

NEW ZEALAND DATA SHEET

1. PRODUCT NAME

TOPIRAMATE ACTAVIS 25, 50, 100, 200

(Topiramate 25 mg, 50 mg, 100 mg and 200 mg film-coated tablets)

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains:

25 mg topiramate

50 mg topiramate

100 mg topiramate

200 mg topiramate

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Topiramate is a white crystalline powder with a bitter taste. It is most soluble in alkaline solutions containing sodium hydroxide or sodium phosphate and has a pH of 9 to 10. It is freely soluble in acetone, chloroform, dimethylsulfoxide and ethanol. The solubility in water is 9.8 mg/mL. Its saturated solution has a pH of 6.3.

Topiramate Actavis Tablets:

25 mg – White, round, biconvex, film coated tablet marked with ‘V1’.

50 mg – Light yellow, round biconvex, film coated tablet marked with ‘V3’.

100 mg – Yellow, round biconvex film, coated tablet marked with ‘V4’.

200 mg – Salmon, oval biconvex, film coated tablet marked with ‘V5’.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Epilepsy

Topiramate Actavis is indicated in adults and children 2 years and over**[†]: as monotherapy in patients with newly diagnosed epilepsy

- for conversion to monotherapy in patients with epilepsy
- as add-on therapy in partial onset seizures, generalised tonic-clonic seizures or seizures associated with Lennox-Gastaut syndrome.

** Topiramate Actavis tablet range cannot deliver lower doses required for younger paediatric patients (See *Dosage and Administration*).

Migraine

Topiramate Actavis is indicated in adults for the prophylaxis of migraine headache. The usefulness of Topiramate Actavis in the acute treatment of migraine headache has not been studied.

4.2 Dose and method of administration

Topiramate Actavis Tablets should be swallowed whole. Topiramate Actavis Tablets can be taken with or without food.

For optimum seizure control in both adults and children, it is recommended that therapy should be initiated at a low dose followed by slow titration to an effective dose. Dose titration should be guided by clinical outcome.

The recommended dosages of Topiramate Actavis in adults and children with epilepsy are listed as follows and summarised in Table 1.

Epilepsy - Monotherapy

In newly diagnosed epileptic patients, Topiramate Actavis monotherapy should be initiated at a low dose (see Table 1).

In patients who are being converted to Topiramate Actavis monotherapy, consideration should be given to the effects of seizure control when withdrawing concomitant antiepileptic agents (AEAs). Unless safety concerns require an abrupt withdrawal of the concomitant AEA, a gradual discontinuation at the rate of approximately one-third of the concomitant AEA dose every 2 weeks is recommended. When enzyme inducing medicines are withdrawn, topiramate levels will increase. A decrease in topiramate dosage may be required if clinically indicated.

Adults

Titration for monotherapy should begin at 25 mg as a single (nightly) dose for one week or longer. The dosage should then be increased by 25 to 50 mg/day at weekly or longer intervals to the recommended target dose of 100 mg/day. The maximum recommended dose is 500 mg/day. Some patients with refractory forms of epilepsy have tolerated doses of 1,000 mg/day. The daily dosage should be taken as two divided doses.

Children**

Titration for monotherapy should begin at 0.5 to 1 mg/kg as a single (nightly) dose for the first week. The dosage should then be increased by 0.5 to 1 mg/kg/day at weekly or longer intervals to the recommended target dose of 100 to 400 mg/day. The daily dosage should be given as two divided doses.

** Topiramate Actavis tablet range cannot deliver lower doses required for younger paediatric patients (See *Dosage and Administration*).

Epilepsy - Add-on therapy

Adults

Titration for add-on therapy should begin at 25 to 50 mg as a single (nightly) or divided dose for one week or longer. The dosage should then be increased by 25 to 100 mg/day at weekly or longer intervals to the target dose of 200 to 400 mg/day. The maximum recommended dose should not exceed 1000 mg/day. The daily dosage should be taken as two divided doses.

Children**

Titration for add-on therapy should begin at 1 to 3 mg/kg/day up to 25 mg/day as a single (nightly) dose for the first week. The dosage should then be increased by 1 to 3 mg/kg/day at weekly or longer intervals to the recommended total daily dose of 5 to 9 mg/kg/day. Daily doses up to 30 mg/kg have been studied and were generally well tolerated. The daily dosage should be given as two divided doses.

** Topiramate Actavis tablet range cannot deliver lower doses required for younger paediatric patients (See *Dosage and Administration*).

