ABILIFY® (aripiprazole) Tablets
ABILIFY DISCMELT® (aripiprazole) Orally Disintegrating Tablets
ABILIFY® (aripiprazole) Oral Solution

℞ ONLY

Brief Summary of Prescribing Information. For complete prescribing information consult official package insert.

WARNINGS: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS and SUICIDALITY AND ANTIDEPRESSANT DRUGS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. ABILIFY (aripiprazole) is not approved for the treatment of patients with dementia-related psychosis [see *Warnings and Precautions*].

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of adjunctive ABILIFY or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical *worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for* close observation and communication with the prescriber. ABILIFY is not approved for use in pediatric patients with depression [see *Warnings and Precautions*].

INDICATIONS AND USAGE: ABILIFY (aripiprazole) is indicated for use as an adjunctive therapy to antidepressants for the acute treatment of Major Depressive Disorder in adults [see *Clinical Studies (14.3) in Full Prescribing Information*].

CONTRAINDICATIONS: Known hypersensitivity reaction to ABILIFY. Reactions have ranged from pruritus/urticaria to anaphylaxis [see *Adverse Reactions*].

WARNINGS AND PRECAUTIONS: Use in Elderly Patients with Dementia-Related Psychosis - Increased Mortality: Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. ABILIFY is not approved for the treatment of patients with dementia-related psychosis [see *Boxed Warning*].

Cerebrovascular Adverse Events, Including Stroke: In placebo-controlled clinical studies (two flexible dose and one fixed dose study) of dementia-related psychosis, there was an increased incidence of cerebrovascular adverse events (eg, stroke, transient ischemic attack), including fatalities, in aripiprazole-treated patients (mean age: 84 years; range: 78-88 years). In the fixed-dose study, there was a statistically significant dose response relationship for cerebrovascular adverse events in patients treated with aripiprazole. Aripiprazole is not approved for the treatment of patients with dementia-related psychosis [see also *Boxed Warning*].

Safety Experience in Elderly Patients with Psychosis Associated with Alzheimer's Disease: In three, 10-week, placebo-controlled studies of aripiprazole in elderly patients with psychosis associated with Alzheimer's disease (n=938; mean age: 82.4 years; range: 56-99 years), the treatment-emergent adverse events that were reported at an incidence of ≥3% and aripiprazole incidence at least twice that for placebo were lethargy [placebo 2%, aripiprazole 5%], somnolence (including sedation) [placebo 3%, aripiprazole 8%], and incontinence (primarily, urinary incontinence) [placebo 1%, aripiprazole 5%], excessive salivation [placebo 0%, aripiprazole 4%], and lightheadedness [placebo 1%, aripiprazole 4%]. The safety and efficacy of ABILIFY in the treatment of patients with psychosis associated with dementia have not been established. If the prescriber elects to treat such patients with ABILIFY, vigilance should be exercised, particularly for the emergence of difficulty swallowing or excessive somnolence, which could predispose to accidental injury or aspiration [see also *Boxed Warning*].

Clinical Worsening of Depression and Suicide Risk - Patients with Major Depressive Disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with Major Depressive Disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older.

The pooled analyses of placebo-controlled trials in children and adolescents with MDD, Obsessive Compulsive Disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs. placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) were reported as: **Increases compared to placebo**: <18 (14 additional cases); 18-24 (5 additional cases); and **Decreases compared to placebo**: 25-64 (1 fewer case); ≥65 (6 fewer cases).

No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide.

It is unknown whether the suicidality risk extends to longer-term use, ie, beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression.

***All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical* worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.** The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for Major Depressive Disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality.

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

Families and caregivers of patients being treated with antidepressants for Major Depressive Disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to healthcare providers. Such monitoring should include daily observation by families and caregivers. Prescriptions for ABILIFY should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose.

Screening Patients for Bipolar Disorder: A major depressive episode may be the initial presentation of Bipolar Disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for Bipolar Disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for Bipolar Disorder; such screening should include a detailed psychiatric history, including a family history of suicide, Bipolar Disorder, and depression.

It should be noted that ABILIFY is not approved for use in treating depression in the pediatric population.

Neuroleptic Malignant Syndrome (NMS) - A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) may occur with administration of antipsychotic drugs, including aripiprazole. Rare cases of NMS occurred during aripiprazole treatment in the worldwide clinical database. 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.

The diagnostic evaluation of patients with this syndrome is complicated. In arriving at a diagnosis, it is important to exclude cases where the clinical presentation includes both serious medical illness (eg, pneumonia, systemic infection) and untreated or inadequately treated extrapyramidal signs *and symptoms (EPS). Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever,* and primary central nervous system pathology.

The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for uncomplicated NMS. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrences of NMS have been reported.

Tardive Dyskinesia - A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

The risk of developing tardive dyskinesia and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and, thereby, may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown.

Given these considerations, ABILIFY (aripiprazole) should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who suffer from a chronic illness that (1) is known to respond to antipsychotic drugs and (2) for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically. If signs and symptoms of tardive dyskinesia appear in a patient on ABILIFY, drug discontinuation should be considered. However, some patients may require treatment with ABILIFY despite the presence *of the syndrome.*

Hyperglycemia and Diabetes Mellitus - Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. There have been few reports of hyperglycemia in patients treated with ABILIFY [see *Adverse Reactions*]. Although fewer patients have been treated with ABILIFY, it is not known if this more limited experience is the sole reason for the paucity of such reports. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with Schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies which did not include ABILIFY suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics included in these studies. Because ABILIFY was not marketed at the time these studies were performed, it is not known if ABILIFY is associated with this increased risk. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available.

Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (eg, obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

Orthostatic Hypotension - Aripiprazole may cause orthostatic hypotension, perhaps due to its α_1-adrenergic receptor antagonism. The incidence of orthostatic hypotension-associated events from short-term, placebo-controlled trials of adult patients on oral ABILIFY (n=2467) included (aripiprazole incidence, placebo incidence): orthostatic hypotension (1%, 0.3%), postural dizziness (0.5%, 0.3%), and syncope (0.5%, 0.4%). The incidence of a significant orthostatic change in blood pressure (defined as a decrease in systolic blood pressure ≥20 mmHg accompanied by an increase in heart rate ≥25 when comparing standing to supine values) for aripiprazole was not meaningfully different from placebo (aripiprazole incidence, placebo incidence): in adult oral aripiprazole-treated patients (4%, 2%).

Aripiprazole should be used with caution in patients with known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease, or conditions which would predispose patients to hypotension (dehydration, hypovolemia, and treatment with antihypertensive medications).

Seizures/Convulsions - In short-term, placebo-controlled trials, seizures/convulsions occurred in 0.1% (3/2467) of adult patients treated with oral aripiprazole. As with other antipsychotic drugs, aripiprazole should be used cautiously in patients with a history of seizures or with conditions *that lower the seizure threshold, eg, Alzheimer's dementia. Conditions that lower the seizure threshold may be more prevalent in a population of* 65 years or older.

Potential for Cognitive and Motor Impairment - ABILIFY, like other antipsychotics, may have the potential to impair judgment, thinking, or motor skills. For example, in short-term, placebo-controlled trials, somnolence (including sedation) was reported as follows (aripiprazole incidence, placebo incidence): in adult patients (n=2467) treated with oral ABILIFY (11%, 6%). Somnolence (including sedation) led to discontinuation in 0.3% (8/2467) of adult patients on oral ABILIFY in short-term, placebo-controlled trials. Despite the relatively modest increased incidence of these events compared to placebo, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that therapy with ABILIFY does not affect them adversely.

Body Temperature Regulation - Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing aripiprazole for patients who will be experiencing conditions which may contribute to an elevation in core body temperature (eg, exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration) [see *Adverse Reactions*].

Suicide - The possibility of a suicide attempt is inherent in psychotic illnesses, Bipolar Disorder, and Major Depressive Disorder, and close supervision of high-risk patients should accompany drug therapy. Prescriptions for ABILIFY should be written for the smallest quantity consistent with good patient *management in order to reduce the risk of overdose [see Adverse Reactions].*

In two 6-week, placebo-controlled studies of aripiprazole as adjunctive treatment of Major Depressive Disorder, the incidences of suicidal ideation and suicide attempts were 0% (0/371) for aripiprazole and 0.5% (2/366) for placebo.

Dysphagia - Esophageal dysmotility and aspiration have been associated with antipsychotic drug use, including ABILIFY. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. Aripiprazole and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia [see *Warnings and Precautions* and *Adverse Reactions*].

Use in Patients with Concomitant Illness - Clinical experience with ABILIFY in patients with certain concomitant systemic illnesses is limited [see *Use In Specific Populations*]. ABILIFY has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from premarketing clinical studies [see *Warnings and Precautions*].

ADVERSE REACTIONS: Overall Adverse Reactions Profile - The following are discussed in more detail in other sections of the labeling [see *Boxed Warning* and *Warnings and Precautions*]: Use in Elderly Patients with Dementia-Related Psychosis; Clinical Worsening of Depression and Suicide Risk; Neuroleptic Malignant Syndrome (NMS); Tardive Dyskinesia; Hyperglycemia and Diabetes Mellitus; Orthostatic Hypotension; Seizures/Convulsions; Potential for Cognitive and Motor Impairment; Body Temperature Regulation; Suicide; Dysphagia; Use in Patients with Concomitant Illness.

The most common adverse reactions in adult patients in clinical trials (≥10%) were nausea, vomiting, constipation, headache, dizziness, akathisia, anxiety, insomnia, and restlessness.

Aripiprazole has been evaluated for safety in 13,543 adult patients who participated in multiple-dose, clinical trials in Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Dementia of the Alzheimer's type, Parkinson's disease, and alcoholism, and who had approximately 7619 patient-years of exposure to oral aripiprazole. A total of 3390 patients were treated with oral aripiprazole for at least 180 days and 1933 patients treated with oral aripiprazole had at least 1 year of exposure. Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Clinical Studies Experience - ***Adult Patients Receiving ABILIFY as Adjunctive Treatment of Major Depressive Disorder:*** The following findings are based on a pool of two placebo-controlled trials of patients with Major Depressive Disorder in which aripiprazole was administered at doses of 2 mg to 20 mg as adjunctive treatment to continued antidepressant therapy.

Adverse Reactions Associated with Discontinuation of Treatment: The incidence of discontinuation due to adverse reactions was 6% for adjunctive aripiprazole-treated patients and 2% for adjunctive placebo-treated patients.

Commonly Observed Adverse Reactions: The commonly observed adverse reactions associated with the use of adjunctive aripiprazole in patients with Major Depressive Disorder (incidence of 5% or greater and aripiprazole incidence at least twice that for placebo) were: akathisia, restlessness, insomnia, constipation, fatigue, and blurred vision.

Less Common Adverse Reactions: The following treatment-emergent reactions reported at an incidence of ≥2%, rounded to the nearest percent, with adjunctive aripiprazole (doses ≥2 mg/day), and at a greater incidence with adjunctive aripiprazole than with adjunctive placebo during short-term (up to 6 weeks), placebo-controlled trials (aripiprazole + ADT n=371, placebo + ADT n=366), respectively, were: akathisia (25%, 4%), restlessness (12%, 2%), fatigue (8%, 4%), insomnia (8%, 2%), somnolence (6%, 4%), upper respiratory tract infection (6%, 4%), blurred vision (6%, 1%), tremor (5%, 4%), constipation (5%, 2%), arthralgia (4%, 3%), dizziness (4%, 2%), sedation (4%, 2%), increased appetite (3%, 2%), weight increased (3%, 2%), disturbance in attention (3%, 1%), feeling jittery (3%, 1%), myalgia (3%, 1%), and extrapyramidal disorder (2%, 0%). ADT= Antidepressant Therapy.

