

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use POTIGA safely and effectively. See full prescribing information for POTIGA.

**POTIGA (ezogabine) Tablets, CV**  
**Initial U.S. Approval: 2011**

-----**INDICATIONS AND USAGE**-----

POTIGA is a potassium channel opener indicated as adjunctive treatment of partial-onset seizures in patients aged 18 years and older. (1)

-----**DOSAGE AND ADMINISTRATION**-----

- Administer in 3 divided doses daily, with or without food. (2)
- The initial dosage should be 100 mg 3 times daily (300 mg per day) for 1 week. (2)
- Titrate to maintenance dosage by increasing the dosage at weekly intervals by no more than 150 mg per day. (2)
- Optimize effective dosage between 200 mg 3 times daily (600 mg per day) to 400 mg 3 times daily (1,200 mg per day). (2)
- In controlled clinical trials, 400 mg 3 times daily (1,200 mg per day) showed limited improvement compared to 300 mg 3 times daily (900 mg per day) with an increase in adverse reactions and discontinuations. (2)
- When discontinuing POTIGA, reduce the dosage gradually over a period of at least 3 weeks. (2, 5.6)
- Dosing adjustments are required for geriatric patients and patients with moderate to severe renal or hepatic impairment. (2)

-----**DOSAGE FORMS AND STRENGTHS**-----

Tablets: 50 mg, 200 mg, 300 mg, and 400 mg. (3)

-----**CONTRAINDICATIONS**-----

None. (4)

-----**WARNINGS AND PRECAUTIONS**-----

- Urinary retention: Patients should be carefully monitored for urologic symptoms. (5.1)
- Neuropsychiatric symptoms: Monitor for confusional state, psychotic

symptoms, and hallucinations. (5.2)

- Dizziness and somnolence: Monitor for dizziness and somnolence. (5.3)
- QT prolongation: QT interval should be monitored in patients taking concomitant medications known to increase the QT interval or with certain heart conditions. (5.4)
- Suicidal behavior and ideation: Monitor for suicidal thoughts or behaviors. (5.5)

-----**ADVERSE REACTIONS**-----

The most common adverse reactions (incidence  $\geq 4\%$  and approximately twice placebo) are dizziness, somnolence, fatigue, confusional state, vertigo, tremor, abnormal coordination, diplopia, disturbance in attention, memory impairment, asthenia, blurred vision, gait disturbance, aphasia, dysarthria, and balance disorder. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact GlaxoSmithKline at 1-888-825-5249 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

-----**DRUG INTERACTIONS**-----

- Ezogabine plasma levels may be reduced by concomitant administration of phenytoin or carbamazepine. An increase in dosage of POTIGA should be considered when adding phenytoin or carbamazepine. (7.1)
- N-acetyl metabolite of ezogabine may inhibit renal clearance of digoxin, a P-glycoprotein substrate. Monitor digoxin levels. (7.2)

-----**USE IN SPECIFIC POPULATIONS**-----

- Pregnancy: Based on animal data, may cause fetal harm. Pregnancy registry available. (8.1)
- Pediatric use: Safety and effectiveness in patients under 18 years of age have not been established. (8.4)

See 17 for PATIENT COUNSELING INFORMATION and MEDICATION GUIDE.

Revised:

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\*Sections or subsections omitted from the full prescribing information are not listed.

1 **FULL PRESCRIBING INFORMATION**

2 **1 INDICATIONS AND USAGE**

3 POTIGA™ is indicated as adjunctive treatment of partial-onset seizures in patients aged  
4 18 years and older.

5 **2 DOSAGE AND ADMINISTRATION**

6 The initial dosage should be 100 mg 3 times daily (300 mg per day). The dosage should  
7 be increased gradually at weekly intervals by no more than 50 mg 3 times daily (increase in the  
8 daily dose of no more than 150 mg per day) up to a maintenance dosage of 200 mg to 400 mg 3  
9 times daily (600 mg to 1,200 mg per day), based on individual patient response and tolerability.  
10 This information is summarized in Table 1 under General Dosing. In the controlled clinical trials,  
11 400 mg 3 times daily showed limited evidence of additional improvement in seizure reduction,  
12 but an increase in adverse events and discontinuations, compared to the 300 mg 3 times daily  
13 dosage. The safety and efficacy of doses greater than 400 mg 3 times daily (1,200 mg per day)  
14 have not been examined in controlled trials.

15 No adjustment in dosage is required for patients with mild renal or hepatic impairment  
16 (see General Dosing, Table 1). Dosage adjustment is required in patients with moderate and  
17 greater renal or hepatic impairment (see Dosing in Specific Populations, Table 1).

18 POTIGA should be given orally in 3 equally divided doses daily, with or without food.

19 POTIGA Tablets should be swallowed whole.

20 If POTIGA is discontinued, the dosage should be gradually reduced over a period of at  
21 least 3 weeks, unless safety concerns require abrupt withdrawal.

22

23 **Table 1. Dosing Recommendations**

Specific Population	Initial Dose	Titration	Maximum Dose
<b>General Dosing</b>			
<u>General population</u> (including patients with mild renal or hepatic impairment)	100 mg 3 times daily (300 mg per day)	Increase by no more than 50 mg 3 times daily, at weekly intervals	400 mg 3 times daily (1,200 mg per day)
<b>Dosing in Specific Populations</b>			
<u>Geriatrics</u> (patients >65 years)	50 mg 3 times daily (150 mg per day)	Increase by no more than 50 mg 3 times daily, at weekly intervals	250 mg 3 times daily (750 mg per day)
<u>Renal impairment</u> (patients with CrCL <50 mL per min or end-stage renal disease on dialysis)	50 mg 3 times daily (150 mg per day)		200 mg 3 times daily (600 mg per day)
<u>Hepatic impairment</u> (patients with Child-Pugh 7-9)	50 mg 3 times daily (150 mg per day)		250 mg 3 times daily (750 mg per day)
<u>Hepatic impairment</u> (patients with Child-Pugh >9)	50 mg 3 times daily (150 mg per day)		200 mg 3 times daily (600 mg per day)

24

25 **3 DOSAGE FORMS AND STRENGTHS**

- 26 50 mg, purple, round, film-coated tablets debossed with “RTG 50” on one side.  
 27 200 mg, yellow, oblong, film-coated tablets debossed with “RTG-200” on one side.  
 28 300 mg, green, oblong, film-coated tablets debossed with “RTG-300” on one side.  
 29 400 mg, purple, oblong, film-coated tablets debossed with “RTG-400” on one side.

30 **4 CONTRAINDICATIONS**

31 None.

32 **5 WARNINGS AND PRECAUTIONS**

33 **5.1 Urinary Retention**

34 POTIGA caused urinary retention in clinical trials. Urinary retention was generally  
 35 reported within the first 6 months of treatment, but was also observed later. Urinary retention  
 36 was reported as an adverse event in 29 of 1,365 (approximately 2%) patients treated with  
 37 POTIGA in the open-label and placebo-controlled epilepsy database [see *Clinical Studies (14)*].  
 38 Of these 29 patients, 5 (17%) required catheterization, with post-voiding residuals of up to  
 39 1,500 mL. POTIGA was discontinued in 4 patients who required catheterization. Following

40 discontinuation, these 4 patients were able to void spontaneously; however, 1 of the 4 patients  
41 continued intermittent self-catheterization. A fifth patient continued treatment with POTIGA and  
42 was able to void spontaneously after catheter removal. Hydronephrosis occurred in 2 patients,  
43 one of whom had associated renal function impairment that resolved upon discontinuation of  
44 POTIGA. Hydronephrosis was not reported in placebo patients.

