with epilepsy participating in Gabapentin placebo controlled trials. In these studies, either gabapentin or placebo was added to the patient's current antiepileptic drug therapy. Adverse events were usually mild to moderate in intensity.

Table 3: Adverse events reported in at least 1% of participants in Gabapentin placebo- controlled Trials

Body system/Adverse events	Gabapentin ^a n=543 (%)	Placebo ^a n=378 (%)
Body as a whole		
Fatigue	11.0	5.0
Weight increase	2.9	1.6
Back pain	1.8	0.5
Peripheral oedema	1.7	0.5
Viral infection	1.3	2.1
Fever	1.3	1.3
Cardiovascular		
Vasodilatation	1.1	0.3
Digestive system		
Nausea and /or vomiting	6.1	7.1
Dyspepsia	2.2	0.5
Abdominal pain	1.8	2.4
Mouth or throat dry	1.7	0.5
Constipation	1.5	0.8
Dental abnormalities	1.5	0.3
Diarrhoea	1.3	2.1
Increased appetite	1.1	0.8
Haematological and lymphatic systems		
Leukopenia	1.1	0.5
Musculoskeletal system		
Myalgia	2.0	1.9

Body system/Adverse events	Gabapentin^a n=543 (%)	Placebo^a n=378 (%)
Fracture	1.1	0.8
Nervous system		
Somnolence	19.3	8.7
Dizziness	17.1	6.9
Ataxia	12.5	5.6
Nystagmus	8.3	4.0
Headache	8.1	9.0
Tremor	6.8	3.2
Nervousness	2.4	1.9
Dysarthria	2.4	0.5
Amnesia	2.2	0.0
Depression	1.8	1.1
Thinking abnormal	1.7	1.3
Confusion	1.7	1.9
Twitching	1.3	0.5
Coordination abnormal	1.1	0.3
Insomnia	1.1	1.9
Emotional lability	1.1	1.3
Respiratory system		
Rhinitis	4.1	3.7
Pharyngitis	2.8	1.6
Coughing	1.8	1.3
Skin and appendages		
Rash	1.5	1.6
Abrasion	1.3	0.0
Pruritus	1.3	0.5
Acne	1.1	1.3
Urogenital system		
Impotence	1.5	1.1
Special senses		
Diplopia	5.9	1.9
Amblyopia ^b	4.2	1.1
Laboratory deviations		
WBC decreased	1.1	0.5

^a Plus background antiepileptic drug therapy

^b Amblyopia was often described as blurred vision

Other adverse events observed during all clinical studies

Those events that occurred in at least 1% of the study participants with epilepsy who received gabapentin as adjunctive therapy in any clinical study and that are not described in the previous section as frequently occurring treatment emergent signs and symptoms during placebo controlled studies are summarised below:

- **Body as a whole.** Asthenia, malaise, facial oedema.
- **Cardiovascular system.** Hypertension.

- **Digestive system.** Flatulence, anorexia, gingivitis.
- **Haemic, lymphatic systems.** Purpura (most often described as bruises resulting from physical trauma).
- **Musculoskeletal system.** Arthralgia.
- **Nervous system.** Vertigo, hyperkinesia, increased, decreased or absent reflexes, paraesthesia, anxiety, hostility.
- **Respiratory system.** Pneumonia.
- **Urogenital system.** Urinary tract infection.
- **Special senses.** Abnormal vision, most often described as a visual disturbance.

Adults over 18 years of age with neuropathic pain

The most commonly observed adverse events reported with the use of gabapentin in adults over 18 years of age with neuropathic pain, seen in at least twice the frequency among placebo treated patients, were dry mouth, peripheral oedema, weight gain, abnormal gait, amnesia, ataxia, confusion, dizziness, hypoaesthesia, somnolence, abnormal thinking, vertigo, rash and amblyopia.

Of the 821 adults who received gabapentin, in the painful diabetic peripheral neuropathy and postherpetic neuralgia trials, 13.2% discontinued treatment because of an adverse event. The adverse events most commonly associated with withdrawal were dizziness (4.4%), somnolence (2.9%) and nausea (1.3%). See Table 4.