Dose-Related Adverse Reactions:

Extrapyramidal Symptoms: In the short-term, placebo-controlled trials in Major Depressive Disorder, the incidence of reported EPS-related events, excluding events related to akathisia, for adjunctive aripiprazole-treated patients was 8% vs. 5% for adjunctive placebo-treated patients; and the incidence of akathisia-related events for adjunctive aripiprazole-treated patients was 25% vs. 4% for adjunctive placebo-treated patients. Objectively collected data from those trials was collected on the Simpson Angus Rating Scale (for EPS), the Barnes Akathisia Scale (for akathisia), and the Assessments of Involuntary Movement Scales (for dyskinesias). In the Major Depressive Disorder trials, the Simpson Angus Rating Scale and the Barnes Akathisia Scale showed a significant difference between adjunctive aripiprazole and adjunctive placebo (aripiprazole, 0.31; *placebo, 0.03 and aripiprazole, 0.22; placebo, 0.02). Changes in the Assessments of Involuntary Movement Scales were similar for the adjunctive* aripiprazole and adjunctive placebo groups.

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 drugs. An elevated risk of acute dystonia is observed in males and younger age groups.

Laboratory Test Abnormalities: In the 6-week trials of aripiprazole as adjunctive therapy for Major Depressive Disorder, there were no clinically important differences between the adjunctive aripiprazole-treated and adjunctive placebo-treated patients in the median change from baseline in prolactin, fasting glucose, HDL, LDL, or total cholesterol measurements. The median % change from baseline in triglycerides was 5% for adjunctive aripiprazole-treated patients vs. 0% for adjunctive placebo-treated patients.

Weight Gain: In the trials adding aripiprazole to antidepressants, patients first received 8 weeks of antidepressant treatment followed by 6 weeks of adjunctive aripiprazole or placebo in addition to their ongoing antidepressant treatment. The mean weight gain with adjunctive aripiprazole was 1.7 kg vs. 0.4 kg with adjunctive placebo. The proportion of patients meeting a weight gain criterion of ≥7% of body weight was 5% with adjunctive aripiprazole compared to 1% with adjunctive placebo.

ECG Changes: Between group comparisons for a pooled analysis of placebo-controlled trials in patients with Major Depressive Disorder revealed no significant differences between oral aripiprazole and placebo in the proportion of patients experiencing potentially important changes in ECG parameters. Aripiprazole was associated with a median increase in heart rate of 2 beats per minute compared to no increase among placebo patients.

Other Adverse Reactions Observed During the Premarketing Evaluation of Aripiprazole: Following is a list of MedDRA terms that reflect adverse reactions as defined in *Adverse Reactions* reported by patients treated with oral aripiprazole at multiple doses ≥2 mg/day during any phase of a trial within the database of 13,543 adult patients, oral aripiprazole excluding those events already listed as adverse reactions in other parts of Full Prescribing Information, or those considered in *Warnings and Precautions*. Although the reactions reported occurred during treatment with aripiprazole, they were not necessarily caused by it.

Adults: Oral Administration - *Blood and Lymphatic System Disorders:* ≥*1/1000 patients and <1/100 patients* - leukopenia, neutropenia, thrombocytopenia; *Cardiac Disorders:* ≥*1/1000 patients and <1/100 patients* - bradycardia, palpitations, cardiopulmonary failure, myocardial infarction, cardio-respiratory arrest, atrioventricular block, extrasystoles, sinus tachycardia, atrial fibrillation, angina pectoris, myocardial ischemia; *<1/1000 patients* - atrial flutter, supraventricular tachycardia, ventricular tachycardia; *Eye Disorders:* ≥*1/1000 patients and <1/100 patients* - photophobia, diplopia, eyelid edema, photopsia; *Gastrointestinal Disorders:* ≥*1/1000 patients and <1/100 patients* - gastro-esophageal reflux disease, swollen tongue, esophagitis; *<1/1000 patients* - pancreatitis; *General Disorders and Administration Site Conditions:* ≥*1/100 patients* - asthenia, peripheral edema, irritability, chest pain; ≥*1/1000 patients and <1/100 patients* - face edema, thirst, angioedema; *<1/1000 patients* - hypothermia; *Hepatobiliary Disorders: <1/1000 patients* - hepatitis, jaundice; *Immune System Disorders:* ≥*1/1000 patients and <1/100 patients* - hypersensitivity; *Injury, Poisoning, and Procedural Complications:* ≥*1/100 patients* - fall; ≥*1/1000 patients and <1/100 patients* - self mutilation; *<1/1000 patients* - heat stroke; *Investigations:* ≥*1/100 patients* - weight decreased, creatine phosphokinase increased; ≥*1/1000 patients and <1/100 patients* - hepatic enzyme increased, blood glucose increased, blood prolactin increased, blood urea increased, electrocardiogram QT prolonged, blood creatinine increased, blood bilirubin increased; *<1/1000 patients* - blood lactate dehydrogenase increased, glycosylated hemoglobin increased, gamma-glutamyl transferase increased; *Metabolism and Nutrition Disorders:* ≥*1/100 patients* - decreased appetite; ≥*1/1000 patients and <1/100 patients* - hyperlipidemia, anorexia, diabetes mellitus (including blood insulin increased, carbohydrate tolerance decreased, diabetes mellitus non-insulin-dependent, glucose tolerance impaired, glycosuria, glucose urine, glucose urine present), hyperglycemia, hypokalemia, hyponatremia, hypoglycemia, polydipsia; *<1/1000 patients* - diabetic ketoacidosis; *Musculoskeletal and Connective Tissue Disorders:* ≥*1/1000 patients and <1/100 patients* - muscle rigidity, muscular weakness, muscle tightness, mobility decreased; *<1/1000 patients* - rhabdomyolysis; *Nervous System Disorders:* ≥*1/100 patients* - coordination abnormal; ≥*1/1000 patients and <1/100 patients* - speech disorder, parkinsonism, memory impairment, cogwheel rigidity, cerebrovascular accident, hypokinesia, tardive dyskinesia, hypotonia, myoclonus, hypertonia, akinesia, bradykinesia; *<1/1000 patients* - Grand Mal convulsion, choreoathetosis; *Psychiatric Disorders:* ≥*1/100 patients* - suicidal ideation; ≥*1/1000 patients and <1/100 patients* - aggression, loss of libido, suicide attempt, hostility, libido increased, anger, anorgasmia, delirium, intentional self injury, completed suicide, tic, homicidal ideation; *<1/1000 patients* - catatonia, sleep walking; *Renal and Urinary Disorders:* ≥*1/1000 patients and <1/100 patients* - urinary retention, polyuria, nocturia; *Reproductive System and Breast Disorders:* ≥*1/1000 patients and <1/100 patients* - menstruation irregular, erectile dysfunction, amenorrhea, breast pain; *<1/1000 patients* - gynaecomastia, priapism; *Respiratory, Thoracic, and Mediastinal Disorders:* ≥*1/100 patients* - nasal congestion, dyspnea, pneumonia aspiration; *Skin and Subcutaneous Tissue Disorders:* ≥*1/100 patients* - rash (including erythematous, exfoliative, generalized, macular, maculopapular, papular rash; acneiform, allergic, contact, exfoliative, seborrheic dermatitis, neurodermatitis, and drug eruption), hyperhydrosis; ≥*1/1000 patients and <1/100 patients* - pruritus, photosensitivity reaction, alopecia, urticaria; *Vascular Disorders:* ≥*1/100 patients* - hypertension; ≥*1/1000 patients and <1/100 patients* - hypotension.