45 In the placebo-controlled epilepsy trials, “urinary retention,” “urinary hesitation,” and  
46 “dysuria” were reported in 0.9%, 2.2%, and 2.3% of patients on POTIGA, respectively, and in  
47 0.5%, 0.9%, and 0.7% of patients on placebo, respectively.

48 Because of the increased risk of urinary retention on POTIGA, urologic symptoms should  
49 be carefully monitored. Closer monitoring is recommended for patients who have other risk  
50 factors for urinary retention (e.g., benign prostatic hyperplasia [BPH]), patients who are unable  
51 to communicate clinical symptoms (e.g., cognitively impaired patients), or patients who use  
52 concomitant medications that may affect voiding (e.g., anticholinergics). In these patients, a  
53 comprehensive evaluation of urologic symptoms prior to and during treatment with POTIGA  
54 may be appropriate.

## 55 **5.2 Neuro-Psychiatric Symptoms**

56 Confusional state, psychotic symptoms, and hallucinations were reported more frequently  
57 as adverse reactions in patients treated with POTIGA than in those treated with placebo in  
58 placebo-controlled epilepsy trials (see Table 2). Discontinuations resulting from these reactions  
59 were more common in the drug-treated group (see Table 2). These effects were dose-related and  
60 generally appeared within the first 8 weeks of treatment. Half of the patients in the controlled  
61 trials who discontinued POTIGA due to hallucinations or psychosis required hospitalization.  
62 Approximately two-thirds of patients with psychosis in controlled trials had no prior psychiatric  
63 history. The psychiatric symptoms in the vast majority of patients in both controlled and open-  
64 label trials resolved within 7 days of discontinuation of POTIGA. Rapid titration at greater than  
65 the recommended doses appeared to increase the risk of psychosis and hallucinations.

66

67 **Table 2. Major Neuro-Psychiatric Symptoms in Placebo-Controlled Epilepsy Trials**

Adverse Reaction	Number (%) With Adverse Reaction		Number (%) Discontinuing	
	POTIGA (n = 813)	Placebo (n = 427)	POTIGA (n = 813)	Placebo (n = 427)
Confusional state	75 (9%)	11 (3%)	32 (4%)	4 (<1%)
Psychosis	9 (1%)	0	6 (<1%)	0
Hallucinations <sup>a</sup>	14 (2%)	2 (<1%)	6 (<1%)	0

68 <sup>a</sup> Hallucinations includes visual, auditory, and mixed hallucinations.

69

## 70 **5.3 Dizziness and Somnolence**

71 POTIGA causes dose-related increases in dizziness and somnolence [*see Adverse*  
72 *Reactions (6.1)*]. In placebo-controlled trials in patients with epilepsy, dizziness was reported in  
73 23% of patients treated with POTIGA and 9% of patients treated with placebo. Somnolence was

74 reported in 22% of patients treated with POTIGA and 12% of patients treated with placebo. In  
75 these trials 6% of patients on POTIGA and 1.2% on placebo discontinued treatment because of  
76 dizziness; 3% of patients on POTIGA and <1.0% on placebo discontinued because of  
77 somnolence.

78 Most of these adverse reactions were mild to moderate in intensity and occurred during  
79 the titration phase. For those patients continued on POTIGA, dizziness and somnolence appeared  
80 to diminish with continued use.

#### 81 **5.4 QT Interval Effect**

82 A study of cardiac conduction showed that POTIGA produced a mean 7.7-msec QT  
83 prolongation in healthy volunteers titrated to 400 mg 3 times daily. The QT-prolonging effect  
84 occurred within 3 hours. The QT interval should be monitored when POTIGA is prescribed with  
85 medicines known to increase QT interval and in patients with known prolonged QT interval,  
86 congestive heart failure, ventricular hypertrophy, hypokalemia, or hypomagnesemia [*see Clinical*  
87 *Pharmacology (12.2)*].

#### 88 **5.5 Suicidal Behavior and Ideation**

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

93 Pooled analyses of 199 placebo-controlled clinical trials (mono- and adjunctive-therapy)  
94 of 11 different AEDs showed that patients randomized to one of the AEDs had approximately  
95 twice the risk (adjusted relative risk 1.8, 95% confidence interval [CI]: 1.2, 2.7) of suicidal  
96 thinking or behavior compared to patients randomized to placebo. In these trials, which had a  
97 median treatment duration of 12 weeks, the estimated incidence of suicidal behavior or ideation  
98 among 27,863 AED-treated patients was 0.43% compared to 0.24% among 16,029 placebo-  
99 treated patients, representing an increase of approximately 1 case of suicidal thinking or behavior  
100 for every 530 patients treated. There were 4 suicides in drug-treated patients in the trials and  
101 none in placebo-treated patients, but the number is too small to allow any conclusion about drug  
102 effect on suicide.

103 The increased risk of suicidal thoughts or behavior with AEDs was observed as early as 1  
104 week after starting treatment with AEDs and persisted for the duration of treatment assessed.  
105 Because most trials included in the analysis did not extend beyond 24 weeks, the risk of suicidal  
106 thoughts or behavior beyond 24 weeks could not be assessed.

107 The risk of suicidal thoughts or behavior was generally consistent among drugs in the  
108 data analyzed. The finding of increased risk with AEDs of varying mechanism of action and  
109 across a range of indications suggests that the risk applies to all AEDs used for any indication.  
110 The risk did not vary substantially by age (5 to 100 years) in the clinical trials analyzed.

111 Table 3 shows absolute and relative risk by indication for all evaluated AEDs.  
112

113 **Table 3. Risk of Suicidal Thoughts or Behaviors by Indication for Antiepileptic Drugs in**  
114 **the Pooled Analysis**

Indication	Placebo Patients With Events per 1,000 Patients	Drug Patients With Events per 1,000 Patients	Relative Risk: Incidence of Events in Drug Patients/ Incidence in Placebo Patients	Risk Difference: Additional Drug Patients With Events per 1,000 Patients
Epilepsy	1.0	3.4	3.5	2.4
Psychiatric	5.7	8.5	1.5	2.9
Other	1.0	1.8	1.9	0.9
Total	2.4	4.3	1.8	1.9

115  
116 The relative risk for suicidal thoughts or behavior was higher in clinical trials in patients  
117 with epilepsy than in clinical trials in patients with psychiatric or other conditions, but the  
118 absolute risk differences were similar for epilepsy and psychiatric indications.

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

125 Patients, their caregivers, and families should be informed that AEDs increase the risk of  
126 suicidal thoughts and behavior and should be advised of the need to be alert for the emergence or  
127 worsening of the signs and symptoms of depression; any unusual changes in mood or behavior;  
128 or the emergence of suicidal thoughts, behavior, or thoughts about self-harm. Behaviors of  
129 concern should be reported immediately to healthcare providers.

### 130 **5.6 Withdrawal Seizures**

131 As with all AEDs, when POTIGA is discontinued, it should be withdrawn gradually  
132 when possible to minimize the potential of increased seizure frequency [see *Dosage and*  
133 *Administration (2)*]. The dosage of POTIGA should be reduced over a period of at least 3 weeks,  
134 unless safety concerns require abrupt withdrawal.