Table 4: Summary of treatment-emergent signs and symptoms in $\geq 1\%$ of Gabapentin treated patients in neuropathic pain placebo-controlled studies

COSTART Body system / adverse event	Gabapentin n=821		Placebo n=537	
	N of Pts	(%)	N of Pts	(%)
Body as a whole				
Abdominal pain	23	2.8	17	3.2
Accidental injury	32	3.9	17	3.2
Asthenia	41	5.0	25	4.7
Back pain	19	2.3	8	1.5
Flu syndrome	21	2.6	14	2.6
Headache	45	5.5	33	6.1
Infection	38	4.6	40	7.4
Pain	30	3.7	36	6.7
Digestive system				
Constipation	19	2.3	9	1.7
Diarrhoea	46	5.6	24	4.5
Dry mouth	27	3.3	5	0.9
Dyspepsia	16	1.9	10	1.9
Flatulence	14	1.7	6	1.1

COSTART Body system / adverse event	Gabapentin n=821		Placebo n=537	
	N of Pts	(%)	N of Pts	(%)
Nausea	45	5.5	29	5.4
Vomiting	16	1.9	13	2.4
Metabolic and nutritional				
Peripheral oedema	44	5.4	14	2.6
Weight gain	14	1.7	0	0.0
Nervous system				
Abnormal gait	9	1.1	0	0.0
Amnesia	15	1.8	3	0.6
Ataxia	19	2.3	0	0.0
Confusion	15	1.8	5	0.9
Dizziness	173	21.1	35	6.5
Hypoaesthesia	11	1.3	3	0.6
Somnolence	132	16.1	27	5.0
Thinking abnormal	12	1.5	0	0.0
Tremor	9	1.1	6	1.1
Vertigo	8	1.0	2	0.4
Respiratory system				
Dyspnoea	9	1.1	3	0.6
Pharyngitis	15	1.8	7	1.3
Skin and appendages				
Rash	14	1.7	4	0.7
Special senses				
Amblyopia	15	1.8	2	0.4

Post-marketing Experience

The following adverse events have been reported in patients receiving gabapentin post-marketing, however, the data are insufficient to support an estimate of their incidence or to establish causation.

Sudden, unexplained deaths have been reported where a causal relationship to treatment with gabapentin has not been established. Additional post-marketing adverse events reported include blood creatine phosphokinase increased, rhabdomyolysis, abnormal liver function, acute kidney failure, agitation, allergic reaction including urticaria, alopecia, anaphylaxis, anaemia, angioedema, hyperglycemia and hypoglycemia (most often observed in patients with diabetes), breast hypertrophy, gynaecomastia, cardiac arrest, chest pain, convulsions, depersonalisation, drug rash with eosinophilia and systemic symptoms, erythema multiforme, hypersensitivity including systemic reactions, hyponatraemia, jaundice, loss of consciousness, movement disorders such as choreoathetosis, dyskinesia and dystonia, myoclonus, palpitation, pancreatitis, renal impairment, speech disorder, sexual dysfunction, Stevens-Johnson syndrome (including changes in libido, ejaculation disorders and anorgasmia), tachycardia, thrombocytopenia, tinnitus, urinary incontinence and symptoms of psychosis such as delusions, hallucinations, and thinking abnormal.

Generalised oedema, hepatitis, hypotension, neuropathy/peripheral neuropathy and syncope have been rarely reported.

Adverse events following the abrupt discontinuation of gabapentin have also been reported. The most frequently reported events were anxiety, insomnia, nausea, pain, and sweating.

Some cases of hypomania have been reported after commencement of gabapentin. In each case, other anticonvulsants had been used concurrently, and symptoms of hypomania resolved following a reduction in dosage or cessation of the drug.

Reporting suspected adverse effects

Reporting suspected adverse reactions after registration of the medicinal product is important. It allows continued monitoring of the benefit-risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at <http://www.tga.gov.au/reporting-problems>.

4.9 OVERDOSE

Symptoms

Symptoms of an overdose included somnolence, ataxia, dizziness, double vision, nystagmus, slurred speech, drowsiness, lethargy, mild hypotension and gastrointestinal symptoms including diarrhoea. Gabapentin overdose alone has not been reported to produce significant cardiotoxicity.