Postmarketing Experience - The following adverse reactions have been identified during post-approval use of ABILIFY (aripiprazole). Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to establish a causal relationship to drug exposure: rare occurrences of allergic reaction (anaphylactic reaction, angioedema, laryngospasm, pruritus/urticaria, or oropharyngeal spasm), and blood glucose fluctuation.

DRUG INTERACTIONS: Given the primary CNS effects of aripiprazole, caution should be used when ABILIFY is taken in combination with other centrally-acting drugs or alcohol. Due to its alpha adrenergic antagonism, aripiprazole has the potential to enhance the effect of certain antihypertensive agents.

Potential for Other Drugs to Affect ABILIFY - Aripiprazole is not a substrate of CYP1A1, CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, or CYP2E1 enzymes. Aripiprazole also does not undergo direct glucuronidation. This suggests that an interaction of aripiprazole with inhibitors or inducers of these enzymes, or other factors, like smoking, is unlikely.

Both CYP3A4 and CYP2D6 are responsible for aripiprazole metabolism. Agents that induce CYP3A4 (eg, carbamazepine) could cause an increase in aripiprazole clearance and lower blood levels. Inhibitors of CYP3A4 (eg, ketoconazole) or CYP2D6 (eg, quinidine, fluoxetine, or paroxetine) can inhibit aripiprazole elimination and cause increased blood levels.

Ketoconazole and Other CYP3A4 Inhibitors: Coadministration of ketoconazole (200 mg/day for 14 days) with a 15 mg single dose of aripiprazole increased the AUC of aripiprazole and its active metabolite by 63% and 77%, respectively. The effect of a higher ketoconazole dose (400 mg/day) has not been studied. When ketoconazole is given concomitantly with aripiprazole, the aripiprazole dose should be reduced to one-half of its normal dose. Other strong inhibitors of CYP3A4 (itraconazole) would be expected to have similar effects and need similar dose reductions; moderate inhibitors (erythromycin, grapefruit juice) have not been studied. When the CYP3A4 inhibitor is withdrawn from the combination therapy, the aripiprazole dose should be increased.

Quinidine and Other CYP2D6 Inhibitors: Coadministration of a 10 mg single dose of aripiprazole with quinidine (166 mg/day for 13 days), a potent inhibitor of CYP2D6, increased the AUC of aripiprazole by 112% but decreased the AUC of its active metabolite, dehydro-aripiprazole, by 35%. Aripiprazole dose should be reduced to one-half of its normal dose when quinidine is given concomitantly with aripiprazole. Other significant inhibitors of CYP2D6, such as fluoxetine or paroxetine, would be expected to have similar effects and should lead to similar dose reductions. When the CYP2D6 inhibitor is withdrawn from the combination therapy, the aripiprazole dose should be increased. When adjunctive ABILIFY is administered to patients with Major Depressive Disorder, ABILIFY should be administered without dosage adjustment as specified in *Dosage and Administration (2.3)* in Full Prescribing Information.

Carbamazepine and Other CYP3A4 Inducers: Coadministration of carbamazepine (200 mg twice daily), a potent CYP3A4 inducer, with aripiprazole (30 mg/day) resulted in an approximate 70% decrease in C_{max} and AUC values of both aripiprazole and its active metabolite, dehydro-aripiprazole. When carbamazepine is added to aripiprazole therapy, aripiprazole dose should be doubled. Additional dose increases should be based on clinical evaluation. When carbamazepine is withdrawn from the combination therapy, the aripiprazole dose should be reduced.

Potential for ABILIFY to Affect Other Drugs - Aripiprazole is unlikely to cause clinically important pharmacokinetic interactions with drugs metabolized by cytochrome P450 enzymes. In *in vivo* studies, 10 mg/day to 30 mg/day doses of aripiprazole had no significant effect on metabolism by CYP2D6 (dextromethorphan), CYP2C9 (warfarin), CYP2C19 (omeprazole, warfarin), and CYP3A4 (dextromethorphan) substrates. Additionally, aripiprazole and dehydro-aripiprazole did not show potential for altering CYP1A2-mediated metabolism *in vitro*. No effect of aripiprazole was seen on the pharmacokinetics of lithium or valproate.

Alcohol: There was no significant difference between aripiprazole coadministered with ethanol and placebo coadministered with ethanol on performance of gross motor skills or stimulus response in healthy subjects. As with most psychoactive medications, patients should be advised to avoid alcohol while taking ABILIFY.