## 135 **6 ADVERSE REACTIONS**

136 The following adverse reactions are described in more detail in the *Warnings and*  
137 *Precautions* section of the label:

- 138 • Urinary retention [see *Warnings and Precautions (5.1)*]
- 139 • Neuro-psychiatric symptoms [see *Warnings and Precautions (5.2)*]
- 140 • Dizziness and somnolence [see *Warnings and Precautions (5.3)*]
- 141 • QT interval effect [see *Warnings and Precautions (5.4)*]
- 142 • Suicidal behavior and ideation [see *Warnings and Precautions (5.5)*]

- 143 • Withdrawal seizures [see Warnings and Precautions (5.6)]

144 **6.1 Clinical Trials Experience**

145 Because clinical trials are conducted under widely varying conditions and for varying  
 146 durations, adverse reaction frequencies observed in the clinical trials of a drug cannot be directly  
 147 compared with frequencies in the clinical trials of another drug and may not reflect the  
 148 frequencies observed in practice.

149 POTIGA was administered as adjunctive therapy to 1,365 patients with epilepsy in all  
 150 controlled and uncontrolled clinical studies during the premarketing development. A total of 801  
 151 patients were treated for at least 6 months, 585 patients were treated for 1 year or longer, and 311  
 152 patients were treated for at least 2 years.

153 **Adverse Reactions Leading to Discontinuation in All Controlled Clinical Studies:**

154 In the 3 randomized, double-blind, placebo-controlled studies, 199 of 813 patients (25%)  
 155 receiving POTIGA and 45 of 427 patients (11%) receiving placebo discontinued treatment  
 156 because of adverse reactions. The most common adverse reactions leading to withdrawal in  
 157 patients receiving POTIGA were dizziness (6%), confusional state (4%), fatigue (3%), and  
 158 somnolence (3%).

159 **Common Adverse Reactions in All Controlled Clinical Studies:** Overall, the most  
 160 frequently reported adverse reactions in patients receiving POTIGA ( $\geq 4\%$  and occurring  
 161 approximately twice the placebo rate) were dizziness (23%), somnolence (22%), fatigue (15%),  
 162 confusional state (9%), vertigo (8%), tremor (8%), abnormal coordination (7%), diplopia (7%),  
 163 disturbance in attention (6%), memory impairment (6%), asthenia (5%), blurred vision (5%), gait  
 164 disturbance (4%), aphasia (4%), dysarthria (4%), and balance disorder (4%). In most cases the  
 165 reactions were of mild or moderate intensity.

166  
 167 **Table 4. Adverse Reaction Incidence in Placebo-Controlled Adjunctive Trials in Adult**  
 168 **Patients With Partial Onset Seizures (Adverse reactions in at least 2% of patients treated**  
 169 **with POTIGA in any treatment group and numerically more frequent than in the placebo**  
 170 **group.)**

Body System/ Adverse Reaction	Placebo (N = 427) %	POTIGA			
		600 mg/day (N = 281) %	900 mg/day (N = 273) %	1,200 mg/day (N = 259) %	All (N = 813) %
Eye					
Diplopia	2	8	6	7	7
Blurred vision	2	2	4	10	5
Gastrointestinal					
Nausea	5	6	6	9	7
Constipation	1	1	4	5	3
Dyspepsia	2	3	2	3	2

General					
Fatigue	6	16	15	13	15
Asthenia	2	4	6	4	5
Infections and infestations					
Influenza	2	4	1	5	3
Investigations					
Weight increased	1	2	3	3	3
Nervous system					
Dizziness	9	15	23	32	23
Somnolence	12	15	25	27	22
Memory impairment	3	3	6	9	6
Tremor	3	3	10	12	8
Vertigo	2	8	8	9	8
Abnormal coordination	3	5	5	12	7
Disturbance in attention	<1	6	6	7	6
Gait disturbance	1	2	5	6	4
Aphasia	<1	1	3	7	4
Dysarthria	<1	4	2	8	4
Balance disorder	<1	3	3	5	4
Paresthesia	2	3	2	5	3
Amnesia	<1	<1	3	3	2
Dysphasia	<1	1	1	3	2
Psychiatric					
Confusional state	3	4	8	16	9
Anxiety	2	3	2	5	3
Disorientation	<1	<1	<1	5	2
Psychotic disorder	0	0	<1	2	<1
Renal and urinary					
Dysuria	<1	1	2	4	2
Urinary hesitation	<1	2	1	4	2
Hematuria	<1	2	1	2	2
Chromaturia	<1	<1	2	3	2

171

172 Other adverse reactions reported in these 3 studies in <2% of patients treated with  
 173 POTIGA and numerically greater than placebo were increased appetite, hallucinations,  
 174 myoclonus, peripheral edema, hypokinesia, dry mouth, dysphagia, hyperhidrosis, urinary  
 175 retention, malaise, and increased liver enzymes.

176 Most of the adverse reactions appear to be dose related (especially those classified as  
 177 psychiatric and nervous system symptoms), including dizziness, somnolence, confusional state,  
 178 tremor, abnormal coordination, memory impairment, blurred vision, gait disturbance, aphasia,



179 balance disorder, constipation, dysuria, and chromaturia.

180 POTIGA was associated with dose-related weight gain, with mean weight increasing by  
181 0.2 kg, 1.2 kg, 1.6 kg, and 2.7 kg in the placebo, 600 mg per day, 900 mg per day, and 1,200 mg  
182 per day groups, respectively.

183 **Additional Adverse Reactions Observed During All Phase 2 and 3 Clinical Trials:**

184 Following is a list of adverse reactions reported by patients treated with POTIGA during all  
185 clinical trials: rash, nystagmus, dyspnea, leukopenia, muscle spasms, alopecia, nephrolithiasis,  
186 syncope, neutropenia, thrombocytopenia, euphoric mood, renal colic, coma, encephalopathy.

187 **Comparison of Gender, Age, and Race:** The overall adverse reaction profile of  
188 POTIGA was similar for females and males.

189 There are insufficient data to support meaningful analyses of adverse reactions by age or  
190 race. Approximately 86% of the population studied was Caucasian, and 0.8% of the population  
191 was older than 65 years.

192 **7 DRUG INTERACTIONS**

193 **7.1 Antiepileptic Drugs**

194 The potentially significant interactions between POTIGA and concomitant AEDs are  
195 summarized in Table 5.

196

197 **Table 5. Significant Interactions Between POTIGA and Concomitant Antiepileptic Drugs**

AED	Dose of AED (mg/day)	Dose of POTIGA (mg/day)	Influence of POTIGA on AED	Influence of AED on POTIGA	Dosage Adjustment
Carbamazepine <sup>a,b</sup>	600-2,400	300-1,200	None	31% decrease in AUC, 23% decrease in C <sub>max</sub>	consider an increase in dosage of POTIGA when adding carbamazepine <sup>c</sup>
Phenytoin <sup>a,b</sup>	120-600	300-1,200	None	34% decrease in AUC, 18% decrease in C <sub>max</sub>	consider an increase in dosage of POTIGA when adding phenytoin <sup>c</sup>

198 <sup>a</sup> Based on results of a Phase 2 study.

199 <sup>b</sup> Inducer for uridine 5'-diphosphate (UDP)-glucuronyltransferases (UGTs).

200 <sup>c</sup> A decrease in dosage of POTIGA should be considered when carbamazepine or phenytoin is  
201 discontinued.