Overdoses as high as 108 g have been reported with full recovery following symptomatic therapy. Reduced absorption of gabapentin at higher doses may limit drug absorption at the time of overdosing and, hence, minimise toxicity from overdoses.

Management

There is no specific antidote for gabapentin; treatment is symptomatic. The patient should be monitored closely and given supportive care where necessary to maintain vital functions. Overdoses may involve other concurrent medications and should be treated accordingly.

Activated charcoal may reduce absorption of the drug if given within one hour after ingestion. In patients who are not fully conscious or have impaired gag reflex, consideration should be given to administering activated charcoal via nasogastric tube once the airway is protected.

Gabapentin can be removed by haemodialysis. Although haemodialysis has not been performed in the few overdose cases reported, it may be indicated by the patient's clinical state or in patients with significant renal impairment.

Ipecac induced emesis is not recommended because of the potential for CNS depression.

Contact the Poisons Information Centre for advice on the management of an overdose.

5 PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

Mechanism of action

The mechanism by which gabapentin exerts its anticonvulsant action is unknown. Gabapentin is structurally related to the neurotransmitter GABA (gamma-aminobutyric acid) but its mechanism of action is different from that of several other drugs that interact with GABA synapses, including valproate, barbiturates, benzodiazepines, GABA transaminase inhibitors, GABA uptake inhibitors, GABA agonists and GABA prodrugs. *In vitro* studies with radiolabelled gabapentin have characterised a novel peptide binding site in rat brain tissues, including neocortex and hippocampus, which may relate to the anticonvulsant activity of gabapentin and its structural derivatives. However, the identification and function of the gabapentin binding site remains to be elucidated. Gabapentin at relevant clinical concentrations does not bind to other common drug or neurotransmitter receptors of the brain including GABA_A, GABA_B, benzodiazepine, glutamate, glycine or N-methyl-d aspartate (NMDA) receptors.

Gabapentin does not interact with sodium channels *in vitro* and so differs from phenytoin and carbamazepine. Several test systems ordinarily used to assess activity at the NMDA receptor complex have been examined. Results are contradictory. Accordingly, no general statement about the effects, if any, of gabapentin at the NMDA receptor can be made. Gabapentin slightly reduces the release of monoamine neurotransmitters *in vitro*. Gabapentin administration to rats increases GABA turnover in several brain regions in a manner similar to valproate sodium, although in different regions of the brain. The relevance of these various actions of gabapentin to the anticonvulsant effects remains to be established. In animals, gabapentin readily enters the brain and shows efficacy in some, but not all, seizure models. These animal models included genetic models of seizures, and seizures induced by maximal electroshock, from chemical convulsants including inhibitors of GABA synthesis.

Clinical trials

The effectiveness of gabapentin as adjunctive therapy was established in three multicentre, placebo controlled, double blind, parallel group clinical trials in 705 adults with refractory partial seizures. The patients enrolled had a history of at least four partial seizures per month in spite of receiving one or more antiepileptic drugs at therapeutic levels and were observed on their established antiepileptic drug regimen during a 12 week baseline period. In patients continuing to have at least two (or four in some studies) seizures per month, Gabapentin or placebo was then added on to the existing therapy during a 12 week treatment period. Effectiveness was assessed primarily on the basis of the percent of patients with a 50% or greater reduction in seizure frequency from baseline to treatment (the responder rate) and a derived measure called response ratio, a measure of change defined as $(T - B)/(T + B)$, where B is the patient's baseline seizure frequency and T is the patient's seizure frequency during treatment. Response ratio is distributed within the range -1 to +1. A zero value indicates no change while complete elimination of seizures would give a value of -1. Increased seizure rates would give positive values. A response ratio of -0.33 corresponds to a 50% reduction in seizure frequency. The results given below are for all partial seizures in the intent to treat (all patients who received any doses of treatment) population in each study, unless otherwise indicated.