Drugs Having No Clinically Important Interactions with ABILIFY - Famotidine: Coadministration of aripiprazole (given in a single dose of 15 mg) with a 40 mg single dose of the H_2 antagonist famotidine, a potent gastric acid blocker, decreased the solubility of aripiprazole and, hence, its rate of absorption, reducing by 37% and 21% the C_{max} of aripiprazole and dehydro-aripiprazole, respectively, and by 13% and 15%, respectively, the extent of absorption (AUC). No dosage adjustment of aripiprazole is required when administered concomitantly with famotidine.

Valproate: When valproate (500 mg/day-1500 mg/day) and aripiprazole (30 mg/day) were coadministered, at steady-state the C_{max} and AUC of aripiprazole were decreased by 25%. No dosage adjustment of aripiprazole is required when administered concomitantly with valproate.

When aripiprazole (30 mg/day) and valproate (1000 mg/day) were coadministered, at steady-state there were no clinically significant changes in the C_{max} or AUC of valproate. No dosage adjustment of valproate is required when administered concomitantly with aripiprazole.

Lithium: A pharmacokinetic interaction of aripiprazole with lithium is unlikely because lithium is not bound to plasma proteins, is not metabolized, *and is almost entirely excreted unchanged in urine. Coadministration of therapeutic doses of lithium (1200 mg/day-1800 mg/day) for 21 days with* aripiprazole (30 mg/day) did not result in clinically significant changes in the pharmacokinetics of aripiprazole or its active metabolite, dehydro-aripiprazole (C_{max} and AUC increased by less than 20%). No dosage adjustment of aripiprazole is required when administered concomitantly with lithium. Coadministration of aripiprazole (30 mg/day) with lithium (900 mg/day) did not result in clinically significant changes in the pharmacokinetics of lithium. No dosage adjustment of lithium is required when administered concomitantly with aripiprazole.

Lamotrigine: Coadministration of 10 mg/day to 30 mg/day oral doses of aripiprazole for 14 days to patients with Bipolar I Disorder had no effect on the steady-state pharmacokinetics of 100 mg/day to 400 mg/day lamotrigine, a UDP-glucuronosyltransferase 1A4 substrate. No dosage adjustment of lamotrigine is required when aripiprazole is added to lamotrigine.

Dextromethorphan: Aripiprazole at doses of 10 mg/day to 30 mg/day for 14 days had no effect on dextromethorphan's O-dealkylation to its major metabolite, dextrorphan, a pathway dependent on CYP2D6 activity. Aripiprazole also had no effect on dextromethorphan's N-demethylation to its metabolite 3-methoxymorphinan, a pathway dependent on CYP3A4 activity. No dosage adjustment of dextromethorphan is required when administered concomitantly with aripiprazole.

Warfarin: Aripiprazole 10 mg/day for 14 days had no effect on the pharmacokinetics of R-warfarin and S-warfarin or on the pharmacodynamic end point of International Normalized Ratio, indicating the lack of a clinically relevant effect of aripiprazole on CYP2C9 and CYP2C19 metabolism or the binding of highly protein-bound warfarin. No dosage adjustment of warfarin is required when administered concomitantly with aripiprazole.

Omeprazole: Aripiprazole 10 mg/day for 15 days had no effect on the pharmacokinetics of a single 20 mg dose of omeprazole, a CYP2C19 substrate, in healthy subjects. No dosage adjustment of omeprazole is required when administered concomitantly with aripiprazole.

Lorazepam: Coadministration of lorazepam injection (2 mg) and aripiprazole injection (15 mg) to healthy subjects (n=40: 35 males and 5 females; ages 19-45 years old) did not result in clinically important changes in the pharmacokinetics of either drug. No dosage adjustment of aripiprazole is required when administered concomitantly with lorazepam. However, the intensity of sedation was greater with the combination as compared to that observed with aripiprazole alone and the orthostatic hypotension observed was greater with the combination as compared to that observed with lorazepam alone [see *Warnings and Precautions*].

Escitalopram: Coadministration of 10 mg/day oral doses of aripiprazole for 14 days to healthy subjects had no effect on the steady-state pharmacokinetics of 10 mg/day escitalopram, a substrate of CYP2C19 and CYP3A4. No dosage adjustment of escitalopram is required when aripiprazole is added to escitalopram.

Venlafaxine: Coadministration of 10 mg/day to 20 mg/day oral doses of aripiprazole for 14 days to healthy subjects had no effect on the steady-state pharmacokinetics of venlafaxine and O-desmethylvenlafaxine following 75 mg/day venlafaxine XR, a CYP2D6 substrate. No dosage adjustment of venlafaxine is required when aripiprazole is added to venlafaxine.

Fluoxetine, Paroxetine, and Sertraline: A population pharmacokinetic analysis in patients with Major Depressive Disorder showed no substantial change in plasma concentrations of fluoxetine (20 mg/day or 40 mg/day), paroxetine CR (37.5 mg/day or 50 mg/day), or sertraline (100 mg/day or 150 mg/day) dosed to steady-state. The steady-state plasma concentrations of fluoxetine and norfluoxetine increased by about 18% and 36%, respectively and concentrations of paroxetine decreased by about 27%. The steady-state plasma concentrations of sertraline and desmethylsertraline were not substantially changed when these antidepressant therapies were coadministered with aripiprazole. Aripiprazole dosing was 2 mg/day to 15 mg/day (when given with fluoxetine or paroxetine) or 2 mg/day to 20 mg/day (when given with sertraline).

USE IN SPECIFIC POPULATIONS: In general, no dosage adjustment for ABILIFY (aripiprazole) is required on the basis of a patient's age, gender, race, smoking status, hepatic function, or renal function [see *Dosage and Administration (2.5)* in Full Prescribing Information].

Pregnancy Category C: There are no adequate and well-controlled studies in pregnant women. Aripiprazole should be used during pregnancy only if the potential benefit outweighs the potential risk to the fetus. In animal studies, aripiprazole demonstrated developmental toxicity, including possible teratogenic effects in rats and rabbits.

Labor and Delivery - The effect of aripiprazole on labor and delivery in humans is unknown.