Table 1 Recommended dosages of Topiramate Actavis in adults and children

	Monotherapy	Add-on therapy
ADULTS		
Starting dose	25 mg as a single (nightly) dose for one week (or longer)	25 to 50 mg as a single (nightly) or divided dose for one week (or longer)
Escalation dose	Increase by 25 to 50 mg/day at weekly or longer intervals	Increase by 25 to 100 mg/day at weekly or longer intervals
Target dose	100 mg/day	200 to 400 mg/day
Maximum dose	Up to 500 mg/day ¹	Up to 1000 mg/day
CHILDREN **		
Starting dose	0.5 to 1 mg/kg as a single (nightly) dose for the first week	1 to 3 mg/kg/day up to 25 mg/day as a single (nightly) dose for the first week
Escalation dose	Increase by 0.5 to 1 mg/kg/day at weekly or longer intervals	Increase by 1 to 3 mg/kg/day at weekly or longer intervals
Target dose	3 to 6 mg/kg/day	5 to 9 mg/kg/day
Maximum dose	Up to 500 mg/day	Up to 30 mg/kg/day

Note: Daily doses greater or equal to 50 mg should be taken as two divided doses.

¹ Some patients with refractory epilepsy have tolerated doses of 1000 mg/day.

** Topiramate Actavis tablet range cannot deliver lower doses required for younger paediatric patients (See *Dosage and Administration*).

It is not necessary to monitor topiramate plasma concentrations to optimise topiramate therapy. For patients receiving concomitant phenytoin and carbamazepine, dosage adjustment for Topiramate Actavis may be required (see **Interactions**).

Migraine

Adults

Titration should begin at 25 mg nightly for 1 week. The dosage should then be increased weekly in increments of 25 mg/day. If the patient is unable to tolerate the titration regimen, longer intervals between dose adjustments can be used.

The recommended total daily dose of Topiramate Actavis as treatment for prophylaxis of migraine headache is 100 mg/day administered in two divided doses. Some patients may experience a benefit at a total daily dose of 50 mg/day. Patients have received a total daily dose up to 200 mg/day. Dose and titration should be guided by clinical outcome.

Use in patients with hepatic and/or renal impairment

Caution is advised during titration in the elderly and in patients with renal disease and/or hepatic impairment (see Warnings and Precautions). Patients with moderate and severe renal impairment may require a dose reduction. Half of the usual starting and maintenance dose is recommended (see **Pharmacokinetics**).

Use in patients undergoing haemodialysis

Topiramate is cleared by haemodialysis. To avoid rapid reduction in topiramate plasma concentration during haemodialysis, a supplemental dose of topiramate equal to approximately one-half the daily dose should be administered on hemodialysis days. The supplemental dose should be administered in divided doses at the beginning and completion of the hemodialysis procedure. The supplemental dose may differ based on the characteristics of the dialysis equipment being used (see **Pharmacokinetics**).

Drug withdrawal and dosage reduction

In patients with or without a history of seizures or epilepsy, antiepileptic drugs, including Topiramate Actavis, should be gradually withdrawn to minimize the potential for seizures or of increased seizure frequency (see **Warnings and Precautions**). In situations where rapid withdrawal of Topiramate Actavis is medically required, appropriate monitoring is recommended.

4.3 Contraindications

Hypersensitivity to topiramate and the excipients listed under **Further Information**.

4.4 Special warnings and precautions for use

Drug withdrawal

In patients with or without a history of seizures or epilepsy, antiepileptic agents, including Topiramate Actavis, should be gradually withdrawn to minimise the potential for seizures or increased seizure frequency.

In clinical trials, daily dosages were decreased in weekly intervals by 50 to 100 mg in adults with epilepsy and by 25 to 50 mg in adults receiving topiramate at doses up to 100 mg/day for migraine prophylaxis. In clinical trials of children, topiramate was gradually withdrawn over a 2- to 8-week period. In situations where rapid withdrawal of topiramate is medically required, appropriate monitoring is recommended.

Nephrolithiasis

Some patients, especially those with a predisposition to nephrolithiasis, may be at increased risk for renal stone formation and associated signs and symptoms such as renal colic, renal pain or flank pain.

Risk factors for nephrolithiasis include prior stone formation, a family history or nephrolithiasis and hypercalciuria. None of these risk factors can reliably predict stone formation during topiramate treatment. In addition, patients taking other medication associated with nephrolithiasis may be at increased risk.