202 *[See Clinical Pharmacology (12.3)]*

203

204 **7.2 Digoxin**

205 Data from an *in vitro* study showed that the N-acetyl metabolite of ezogabine (NAMR)  
206 inhibited P-glycoprotein-mediated transport of digoxin in a concentration-dependent manner,  
207 indicating that NAMR may inhibit renal clearance of digoxin. Administration of POTIGA at  
208 therapeutic doses may increase digoxin serum concentrations. Serum levels of digoxin should be  
209 monitored [see *Clinical Pharmacology (12.3)*].

210 **7.3 Alcohol**

211 Alcohol increased systemic exposure to POTIGA. Patients should be advised of possible  
212 worsening of ezogabine's general dose-related adverse reactions if they take POTIGA with  
213 alcohol [see *Clinical Pharmacology (12.3)*].

214 **7.4 Laboratory Tests**

215 Ezogabine has been shown to interfere with clinical laboratory assays of both serum and  
216 urine bilirubin, which can result in falsely elevated readings.

217 **8 USE IN SPECIFIC POPULATIONS**

218 **8.1 Pregnancy**

219 Pregnancy Category C. There are no adequate and well-controlled studies in pregnant  
220 women. POTIGA should be used during pregnancy only if the potential benefit justifies the  
221 potential risk to the fetus.

222 In animal studies, doses associated with maternal plasma exposures (AUC) to ezogabine  
223 and its major circulating metabolite, NAMR, similar to or below those expected in humans at the  
224 maximum recommended human dose (MRHD) of 1,200 mg per day produced developmental  
225 toxicity when administered to pregnant rats and rabbits. The maximum doses evaluated were  
226 limited by maternal toxicity (acute neurotoxicity).

227 Treatment of pregnant rats with ezogabine (oral doses of up to 46 mg/kg/day) throughout  
228 organogenesis increased the incidences of fetal skeletal variations. The no-effect dose for  
229 embryo-fetal toxicity in rats (21 mg/kg/day) was associated with maternal plasma exposures  
230 (AUC) to ezogabine and NAMR less than those in humans at the MRHD. Treatment of pregnant  
231 rabbits with ezogabine (oral doses of up to 60 mg/kg/day) throughout organogenesis resulted in  
232 decreased fetal body weights and increased incidences of fetal skeletal variations. The no-effect  
233 dose for embryo-fetal toxicity in rabbits (12 mg/kg/day) was associated with maternal plasma  
234 exposures to ezogabine and NAMR less than those in humans at the MRHD.

235 Administration of ezogabine (oral doses of up to 61.9 mg/kg/day) to rats throughout  
236 pregnancy and lactation resulted in increased pre- and postnatal mortality, decreased body  
237 weight gain, and delayed reflex development in the offspring. The no-effect dose for pre- and  
238 postnatal developmental effects in rats (17.8 mg/kg/day) was associated with maternal plasma  
239 exposures to ezogabine and NAMR less than those in humans at the MRHD.

240 **Pregnancy Registry:** To provide information regarding the effects of *in utero* exposure  
241 to POTIGA, physicians are advised to recommend that pregnant patients taking POTIGA enroll  
242 in the North American Antiepileptic Drug (NAAED) Pregnancy Registry. This can be done by

243 calling the toll-free number 1-888-233-2334, and must be done by patients themselves.  
244 Information on the registry can also be found at the website [www.aedpregnancyregistry.org](http://www.aedpregnancyregistry.org).

## 245 **8.2 Labor and Delivery**

246 The effects of POTIGA on labor and delivery in humans are unknown.

## 247 **8.3 Nursing Mothers**

248 It is not known whether ezogabine is excreted in human milk. However, ezogabine and/or  
249 its metabolites are present in the milk of lactating rats. Because of the potential for serious  
250 adverse reactions in nursing infants from POTIGA, a decision should be made whether to  
251 discontinue nursing or to discontinue the drug, taking into account the importance of the drug to  
252 the mother.

## 253 **8.4 Pediatric Use**

254 The safety and effectiveness of POTIGA in patients under 18 years of age have not been  
255 established.

256 In juvenile animal studies, increased sensitivity to acute neurotoxicity and urinary bladder  
257 toxicity was observed in young rats compared to adults. In studies in which rats were dosed  
258 starting on postnatal day 7, ezogabine-related mortality, clinical signs of neurotoxicity, and renal  
259 and urinary tract toxicities were observed at doses  $\geq 2$  mg/kg/day. The no-effect level was  
260 associated with plasma ezogabine exposures (AUC) less than those expected in human adults at  
261 the MRHD of 1,200 mg per day. In studies in which dosing began on postnatal day 28, acute  
262 central nervous system effects, but no apparent renal or urinary tract effects, were observed at  
263 doses of up to 30 mg/kg/day. These doses were associated with plasma ezogabine exposures less  
264 than those achieved clinically at the MRHD.

## 265 **8.5 Geriatric Use**

266 There were insufficient numbers of elderly patients enrolled in partial-onset seizure  
267 controlled trials (n = 8 patients on ezogabine) to determine the safety and efficacy of POTIGA in  
268 this population. Dosage adjustment is recommended in patients aged 65 years and older [*see*  
269 *Dosage and Administration (2), Clinical Pharmacology (12.3)*].

270 POTIGA may cause urinary retention. Elderly men with symptomatic BPH may be at  
271 increased risk for urinary retention.

## 272 **8.6 Patients With Renal Impairment**

273 Dosage adjustment is recommended for patients with creatinine clearance  $< 50$  mL/min or  
274 patients with end-stage renal disease (ESRD) receiving dialysis treatments [*see Dosage and*  
275 *Administration (2), Clinical Pharmacology (12.3)*].

## 276 **8.7 Patients With Hepatic Impairment**

277 No dosage adjustment is required for patients with mild hepatic impairment.

278 In patients with moderate or severe hepatic impairment, the initial and maintenance  
279 dosage of POTIGA should be reduced [*see Dosage and Administration (2), Clinical*  
280 *Pharmacology (12.3)*].

## 281 **9 DRUG ABUSE AND DEPENDENCE**

### 282 **9.1 Controlled Substance**

283 POTIGA is a Schedule V controlled substance.

### 284 **9.2 Abuse**

285 A human abuse potential study was conducted in recreational sedative-hypnotic abusers  
286 (n = 36) in which single oral doses of ezogabine (300 mg [n = 33], 600 mg [n = 34], 900 mg  
287 [n = 6]), the sedative-hypnotic alprazolam (1.5 mg and 3.0 mg), and placebo were administered.  
288 Euphoria-type subjective responses to the 300-mg and 600-mg doses of ezogabine were  
289 statistically different from placebo but statistically indistinguishable from those produced by  
290 either dose of alprazolam. Adverse events reported following administration of single oral doses  
291 of 300 mg, 600 mg, and 900 mg ezogabine given without titration included euphoric mood (18%,  
292 21%, and 33%, respectively; 8% from placebo), hallucination (0%, 0%, and 17%, respectively;  
293 0% from placebo) and somnolence (18%, 15%, and 67%, respectively; 15% from placebo).

294 In Phase 1 clinical studies, healthy individuals who received oral ezogabine (200 mg to  
295 1,650 mg) reported euphoria (8.5%), feeling drunk (5.5%), hallucination (5.1%), disorientation  
296 (1.7%), and feeling abnormal (1.5%).

297 In the 3 randomized, double-blind, placebo-controlled Phase 2 and 3 clinical studies,  
298 patients with partial seizures who received oral ezogabine (300 mg to 1,200 mg) reported  
299 euphoric mood (0.5%) and feeling drunk (0.9%), while those who received placebo did not  
300 report either adverse event (0%).