Nursing Mothers - Aripiprazole was excreted in milk of rats during lactation. It is not known whether aripiprazole or its metabolites are excreted in human milk. It is recommended that women receiving aripiprazole should not breast-feed.

Pediatric Use - Safety and effectiveness in pediatric patients with Major Depressive Disorder has not been established. The efficacy of adjunctive ABILIFY with concomitant lithium or valproate in the treatment of manic or mixed episodes in pediatric patients has not been systematically evaluated. However, such efficacy and lack of pharmacokinetic interaction between aripiprazole and lithium or valproate can be extrapolated from adult data, along with comparisons of aripiprazole pharmacokinetic parameters in adult and pediatric patients.

Geriatric Use - In formal single-dose pharmacokinetic studies (with aripiprazole given in a single dose of 15 mg), aripiprazole clearance was 20% lower in elderly (≥65 years) subjects compared to younger adult subjects (18 to 64 years). Also, the pharmacokinetics of aripiprazole after multiple doses in elderly patients appeared similar to that observed in young, healthy subjects. No dosage adjustment is recommended for elderly patients [see also *Boxed Warning* and *Warnings and Precautions*].

Of the 13,543 patients treated with oral aripiprazole in clinical trials, 1073 (8%) were ≥65 years old and 799 (6%) were ≥75 years old. The majority (81%) of the 1073 patients were diagnosed with Dementia of the Alzheimer's type.

Placebo-controlled studies of oral aripiprazole in Major Depressive Disorder did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects.

Renal Impairment - In patients with severe renal impairment (creatinine clearance <30 mL/min), C_{max} of aripiprazole (given in a single dose of 15 mg) and dehydro-aripiprazole increased by 36% and 53%, respectively, but AUC was 15% lower for aripiprazole and 7% higher for dehydro-aripiprazole. Renal excretion of both unchanged aripiprazole and dehydro-aripiprazole is less than 1% of the dose. No dosage adjustment is required in subjects with renal impairment.

Hepatic Impairment - In a single-dose study (15 mg of aripiprazole) in subjects with varying degrees of liver cirrhosis (Child-Pugh Classes A, B, and C), the AUC of aripiprazole, compared to healthy subjects, increased 31% in mild HI, increased 8% in moderate HI, and decreased 20% in severe HI. None of these differences would require dose adjustment.

Gender - C_{max} and AUC of aripiprazole and its active metabolite, dehydro-aripiprazole, are 30% to 40% higher in women than in men, and correspondingly, the apparent oral clearance of aripiprazole is lower in women. These differences, however, are largely explained by differences in body weight (25%) between men and women. No dosage adjustment is recommended based on gender.

Race - Although no specific pharmacokinetic study was conducted to investigate the effects of race on the disposition of aripiprazole, *population pharmacokinetic evaluation revealed no evidence of clinically significant race-related differences in the pharmacokinetics of* aripiprazole. No dosage adjustment is recommended based on race.

Smoking - Based on studies utilizing human liver enzymes *in vitro*, aripiprazole is not a substrate for CYP1A2 and also does not undergo direct glucuronidation. Smoking should, therefore, not have an effect on the pharmacokinetics of aripiprazole. Consistent with these *in vitro* results, population pharmacokinetic evaluation did not reveal any significant pharmacokinetic differences between smokers and nonsmokers. No dosage adjustment is recommended based on smoking status.

DRUG ABUSE AND DEPENDENCE: ABILIFY is not a controlled substance.

Abuse and Dependence - Aripiprazole has not been systematically studied in humans for its potential for abuse, tolerance, or physical dependence. While the clinical trials did not reveal any tendency for any drug-seeking behavior, it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Patients should be evaluated carefully for a history of drug abuse and closely observed for signs of ABILIFY misuse or abuse.

OVERDOSAGE: 76 cases of deliberate or accidental overdosage with oral aripiprazole alone or in combination with other substances were reported worldwide [44 cases with known outcome, 33 recovered without sequelae and one recovered with sequelae (mydriasis and feeling abnormal)]. Additionally, 10 of these cases were in children (age 12 and younger) involving oral aripiprazole ingestions up to 195 mg with no fatalities. The largest known acute ingestion was 1080 mg of oral aripiprazole (36 times maximum recommended daily dose) in a patient who fully recovered. Common adverse reactions (reported in at least 5% of all overdose cases) were vomiting, somnolence, and tremor. **For more information on symptoms of overdose, see Full Prescribing Information.**

Management of Overdosage: No specific information is available on the treatment of overdose with aripiprazole. An electrocardiogram should be obtained in case of overdosage and if QT interval prolongation is present, cardiac monitoring should be instituted. Otherwise, management of overdose should concentrate on supportive therapy, maintaining an adequate airway, oxygenation and ventilation, and management of symptoms. Close medical supervision and monitoring should continue until the patient recovers. ***Charcoal:*** In the event of an overdose of ABILIFY, an early charcoal administration may be useful in partially preventing the absorption of aripiprazole. Administration of 50 g of activated charcoal, one hour after a single 15 mg oral dose of aripiprazole, decreased the mean AUC and C_{max} of aripiprazole by 50%. ***Hemodialysis:*** Although there is no information on the effect of hemodialysis in treating an overdose with aripiprazole, hemodialysis is unlikely to be useful in overdose management since aripiprazole is highly bound to plasma proteins.

PATIENT COUNSELING INFORMATION: Information for Patients - Physicians are advised to discuss the following issues with patients for whom they prescribe ABILIFY: [See Medication Guide (17.2) in Full Prescribing Information.]

Increased Mortality in Elderly Patients with Dementia-Related Psychosis - Advise patients and caregivers of increased risk of death [see *Warnings and Precautions*].

Clinical Worsening of Depression and Suicide Risk - Alert families and caregivers of patients to monitor for the emergence of agitation, irritability, unusual changes in behavior, suicidality, and other symptoms as described in *Warnings and Precautions* and to report such symptoms immediately. Advise patients and their families and caregivers to read the Medication Guide and assist them in understanding its contents [see *Warnings and Precautions*].