One study compared Gabapentin 1,200 mg/day three times daily (TID) with placebo. Responder rate was 23% (14/61) in the gabapentin group and 9% (6/66) in the placebo group; the difference between groups was statistically significant. Response ratio was also better in the gabapentin group (-0.199) than in the placebo group (-0.044), a difference that also achieved statistical significance.

A second study primarily compared gabapentin 1,200 mg/day TID (n = 101) with placebo (n = 98). Additional smaller gabapentin dosage groups (600 mg/day, n = 53; 1,800 mg/day, n = 54) were also studied for information regarding dose response. Responder rate was higher in the gabapentin 1,200 mg/day group (16%) than in the placebo group (8%), but the difference was not statistically significant. The responder rate at 600 mg (17%) was also not significantly higher than in the placebo, but the responder rate in the 1,800 mg group (26%) was statistically significantly superior to the placebo rate. Response ratio was better in the gabapentin 1,200 mg/day group (-0.103) than in the placebo group (-0.022); but this difference was also not statistically significant (p = 0.224). A better response was seen in the gabapentin 600 mg/day group (-0.105) and 1,800 mg/day group (-0.222) than in the 1,200 mg/day group, with the 1,800 mg/day group achieving statistical significance compared to the placebo group.

A third study compared gabapentin 900 mg/day TID (n = 111) and placebo (n = 109). An additional gabapentin 1,200 mg/day dosage group (n = 52) provided dose response data. A statistically significant difference in responder rate was seen in the gabapentin 900 mg/day group (22%) compared to that in the placebo group (10%). Response ratio was also statistically significantly superior in the gabapentin 900 mg/day group (-0.119) compared to that in the placebo group (-0.027), as was response ratio in gabapentin 1,200 mg/day (-0.184) compared to placebo.

A one week, prospective, multicentre, randomised, double blind, placebo lead in, parallel group study compared the tolerability of gabapentin administered as an initial dosage of 900 mg/day versus a dosage titrated to 900 mg/day over three days (i.e. 300 mg on day 1, 600 mg on day 2, 900 mg on day 3). 781 patients (titrated = 383, nontitrated = 388) involved in the study had partial seizures which were not adequately controlled with one or two other antiepileptic drugs. For the MITT population, on both the first day of active medication, and all five days of active medication, there were no clinically meaningful treatment group differences in the incidences of fatigue, ataxia and somnolence (i.e. the upper 95% confidence limit for the difference < 7.5%). Only the difference in dizziness exceeded this upper confidence limit (upper confidence limit = 10.7% for the first day and 11.3% for all five days), with the nontitrated group reporting the higher incidence, however it did not lead to increased discontinuation in this group.

The safety and efficacy of gabapentin administered as adjunctive therapy for the treatment of partial seizures in paediatric patients aged 3 to 12 years were assessed in two randomised, double blind, parallel group, placebo controlled, multicentre clinical studies. The studies were conducted in 247 children who had refractory partial seizures and were receiving one to three standard antiepileptic drugs. After a six week baseline phase, during which patients received their prescribed antiepileptic drugs, there was a 12 week double blind treatment phase. Patients who had experienced a minimum of four seizures during baseline were randomised and had either gabapentin (25 to 35 mg/kg/day) or placebo added to their baseline AEDs. The primary analysis of RRatio (MITT population) demonstrated that gabapentin was significantly better than placebo in controlling

partial seizures ($p = 0.04$). Results for the ITT population did not show a significant difference in RRatio between the treatment groups. Further analysis using rank transformed data was performed as the data showed evidence of non-normality of distribution. Results of this analysis showed that mean RRatio was significantly lower (better) for the gabapentin treatment group than for the placebo group in both the MITT ($p = 0.01$) and ITT ($p = 0.03$) populations.