### 301 **9.3 Dependence**

302 There are no adequate data to assess the ability of ezogabine to induce symptoms of  
303 withdrawal indicative of physical dependence. However, the ability of ezogabine to produce  
304 psychological dependence is suggested by adverse event reports of euphoric mood (18% [6 of 33  
305 subjects] to 33% [2 of 6 subjects]) in sedative-hypnotic abusers in the human abuse potential  
306 study and adverse event reports of euphoria (8.5%) in healthy individuals who participated in  
307 Phase 1 studies.

## 308 **10 OVERDOSAGE**

### 309 **10.1 Signs, Symptoms, and Laboratory Findings**

310 There is limited experience of overdose with POTIGA. Total daily doses of POTIGA  
311 over 2,500 mg were reported during clinical trials. In addition to adverse reactions seen at  
312 therapeutic doses, symptoms reported with POTIGA overdose included agitation, aggressive  
313 behavior, and irritability. There were no reported sequelae.

314 In an abuse potential study, cardiac arrhythmia (asystole or ventricular tachycardia)  
315 occurred in 2 volunteers within 3 hours of receiving a single 900-mg dose of POTIGA. The  
316 arrhythmias spontaneously resolved and both volunteers recovered without sequelae.

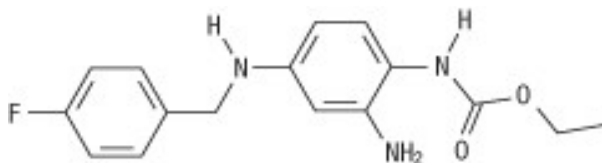
### 317 **10.2 Management of Overdose**

318 There is no specific antidote for overdose with POTIGA. In the event of overdose,  
319 standard medical practice for the management of any overdose should be used. An adequate

320 airway, oxygenation, and ventilation should be ensured; monitoring of cardiac rhythm and vital  
321 sign measurement is recommended. A certified poison control center should be contacted for  
322 updated information on the management of overdose with POTIGA.

## 323 11 DESCRIPTION

324 The chemical name of ezogabine is N-[2-amino-4-(4-fluorobenzylamino)-phenyl]  
325 carbamic acid ethyl ester, and it has the following structure:



326  
327 The empirical formula is  $C_{16}H_{18}FN_3O_2$ , representing a molecular weight of 303.3.  
328 Ezogabine is a white to slightly colored, odorless, tasteless, crystalline powder. At room  
329 temperature, ezogabine is practically insoluble in aqueous media at pH values above 4, while the  
330 solubility is higher in polar organic solvents. At gastric pH, ezogabine is sparingly soluble in  
331 water (about 16 g/L). The pKa is approximately 3.7 (basic).

332 POTIGA is supplied for oral administration as 50-mg, 200-mg, 300-mg, and 400-mg  
333 film-coated immediate-release tablets. Each tablet contains the labeled amount of ezogabine and  
334 the following inactive ingredients: carmine (50-mg and 400-mg tablets), croscarmellose sodium,  
335 FD&C Blue No. 2 (50-mg, 300-mg, and 400-mg tablets), hypromellose, iron oxide yellow  
336 (200-mg and 300-mg tablets), lecithin, magnesium stearate, microcrystalline cellulose, polyvinyl  
337 alcohol, talc, titanium dioxide, and xanthan gum.

## 338 12 CLINICAL PHARMACOLOGY

### 339 12.1 Mechanism of Action

340 The mechanism by which ezogabine exerts its therapeutic effects has not been fully  
341 elucidated. *In vitro* studies indicate that ezogabine enhances transmembrane potassium currents  
342 mediated by the KCNQ (Kv7.2 to 7.5) family of ion channels. By activating KCNQ channels,  
343 ezogabine is thought to stabilize the resting membrane potential and reduce brain excitability. *In*  
344 *vitro* studies suggest that ezogabine may also exert therapeutic effects through augmentation of  
345 GABA-mediated currents.

### 346 12.2 Pharmacodynamics

347 The QTc prolongation risk of POTIGA was evaluated in healthy subjects. In a  
348 randomized, double-blind, active- and placebo-controlled parallel-group study, 120 healthy  
349 subjects (40 in each group) were administered POTIGA titrated up to the final dose of 400 mg 3  
350 times daily, placebo, and placebo and moxifloxacin (on day 22). After 22 days of dosing, the  
351 maximum mean (upper 1-sided, 95% CI) increase of baseline- and placebo-adjusted QTc interval  
352 based on Fridericia correction method (QTcF) was 7.7 msec (11.9 msec) and was observed at 3  
353 hours after dosing in subjects who achieved 1,200 mg per day. No effects on heart rate, PR, or  
354 QRS intervals were noted.

355 Patients who are prescribed POTIGA with medicines known to increase QT interval or  
356 who have known prolonged QT interval, congestive heart failure, ventricular hypertrophy,  
357 hypokalemia, or hypomagnesemia should be observed closely [see *Warnings and Precautions*  
358 (5.4)].

### 359 **12.3 Pharmacokinetics**

360 The pharmacokinetic profile is approximately linear in daily doses between 600 mg and  
361 1,200 mg in patients with epilepsy, with no unexpected accumulation following repeated  
362 administration. The pharmacokinetics of ezogabine are similar in healthy volunteers and patients  
363 with epilepsy.

364 **Absorption:** After both single and multiple oral doses, ezogabine is rapidly absorbed  
365 with median time to maximum plasma concentration ( $T_{max}$ ) values generally between 0.5 and 2  
366 hours. Absolute oral bioavailability of ezogabine relative to an intravenous dose of ezogabine is  
367 approximately 60%. High-fat food does not affect the extent to which ezogabine is absorbed  
368 based on plasma AUC values, but it increases peak concentration ( $C_{max}$ ) by approximately 38%  
369 and delays  $T_{max}$  by 0.75 hour.

370 POTIGA can be taken with or without food.

371 **Distribution:** Data from *in vitro* studies indicate that ezogabine and NAMR are  
372 approximately 80% and 45% bound to plasma protein, respectively. Clinically significant  
373 interactions with other drugs through displacement from proteins are not anticipated. The steady-  
374 state volume of distribution of ezogabine is 2 to 3 L/kg following intravenous dosing, suggesting  
375 that ezogabine is well distributed in the body.

376 **Metabolism:** Ezogabine is extensively metabolized primarily via glucuronidation and  
377 acetylation in humans. A substantial fraction of the ezogabine dose is converted to inactive N-  
378 glucuronides, the predominant circulating metabolites in humans. Ezogabine is also metabolized  
379 to NAMR that is also subsequently glucuronidated. NAMR has antiepileptic activity, but it is  
380 less potent than ezogabine in animal seizure models. Additional minor metabolites of ezogabine  
381 are an N-glucoside of ezogabine and a cyclized metabolite believed to be formed from NAMR.  
382 *In vitro* studies using human biomaterials showed that the N-acetylation of ezogabine was  
383 primarily carried out by NAT2, while glucuronidation was primarily carried out by UGT1A4,  
384 with contributions by UGT1A1, UGT1A3, and UGT1A9.

385 *In vitro* studies showed no evidence of oxidative metabolism of ezogabine or NAMR by  
386 cytochrome P450 enzymes. Coadministration of ezogabine with medications that are inhibitors  
387 or inducers of cytochrome P450 enzymes is therefore unlikely to affect the pharmacokinetics of  
388 ezogabine or NAMR.