Interference with Cognitive and Motor Performance - Because aripiprazole may have the potential to impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that aripiprazole therapy does not affect them adversely [see *Warnings and Precautions*].

Pregnancy - Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy with ABILIFY [see *Use In Specific Populations*].

Nursing - Patients should be advised not to breast-feed an infant if they are taking ABILIFY [see *Use In Specific Populations*].

Concomitant Medication - Patients should be advised to inform their physicians if they are taking, or plan to take, any prescription or over-the-counter drugs, since there is a potential for interactions [see *Drug Interactions*].

Alcohol - Patients should be advised to avoid alcohol while taking ABILIFY [see *Drug Interactions*].

Heat Exposure and Dehydration - Patients should be advised regarding appropriate care in avoiding overheating and dehydration [see *Warnings and Precautions*].

Sugar Content - Patients should be advised that each mL of ABILIFY Oral Solution contains 400 mg of sucrose and 200 mg of fructose.

Phenylketonurics - Phenylalanine is a component of aspartame. Each ABILIFY DISCMELT Orally Disintegrating Tablet contains the following amounts: 10 mg - 1.12 mg phenylalanine and 15 mg - 1.68 mg phenylalanine.

Tablets manufactured by Otsuka Pharmaceutical Co, Ltd, Tokyo, 101-8535 Japan or Bristol-Myers Squibb Company, Princeton, NJ 08543 USA. Orally Disintegrating Tablets, Oral Solution, and Injection manufactured by Bristol-Myers Squibb Company, Princeton, NJ 08543 USA. Distributed and marketed by Otsuka America Pharmaceutical, Inc, Rockville, MD 20850 USA. Marketed by Bristol-Myers Squibb Company, Princeton, NJ 08543 USA. US Patent Nos: 5,006,528; 6,977,257; and 7,115,587

Bristol-Myers Squibb Otsuka Otsuka America Pharmaceutical, Inc.

Based on 1239550A3, 0308L-1336A D6-B0001A-08-08-MDD 570US08PBS01403 0308L-1389

Rev August 2008

IMPORTANT SAFETY INFORMATION and INDICATION for ABILIFY® (aripiprazole)

INDICATION

- ABILIFY (aripiprazole) is indicated for use as an adjunctive therapy to antidepressants for the acute treatment of Major Depressive Disorder in adults

IMPORTANT SAFETY INFORMATION

Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk (1.6 to 1.7 times) of death compared to placebo (4.5% vs 2.6%, respectively). Although the causes of death were varied, most of the deaths appeared to be cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. ABILIFY is not approved for the treatment of patients with dementia-related psychosis.

Suicidality and Antidepressant Drugs

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of adjunctive ABILIFY or another antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increased risk of suicidality in adults beyond age 24. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. ABILIFY is not approved for use in pediatric patients with depression.

See Full Prescribing Information for complete Boxed WARNINGS

Contraindication – Known hypersensitivity reaction to ABILIFY. Reactions have ranged from pruritus/urticaria to anaphylaxis.

- **Cerebrovascular Adverse Events, Including Stroke** – Increased incidence of cerebrovascular adverse events (eg, stroke, transient ischemic attack), including fatalities, have been reported in clinical trials of elderly patients with dementia-related psychosis treated with ABILIFY
- **Neuroleptic Malignant Syndrome (NMS)** – As with all antipsychotic medications, a rare and potentially fatal condition known as NMS has been reported with ABILIFY. NMS can cause hyperpyrexia, muscle rigidity, diaphoresis, tachycardia, irregular pulse or blood pressure, cardiac dysrhythmia, and altered mental status. If signs and symptoms appear, immediate discontinuation is recommended
- **Tardive Dyskinesia (TD)** – The risk of developing TD and the potential for it to become irreversible may increase as the duration of treatment and the total cumulative dose increase. Prescribing should be consistent with the need to minimize TD. If signs and symptoms appear, discontinuation should be considered since TD may remit, partially or completely
- **Hyperglycemia and Diabetes Mellitus** – Hyperglycemia, in some cases associated with ketoacidosis, coma, or death, has been reported in patients treated with atypical antipsychotics including ABILIFY. Patients with diabetes should be monitored for worsening of glucose control; those with risk factors for diabetes should undergo baseline and periodic fasting blood glucose testing. Patients who develop symptoms of hyperglycemia should also undergo fasting blood glucose testing. There have been few reports of hyperglycemia with ABILIFY

Orthostatic Hypotension – ABILIFY may be associated with orthostatic hypotension and should be used with caution in patients with known cardiovascular disease, cerebrovascular disease, or conditions which would predispose them to hypotension.

Seizures/Convulsions – As with other antipsychotic drugs, ABILIFY should be used with caution in patients with a history of seizures or with conditions that lower the seizure threshold.

Potential for Cognitive and Motor Impairment – Like other antipsychotics, ABILIFY may have the potential to impair judgment, thinking, or motor skills. Patients should not drive or operate hazardous machinery until they are certain ABILIFY does not affect them adversely.

Body Temperature Regulation – Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotics. Appropriate care is advised for patients who may exercise strenuously, be exposed to extreme heat, receive concomitant medication with anticholinergic activity, or be subject to dehydration.

Suicide – The possibility of a suicide attempt is inherent in psychotic illnesses, Bipolar Disorder, and Major Depressive Disorder, and close supervision of high-risk patients should accompany drug therapy. Prescriptions should be written for the smallest quantity consistent with good patient management in order to reduce the risk of overdose.

Dysphagia – Esophageal dysmotility and aspiration have been associated with antipsychotic drug use, including ABILIFY; use caution in patients at risk for aspiration pneumonia.

Physicians should advise patients to avoid alcohol while taking ABILIFY.

Strong CYP3A4 (eg, ketoconazole) or CYP2D6 (eg, fluoxetine) inhibitors will increase ABILIFY drug concentrations; reduce ABILIFY dose by one-half when used concomitantly, except when used as adjunctive treatment with antidepressants in adults with Major Depressive Disorder.