The efficacy and safety of gabapentin for the treatment of neuropathic pain in adults over 18 years of age were assessed in two randomised, double blind, parallel group, placebo controlled, multicentre studies. One study examined the efficacy and safety of gabapentin in the treatment of painful diabetic peripheral neuropathy and the other study was conducted in patients with postherpetic neuralgia. The studies were of a similar design. Following a baseline screening week and randomisation, gabapentin was titrated from 900 mg/day to 1,800 mg, 2,400 mg and 3,600 mg/day divided into three times a day dosing consecutively over the first four weeks of the study. Patients were then maintained at the maximum dose that was tolerated for the remaining four weeks. The primary efficacy measure used in both studies was change from baseline to the final week in mean pain score obtained from daily pain diaries (pain was measured using an eleven point Likert scale). Several secondary outcomes were also assessed, including the Short Form McGill Pain Questionnaire (SF-MPQ) (sensory, affective and total pain scores), SF-MPQ visual analogue scale (VAS) and present pain intensity scale (PPI), mean sleep interference score, Patient and Clinical Global Impression of Change (PGIC and CGIC) and the quality of life measures SF-36 Quality of Life Questionnaire (QOL) and Profile of Mood States (POMS).

Results from both studies demonstrated that gabapentin provided statistically significantly greater improvement in relief of neuropathic pain than placebo. In patients with painful diabetic peripheral neuropathy, mean pain score decreased by 2.6 in patients receiving gabapentin and 1.4 in patients receiving placebo ($p < 0.001$). In the postherpetic neuralgia study, mean pain score decreased by 2.1 in patients receiving gabapentin and 0.5 in patients receiving placebo ($p < 0.001$). gabapentin was significantly better than placebo in controlling pain from week 2 of both studies ($p < 0.001$). Sleep interference scores, Short Form McGill sensory, affective and total pain scores, VAS and PPI scale as well as PGIC, CGIC and some of the quality of life measures showed significant differences in favour of Gabapentin.

5.2 PHARMACOKINETIC PROPERTIES

All pharmacological actions following gabapentin administration are due to the activity of the parent compound; gabapentin is not appreciably metabolised in humans.

Absorption

Gabapentin bioavailability is not dose proportional, i.e. as the dose is increased, the bioavailability is decreased. A 400 mg dose, for example, has about 25% less bioavailability than a 100 mg dose. Over the recommended dose range of 300 to 600 mg three times a day, however, the difference in bioavailability is not large, and bioavailability is about 60%. The bioavailability of the 800 mg dose was found to be approximately 35% in single and multiple dose studies. The absolute bioavailability of gabapentin following daily doses of 1,200, 2,400, 3,600 and 4,800 mg/day averaged 47%, 34%, 33% and 27%, respectively. Food has no effect on the rate and extent of absorption of gabapentin.

Distribution

Gabapentin circulates largely unbound (< 3%) to plasma proteins. The apparent volume of distribution of gabapentin after 150 mg intravenous administration is 58 +/- 6 L (mean +/- standard deviation (SD)). In patients with epilepsy, steady-state predose (C_{min}) concentrations of gabapentin in cerebrospinal fluid were approximately 20% of the corresponding plasma concentrations.

Metabolism

Gabapentin is not appreciably metabolised in humans.

Excretion

Gabapentin is eliminated from the systemic circulation by renal excretion as unchanged drug.

The elimination half-life of gabapentin is five to seven hours and is unaltered by dose or following multiple dosing. Gabapentin elimination rate constant, plasma clearance and renal clearance are directly proportional to creatinine clearance. In elderly patients and in patients with impaired renal function, gabapentin plasma clearance is reduced. Gabapentin can be removed by haemodialysis.

Dosage adjustment is recommended in patients with compromised renal function or undergoing haemodialysis (see **Section 4.2 Dose and method of administration**).

Special populations

Patients with renal insufficiency

Subjects with renal insufficiency (mean creatinine clearance ranging from 13 to 114 mL/minute) were administered an oral dose of gabapentin 400 mg. The mean gabapentin half-life ranged from about 6.5 hours (patients with creatinine clearance (Cl_{Cr}) > 60 mL/minute) to 52 hours (Cl_{Cr} < 30 mL/minute) and gabapentin renal clearance ranged from about 90 mL/minute (Cl_{Cr} > 60 mL/minute) to about 10 mL/minute (Cl_{Cr} < 30 mL/minute). Gabapentin dosage should be adjusted in patients with compromised renal function (see **Section 4.2 Dose and method of administration**).