Adequate hydration while using Topiramate Actavis is very important. Hydration can reduce the risk of nephrolithiasis. Proper hydration prior to and during activities such as exercise or exposure to warm temperatures may reduce the risk of heat-related adverse events.

Suicidality (suicidal behaviour and ideation)

An analysis of reports of suicidality (suicidal behaviour or ideation) from placebo controlled clinical studies of eleven medicines used to treat epilepsy as well as psychiatric disorders, and other conditions revealed that patients receiving anti-epileptic drugs had approximately twice the risk of suicidal behaviour or ideation (0.43%) compared to patients receiving placebo (0.24%). The increased risk of suicidal behaviour and suicidal ideation was observed as early as one week after starting the anti-epileptic medicine and continued through 24 weeks. The results were generally consistent among the eleven medicines. As most trials included in the analysis did not extend beyond 24 weeks, the risk of suicidal thoughts or behaviour beyond 24 weeks could not be assessed.

Patients who were treated for epilepsy, psychiatric disorders, and other conditions were all at increased risk for suicidality when compared to placebo, and there did not appear to be a specific demographic subgroup of patients to which the increased risk could be attributed. The relative risk for suicidality was higher in the patients with epilepsy compared to patients who were given one of the medicines in the class for psychiatric or other conditions.

In double-blind clinical trials, suicide related events (suicidal ideation, suicide attempts, and suicide) occurred at a frequency of 0.5% in topiramate treated patients (46 out of 8,652 patients treated) compared to 0.2% treated with placebo (8 out of 4,045 patients treated). One completed suicide was reported in a bipolar disorder double-blind trial in a patient on topiramate.

All patients who are currently taking or starting on any anti-epileptic drug should be closely monitored for notable changes in behaviour that could indicate the emergence or worsening of suicidal thoughts or behaviour or depression.

Healthcare professionals should inform patients, their families, and caregivers of the potential for an increase in the risk of suicidality. Prescribers should advise patients to seek medical advice immediately if they develop any symptoms suggestive of suicidality.

Rapid dose reduction, discontinuation or substitution of topiramate

In patients who are seizure-free or whose seizures are well controlled, the need for dosage reduction, discontinuation or substitution should be assessed by a healthcare professional and any changes should be implemented gradually.

Oligohydrosis and Hyperthermia

Oligohydrosis (decreased sweating), infrequently resulting in hospitalization, has been reported in association with topiramate use. Decreased sweating and an elevation in body temperature above normal characterized these cases. Some of the cases were reported after exposure to elevated environmental temperature.

The majority of the reports have been in children. Patients, especially paediatric patients, treated with topiramate should be monitored closely for evidence of decreased sweating and increased body temperature, especially in hot weather. Caution should be used when Topiramate Actavis is prescribed with other drugs that predispose patients to heat-related disorders; these drugs include, but are not limited to, other carbonic anhydrase inhibitors and drugs with anticholinergic activity.

Patients, especially paediatric patients, treated with topiramate should be monitored closely for evidence of decreased sweating and increased body temperature, especially in hot weather.

Decreased hepatic function

In patients with hepatic impairment, topiramate should be administered with caution as the clearance of topiramate may be decreased.

Acute myopia and secondary angle closure glaucoma

A syndrome consisting of acute myopia associated with secondary angle closure glaucoma has been reported in patients receiving topiramate. Symptoms include acute onset of decreased visual acuity and/or ocular pain. Ophthalmologic findings can include myopia, anterior chamber shallowing, ocular hyperaemia (redness) and increased intraocular pressure. Mydriasis may or may not be present. This syndrome may be associated with supraciliary effusion resulting in anterior displacement of the lens and iris, with secondary angle closure glaucoma. Symptoms typically occur within 1 month of initiating topiramate therapy. In contrast to primary narrow angle glaucoma, which is rare under 40 years of age, secondary angle closure glaucoma associated with topiramate has been reported in paediatric patients as well as adults. Treatment includes discontinuation of topiramate, as rapidly as possible in the judgement of the treating physician, and appropriate measures to reduce intraocular pressure. These measures generally result in a decrease in intraocular pressure.

Elevated intraocular pressure of any aetiology, if left untreated, can lead to serious sequelae including permanent vision loss.

Visual field defects

Visual field defects have been reported in patients receiving topiramate independent of elevated intraocular pressure. In clinical trials, most of these events were reversible after topiramate discontinuation. If visual problems occur at any time during topiramate treatment, consideration should be given to discontinuing the drug.