CYP3A4 inducers (eg, carbamazepine) will decrease ABILIFY drug concentrations; double ABILIFY dose when used concomitantly.

Commonly observed adverse reactions (≥5% incidence and at least twice the rate of placebo for adjunctive ABILIFY vs adjunctive placebo, respectively):

- Adult patients (with Major Depressive Disorder): akathisia (25% vs 4%), restlessness (12% vs 2%), insomnia (8% vs 2%), constipation (5% vs 2%), fatigue (8% vs 4%), and blurred vision (6% vs 1%)

Dystonia is a class effect of antipsychotic drugs. Symptoms of dystonia may occur in susceptible individuals during the first days of treatment and at low doses.

Reference:

1. *PDR® Electronic Library™* (n.d.). Greenwood Village, CO: Thomson Micromedex. http://www.thomsonhc.com. Accessed October 16, 2007.

Please see accompanying FULL PRESCRIBING INFORMATION, including **Boxed WARNINGS**, for ABILIFY.

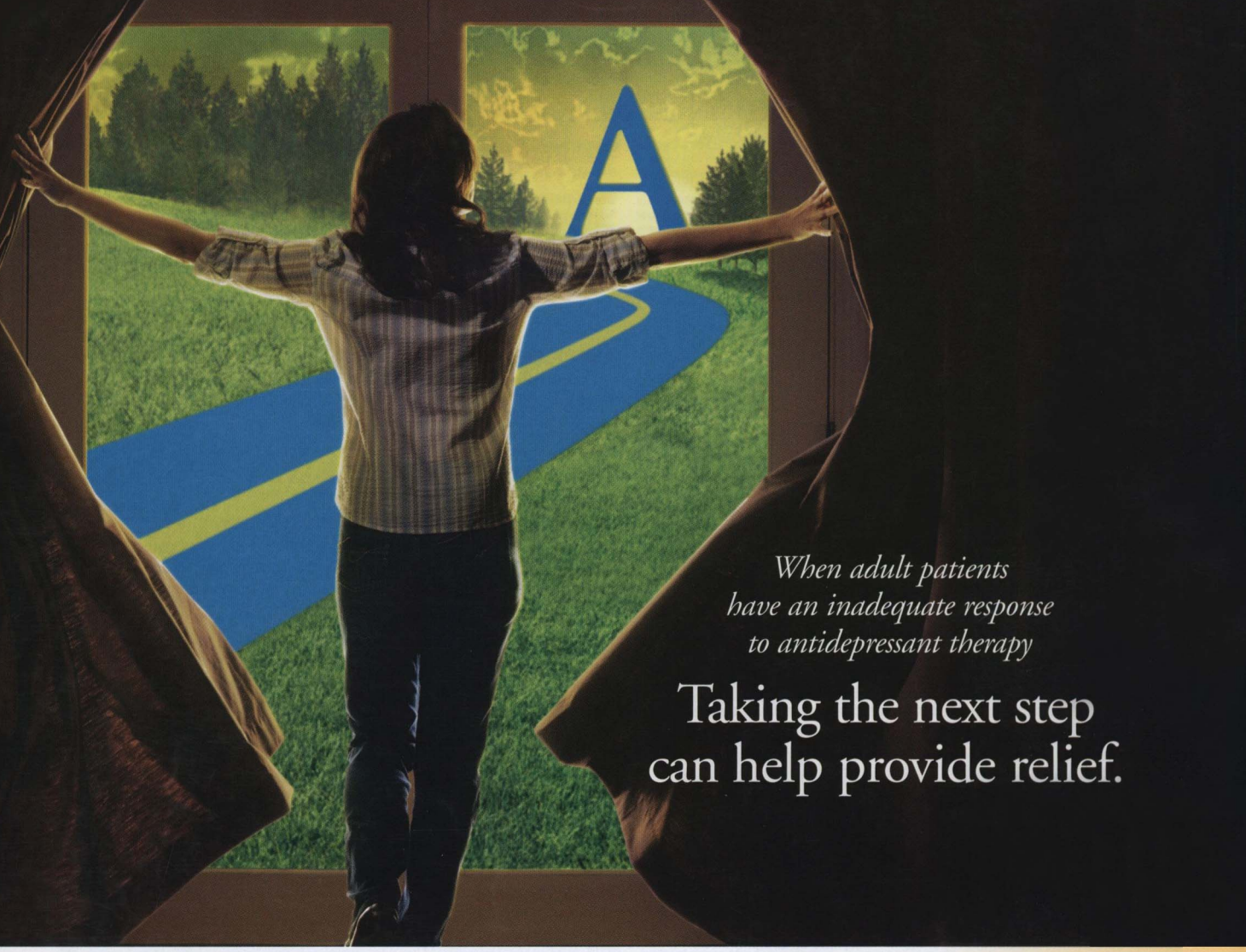
Bristol-Myers Squibb

Otsuka Otsuka America Pharmaceutical, Inc.

570US08AB16509 September 2008 0308A-1466 Printed in USA Printed on recycled paper.

ABILIFY® (aripiprazole)
2 mg, 5 mg Tablet

https://doi.org/10.1017/S1092852900013961 Published online by Cambridge University Press



When adult patients have an inadequate response to antidepressant therapy

Taking the next step can help provide relief.

The **first and only** adjunctive therapy to antidepressants for Major Depressive Disorder in adults.[1]

ABILIFY®
(aripiprazole)
2 mg, 5 mg Tablet

HELP ILLUMINATE THE PERSON WITHIN

ABILIFY is indicated for use as an adjunctive therapy to antidepressants for the acute treatment of Major Depressive Disorder in adults.

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorder and other psychiatric disorders. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior, especially during the initial few months of therapy, or at times of dose changes. ABILIFY is not approved for use in pediatric patients with depression (see Boxed WARNING).

Please see IMPORTANT SAFETY INFORMATION, including **Boxed WARNINGS**, on inside back cover.

www.abilify.com

https://doi.org/10.1017/S1092852900013961 Published online by Cambridge University Press