Patients on haemodialysis

In a study in anuric patients, the elimination half-life of gabapentin on nondialysis day was about 132 hours. Dialysis three times a week (four hour duration) lowered the apparent half-life of gabapentin by about 60%, from 132 to 51 hours. Gabapentin dosage should be adjusted in patients undergoing haemodialysis (see **Section 4.2 Dose and method of administration**).

Elderly (≥ 65 years) patients

In a study examining the effect of age on the elimination of gabapentin, apparent oral clearance (CL/F) of gabapentin decreased as age increased, from about 225 mL/minute in those under 30 years of age to about 125 mL/minute in those over 70 years of age. Renal clearance also declined with age, however the decline in the renal clearance of gabapentin can largely be explained by the decline in renal function. Reduction of gabapentin dose may be required in patients who have age related compromised renal function.

Paediatric patients

Gabapentin pharmacokinetics were determined in 24 healthy paediatric subjects between the ages of 4 and 12 years. In general, plasma gabapentin concentrations in these children are similar to those in adults.

5.3 PRECLINICAL SAFETY DATA

Genotoxicity

There is no evidence that gabapentin has genotoxic potential. It was not mutagenic *in vitro* in standard assays using bacterial or mammalian cells. Gabapentin did not induce structural chromosome aberrations in mammalian cells *in vitro* or *in vivo*, and did not induce micronucleus formation in the bone marrow of hamsters.

Carcinogenicity

Gabapentin was given in the diet to mice at 200, 600 and 2,000 mg/kg/day and to rats at 250, 1,000 and 2,000 mg/kg/day for two years. A statistically significant increase in the incidence of pancreatic acinar cell adenoma and carcinoma was found only in male rats at the highest dose. Peak plasma drug concentrations and areas under the concentration time curve in rats at 2,000 mg/kg/day are 14 times higher than plasma concentrations in humans given the recommended maximum tolerated dose of 2,400 mg/day. The pancreatic acinar cell tumours in male rats are low grade malignancies, did not metastasise or invade surrounding tissue and were similar to those seen in concurrent controls. The relevance of these pancreatic acinar cell tumours in male rats to carcinogenic risk in humans is unclear.

6 PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

Gabapentin tablets contain maize starch, copovidone, poloxamer, hydroxypropylcellulose, magnesium stearate and purified talc.

6.2 INCOMPATIBILITIES

Incompatibilities were either not assessed or not identified as part of the registration of this medicine.

6.3 SHELF LIFE

In Australia, information on the shelf life can be found on the public summary of the Australian Register of Therapeutic Goods (ARTG). The expiry date can be found on the packaging.

6.4 SPECIAL PRECAUTIONS FOR STORAGE

Store below 25°C.

6.5 NATURE AND CONTENTS OF CONTAINER

GAPENTIN 600 mg tablets are available in blister pack (PVC/PVDC/Al) of 100 tablets.

GAPENTIN 800 mg tablets are available in blister pack (PVC/PVDC/Al) of 100 tablets.

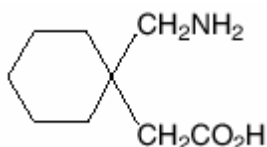
6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

In Australia, any unused medicine or waste material should be disposed of by taking to your local pharmacy.

6.7 PHYSICOCHEMICAL PROPERTIES

Chemical structure

Gabapentin is described as 1-(aminomethyl) cyclohexanecarboxylic acid with an empirical formula of $C_9H_{17}NO_2$ and a molecular weight of 171.24. The molecular structure of gabapentin is:



CAS number

CAS 60142-96-3

7 MEDICINE SCHEDULE (POISONS STANDARD)

S 4- Prescription Only Medicine

8 SPONSOR

Arrow Pharma Pty Ltd
15-17 Chapel Street
Cremorne
VIC, 3121
Australia

9 DATE OF FIRST APPROVAL

3rd June 2010

10 DATE OF REVISION

2nd May 2018

SUMMARY TABLE OF CHANGES

Section Changed	Summary of new information
n/a	Reformatting
4.4	Safety Related Changes
4.5	Safety Related Changes