389 **Elimination:** Results of a mass balance study suggest that renal excretion is the major  
390 route of elimination for ezogabine and NAMR. About 85% of the dose was recovered in the  
391 urine, with the unchanged parent drug and NAMR accounting for 36% and 18% of the  
392 administered dose, respectively, and the total N-glucuronides of ezogabine and NAMR  
393 accounting for 24% of the administered dose. Approximately 14% of the radioactivity was

394 recovered in the feces, with unchanged ezogabine accounting for 3% of the total dose. Average  
395 total recovery in both urine and feces within 240 hours after dosing is approximately 98%.

396 Ezogabine and its N-acetyl metabolite have similar elimination half-lives ( $t_{1/2}$ ) of 7 to 11  
397 hours. The clearance of ezogabine following intravenous dosing was approximately 0.4 to  
398 0.6 L/hr/kg. Ezogabine is actively secreted into the urine.

399 **Specific Populations: Race:** No study has been conducted to investigate the impact of  
400 race on pharmacokinetics of ezogabine. A population pharmacokinetic analysis comparing  
401 Caucasians and non-Caucasians (predominately African American and Hispanic patients)  
402 showed no significant pharmacokinetic difference. No adjustment of the ezogabine dose for race  
403 is recommended.

404 **Gender:** The impact of gender on the pharmacokinetics of ezogabine was examined  
405 following a single dose of POTIGA to healthy young (aged 21 to 40 years) and elderly (aged 66  
406 to 82 years) subjects. The AUC values were approximately 20% higher in young females  
407 compared to young males and approximately 30% higher in elderly females compared to elderly  
408 males. The  $C_{max}$  values were approximately 50% higher in young females compared to young  
409 males and approximately 100% higher in elderly females compared to elderly males. There was  
410 no gender difference in weight-normalized clearance. Overall, no adjustment of the dosage of  
411 POTIGA is recommended based on gender.

412 **Pediatric Patients:** The pharmacokinetics of ezogabine in pediatric patients have not  
413 been investigated.

414 **Geriatric:** The impact of age on the pharmacokinetics of ezogabine was examined  
415 following a single dose of ezogabine to healthy young (aged 21 to 40 years) and elderly (aged 66  
416 to 82 years) subjects. Systemic exposure (AUC) of ezogabine was approximately 40% to 50%  
417 higher and terminal half-life was prolonged by approximately 30% in the elderly compared to the  
418 younger subjects. The peak concentration ( $C_{max}$ ) was similar to that observed in younger  
419 subjects. A dosage reduction in the elderly is recommended [see *Dosage and Administration (2),*  
420 *Use in Specific Populations (8.5)*].

421 **Renal Impairment:** The pharmacokinetics of ezogabine were studied following a  
422 single 100-mg dose of POTIGA in subjects with normal ( $CrCL >80$  ml/min), mild ( $CrCL \geq 50$  to  
423  $<80$  mL/min), moderate ( $CrCL \geq 30$  to  $<50$  mL/min), or severe renal impairment ( $CrCL <30$   
424 mL/min) ( $n = 6$  in each cohort) and in subjects with ESRD requiring hemodialysis ( $n = 6$ ). The  
425 ezogabine AUC was increased by approximately 30% in patients with mild renal impairment and  
426 doubled in patients with moderate impairment to ESRD ( $CrCL <50$  mL/min) relative to healthy  
427 subjects. Similar increases in NAMR exposure were observed in the various degrees of renal  
428 impairment. The effect of hemodialysis on ezogabine clearance has not been established. Dosage  
429 reduction is recommended for patients with creatinine clearance  $<50$  mL/min and for patients  
430 with ESRD receiving dialysis [see *Dosage and Administration (2), Use in Specific Populations*  
431 *(8.6)*].

432 **Hepatic Impairment:** The pharmacokinetics of ezogabine were studied following a  
433 single 100-mg dose of POTIGA in subjects with normal, mild (Child-Pugh score 5 to 6),

434 moderate (Child-Pugh score 7 to 9), or severe hepatic (Child-Pugh score >9) impairment (n = 6  
 435 in each cohort). Relative to healthy subjects, ezogabine AUC was not affected by mild hepatic  
 436 impairment, but was increased by approximately 50% in subjects with moderate hepatic  
 437 impairment and doubled in subjects with severe hepatic impairment. There was an increase of  
 438 approximately 30% in exposure to NAMR in patients with moderate to severe impairment.  
 439 Dosage reduction is recommended for patients with moderate and severe hepatic impairment  
 440 [see *Dosage and Administration (2), Use in Specific Populations (8.7)*].

441 **Drug Interactions:** *In vitro* studies using human liver microsomes indicated that  
 442 ezogabine does not inhibit enzyme activity for CYP1A2, CYP2A6, CYP2C8, CYP2C9,  
 443 CYP2C19, CYP2D6, CYP2E1, and CYP3A4/5. Inhibition of CYP2B6 by ezogabine has not  
 444 been evaluated. In addition, *in vitro* studies in human primary hepatocytes showed that  
 445 ezogabine and NAMR did not induce CYP1A2 or CYP3A4/5 activity. Therefore, ezogabine is  
 446 unlikely to affect the pharmacokinetics of substrates of the major cytochrome P450 isoenzymes  
 447 through inhibition or induction mechanisms.

448 Ezogabine is neither a substrate nor an inhibitor of P-glycoprotein, an efflux transporter.  
 449 NAMR is a P-glycoprotein inhibitor. Data from an *in vitro* study showed that NAMR inhibited  
 450 P-glycoprotein-mediated transport of digoxin in a concentration-dependent manner, indicating  
 451 that NAMR may inhibit renal clearance of digoxin. Administration of POTIGA at therapeutic  
 452 doses may increase digoxin serum concentrations [see *Drug Interactions (7.2)*].

453 **Interactions with Antiepileptic Drugs:** The interactions between POTIGA and  
 454 concomitant AEDs are summarized in Table 6.

455

456 **Table 6. Interactions Between POTIGA and Concomitant Antiepileptic Drugs**

AED	Dose of AED (mg/day)	Dose of POTIGA (mg/day)	Influence of POTIGA on AED	Influence of AED on POTIGA	Dosage Adjustment
Carbamazepine <sup>a,b</sup>	600-2,400	300-1,200	None	31% decrease in AUC, 23% decrease in C <sub>max</sub> , 28% increase in clearance	consider an increase in dosage of POTIGA when adding carbamazepine <sup>c</sup>
Phenytoin <sup>a,b</sup>	120-600	300-1,200	None	34% decrease in AUC, 18% decrease in C <sub>max</sub> , 33% increase in clearance	consider an increase in dosage of POTIGA when adding phenytoin <sup>c</sup>
Topiramate <sup>a</sup>	250-1,200	300-1,200	None	None	None
Valproate <sup>a</sup>	750-2,250	300-1,200	None	None	None
Phenobarbital	90	600	None	None	None
Lamotrigine	200	600	18% decrease	None	None



			in AUC, 22% increase in clearance		
Others <sup>d</sup>			None	None	None

457 <sup>a</sup> Based on results of a Phase 2 study.

458 <sup>b</sup> Inducer for uridine 5'-diphosphate (UDP)-glucuronyltransferases (UGTs).

459 <sup>c</sup> A decrease in dose of POTIGA should be considered when carbamazepine or phenytoin is  
 460 discontinued.

461 <sup>d</sup> Zonisamide, valproic acid, clonazepam, gabapentin, levetiracetam, oxcarbazepine,  
 462 phenobarbital, pregabalin, topiramate, clobazam, and lamotrigine, based on a population  
 463 pharmacokinetic analysis using pooled data from Phase 3 clinical trials.

464

465 **Oral Contraceptives:** In one study examining the potential interaction between  
 466 ezogabine (150 mg 3 times daily for 3 days) and the combination oral contraceptive  
 467 norgestrel/ethinyl estradiol (0.3 mg/0.03 mg) tablets in 20 healthy females, no significant  
 468 alteration in the pharmacokinetics of either drug was observed.

469 In a second study examining the potential interaction of repeated ezogabine dosing  
 470 (250 mg 3 times daily for 14 days) and the combination oral contraceptive norethindrone/ethinyl  
 471 estradiol (1 mg/0.035 mg) tablets in 25 healthy females, no significant alteration in the  
 472 pharmacokinetics of either drug was observed.

473 **Alcohol:** In a healthy volunteer study, the coadministration of ethanol 1g/kg (5  
 474 standard alcohol drinks) over 20 minutes and ezogabine (200 mg) resulted in an increase in the  
 475 ezogabine C<sub>max</sub> and AUC by 23% and 37%, respectively [*see Drug Interactions (7.3)*].

476 **13 NONCLINICAL TOXICOLOGY**

477 **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**

478 **Carcinogenesis:** In a one-year neonatal mouse study of ezogabine (2 single-dose oral  
 479 administrations of up to 96 mg/kg on postnatal days 8 and 15), a dose-related increase in the  
 480 frequency of lung neoplasms (bronchioalveolar carcinoma and/or adenoma) was observed in  
 481 treated males. No evidence of carcinogenicity was observed in rats following oral administration  
 482 of ezogabine (oral gavage doses of up to 50 mg/kg/day) for 2 years. Plasma exposure (AUC) to  
 483 ezogabine at the highest doses tested was less than that in humans at the maximum  
 484 recommended human dose (MRHD) of 1,200 mg per day.

485 **Mutagenesis:** Highly purified ezogabine was negative in the *in vitro* Ames assay, the *in*  
 486 *vitro* Chinese hamster ovary (CHO) *Hprt* gene mutation assay, and the *in vivo* mouse  
 487 micronucleus assay. Ezogabine was positive in the *in vitro* chromosomal aberration assay in  
 488 human lymphocytes. The major circulating metabolite of ezogabine, NAMR, was negative in the  
 489 *in vitro* Ames assay, but positive in the *in vitro* chromosomal aberration assay in CHO cells.

490 **Impairment of Fertility:** Ezogabine had no effect on fertility, general reproductive  
 491 performance, or early embryonic development when administered to male and female rats at

492 doses of up to 46.4 mg/kg/day (associated with a plasma ezogabine exposure [AUC] less than  
493 that in humans at the MRHD) prior to and during mating, and continuing in females through  
494 gestation day 7.

#### 495 **14 CLINICAL STUDIES**

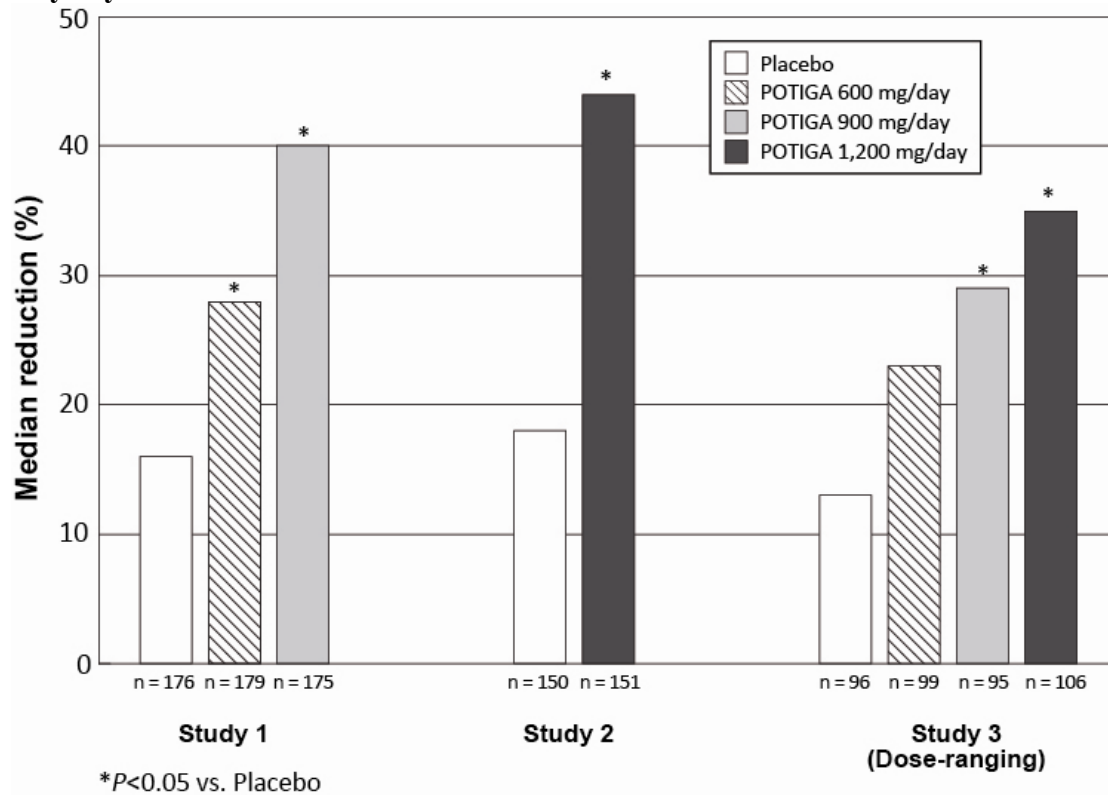
496 The efficacy of POTIGA as adjunctive therapy in partial-onset seizures was established  
497 in 3 multicenter, randomized, double-blind, placebo-controlled studies in 1,239 adult patients.  
498 The primary endpoint consisted of the percent change in seizure frequency from baseline in the  
499 double-blind treatment phase.

500 Patients enrolled in the studies had partial onset seizures with or without secondary  
501 generalization and were not adequately controlled with 1 to 3 concomitant AEDs, with or  
502 without concomitant vagus nerve stimulation. More than 75% of patients were taking 2 or more  
503 concomitant AEDs. During an 8-week baseline period, patients experienced at least 4 partial  
504 onset seizures per 28 days on average with no seizure-free period exceeding 3 to 4 weeks.  
505 Patients had a mean duration of epilepsy of 22 years. Across the 3 studies, the median baseline  
506 seizure frequency ranged from 8 to 12 seizures per month. The criteria for statistical significance  
507 was  $P < 0.05$ .

508 Patients were randomized to the total daily maintenance dosages of 600 mg per day,  
509 900 mg per day, or 1,200 mg per day, each administered in 3 equally divided doses. During the  
510 titration phase of all 3 studies, treatment was initiated at 300 mg per day (100 mg 3 times per  
511 day) and increased in weekly increments of 150 mg per day to the target maintenance dosage.

512 Figure 1 shows the median percent reduction in 28-day seizure frequency (baseline to  
513 double-blind phase) as compared with placebo across all 3 studies. A statistically significant  
514 effect was observed with POTIGA at doses of 600 mg per day (Study 1), at 900 mg per day  
515 (Studies 1 and 3), and at 1,200 mg per day (Studies 2 and 3).  
516

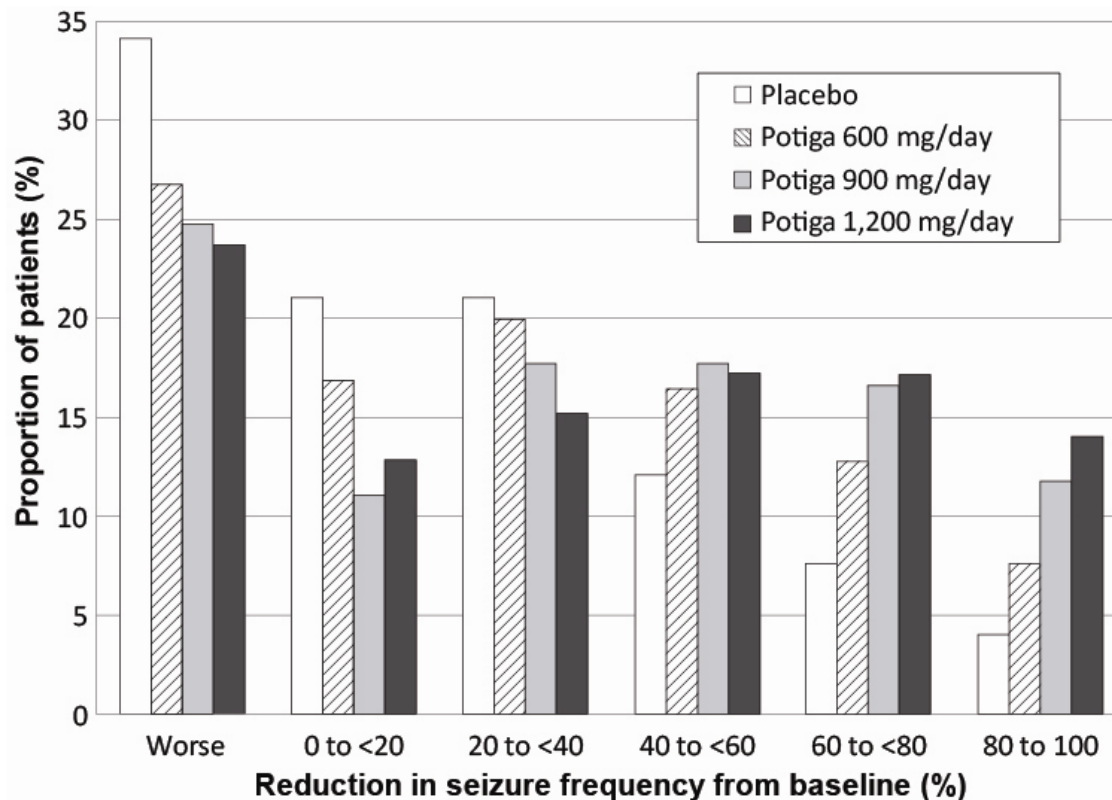
517 **Figure 1. Median Percent Reduction From Baseline in Seizure Frequency per 28**  
518 **Days by Dose**



519  
520

521 Figure 2 shows changes from baseline in the 28-day total partial seizure frequency by  
522 category for patients treated with POTIGA and placebo in an integrated analysis across the 3  
523 clinical trials. Patients in whom the seizure frequency increased are shown at left as “worse.”  
524 Patients in whom the seizure frequency decreased are shown in five categories.  
525

526 **Figure 2. Proportion of Patients by Category of Seizure Response for POTIGA**  
527 **and Placebo Across All Three Double-blind Trials**



528

## 529 **16 HOW SUPPLIED/STORAGE AND HANDLING**

530 POTIGA is supplied as film-coated immediate-release tablets for oral administration  
531 containing 50 mg, 200 mg, 300 mg, or 400 mg of ezogabine in the following packs:

532 **50-mg Tablets:** purple, round, film-coated tablets debossed with “RTG 50” on one side in  
533 bottles of 90 with desiccant (NDC 0173-0810-59).

534 **200-mg Tablets:** yellow, oblong, film-coated tablets debossed with “RTG-200” on one side in  
535 bottles of 90 with desiccant (NDC 0173-0812-59).

536 **300-mg Tablets:** green, oblong, film-coated tablets debossed with “RTG-300” on one side in  
537 bottles of 90 with desiccant (NDC 0173-0813-59).

538 **400-mg Tablets:** purple, oblong, film-coated tablets debossed with “RTG-400” on one side in  
539 bottles of 90 with desiccant (NDC 0173-0814-59).

540 Store at 25°C (77°F); excursions permitted to 15°-30°C (59°-86°F) [See USP Controlled  
541 Room Temperature.]

## 542 **17 PATIENT COUNSELING INFORMATION**

543 *See FDA-approved patient labeling (Medication Guide).*

### 544 **17.1 Urinary Retention**

545 Patients should be informed that POTIGA can cause urinary retention (including urinary  
546 hesitation and dysuria). If patients experience any symptoms of urinary retention, inability to  
547 urinate, and/or pain with urination, they should be instructed to seek immediate medical  
548 assistance [see *Warnings and Precautions (5.1)*]. For patients who cannot reliably report  
549 symptoms of urinary retention (for example, patients with cognitive impairment), urologic  
550 consultation may be helpful.

### 551 **17.2 Psychiatric Symptoms**

552 Patients should be informed that POTIGA can cause psychiatric symptoms such as  
553 confusional state, disorientation, hallucinations, and other symptoms of psychosis. Patients and  
554 their caregivers should be instructed to notify their physicians if they experience psychotic  
555 symptoms [see *Warnings and Precautions (5.2)*].

### 556 **17.3 Central Nervous System Effects**

557 Patients should be informed that POTIGA may cause dizziness, somnolence, memory  
558 impairment, abnormal coordination/balance, disturbance in attention, and ophthalmological  
559 effects such as diplopia or blurred vision. Patients taking POTIGA should be advised not to  
560 drive, operate complex machinery, or engage in other hazardous activities until they have  
561 become accustomed to any such effects associated with POTIGA [see *Warnings and Precautions*  
562 *(5.3)*].

### 563 **17.4 Suicidal Thinking and Behavior**

564 Patients, their caregivers, and families should be informed that AEDs, including  
565 POTIGA, may increase the risk of suicidal thoughts and behavior and should be advised of the  
566 need to be alert for the emergence or worsening of symptoms of depression, any unusual changes  
567 in mood or behavior, or the emergence of suicidal thoughts, behavior, or thoughts about self-  
568 harm. Behaviors of concern should be reported immediately to healthcare providers [see  
569 *Warnings and Precautions (5.5)*].

### 570 **17.5 Pregnancy**

571 Patients should be advised to notify their physicians if they become pregnant or intend to  
572 become pregnant during therapy. Patients should be advised to notify their physicians if they  
573 intend to breastfeed or are breastfeeding an infant.

574 Patients should be encouraged to enroll in the NAAED Pregnancy Registry if they  
575 become pregnant. This registry collects information about the safety of AEDs during pregnancy.  
576 To enroll, patients can call the toll-free number 1-888-233-2334 [see *Use in Specific Populations*  
577 *(8.1)*].

578  
579 POTIGA is a trademark of Valeant Pharmaceuticals North America.

580  
581



582