Metabolic acidosis

Hyperchloraemic, non-anion gap, metabolic acidosis (i.e. decreased serum bicarbonate below the normal reference range in the absence of respiratory alkalosis) is associated with topiramate treatment. This decrease in serum bicarbonate is due to the inhibitory effect of topiramate on renal carbonic anhydrase. Generally, the decrease in bicarbonate occurs early in treatment although it can occur at any time during treatment. These decreases are usually mild to moderate (average decrease of 4 mmol/L at doses of 100 mg/day or above in adults and at approximately 6 mg/kg/day in paediatric patients). Rarely, patients have experienced decreases to values below 10 mmol/L. Conditions or therapies that predispose to acidosis (such as renal disease, severe respiratory disorders, status epilepticus, diarrhoea, surgery, ketogenic diet, or certain drugs) may be additive to the bicarbonate lowering effects of topiramate.

Chronic metabolic acidosis in paediatric patients can reduce growth rates. The effect of topiramate on growth and bone-related sequelae has not been systematically investigated in paediatric or adult populations.

Depending on underlying conditions, appropriate evaluation including serum bicarbonate levels is recommended with Topiramate Actavis therapy. If metabolic acidosis develops and persists, consideration should be given to reducing the dose or discontinuing Topiramate Actavis (using dose tapering).

Mood disturbances and depression

An increased incidence of mood disturbances and depression has been observed during topiramate treatment. Psychiatric or behavioural disturbances (depression or mood problems) in majority of affected patients were dose related for both the add-on epilepsy and migraine populations.

Suicide attempt

In the double-blind phases of clinical trials with topiramate in approved and investigational indications, suicide attempts occurred at a rate of 0.003 on topiramate (13 events/3999 patient years) versus 0 on placebo (0 events/1430 patient years). One completed suicide was reported in a bipolar disorder trial in a patient on topiramate.

Nutritional supplementation

A dietary supplement or increased food intake may be considered if the patient is losing weight while on this medication.

Decreased renal function

The major route of elimination of unchanged topiramate and its metabolites is *via* the kidney. Renal elimination is dependent on renal function and is independent of age. Patients with moderate or severe renal impairment may take 10 to 15 days to reach steady state plasma concentrations as compared to 4 to 8 days in patients with normal renal function.

As with all patients, the titration schedule should be guided by clinical outcome (i.e. seizure control, avoidance of side effects) with the knowledge that subjects with known renal impairment may require a longer time to reach steady-state at each dose.

Pregnancy and lactation

As with other antiepileptic medicines, topiramate was teratogenic in mice, rats and rabbits. In rats, topiramate crosses the placental barrier. There are no adequate and well-controlled studies using topiramate in pregnant women.

Topiramate can cause fetal harm when administered to a pregnant woman. Data from pregnancy registries indicate that infants exposed to topiramate *in utero* have an increased risk of congenital malformations (e.g., craniofacial defects, such as cleft lip/palate, hypospadias, and anomalies involving various body systems). This has been reported with topiramate monotherapy and topiramate as part of a polytherapy regimen.

Data from the North American AED (NAAED) Pregnancy Registry indicate an increased risk of oral clefts in infants exposed to topiramate monotherapy during the first trimester of pregnancy. The prevalence of oral clefts was 1.4% compared to a prevalence of 0.38% - 0.55% in infants exposed to other AEDs, and a prevalence of 0.07 % in infants of mothers without epilepsy or treatment with other AEDs. For comparison, the Centers for Disease Control and Prevention (CDC) reviewed available data on oral clefts in the United States and found a background rate of 0.17%. The relative risk of oral clefts in topiramate-exposed pregnancies in the NAAED Pregnancy Registry was 21.3 (95% Confidence Interval=CI 7.9 – 57.1) as compared to the risk in a background population of untreated women. The UK Epilepsy and Pregnancy Register reported a similarly increased prevalence of oral clefts of 3.2% among infants exposed to topiramate monotherapy. The observed rate of oral clefts was 16 times higher than the background rate in the UK, which is approximately 0.2%.

Compared with a reference group not taking antiepileptic drugs, registry data for topiramate monotherapy showed a higher prevalence of low birth weight (<2500 grams). A causal relationship has not been established. In addition, data from these registries and other studies suggest that, compared with monotherapy, there may be an increased risk of teratogenic effects associated with the use of anti-epileptic drugs in combination therapy.

Topiramate should be used during pregnancy only if potential benefit justifies the potential risk to the fetus. In treating and counseling women of childbearing potential, the prescribing physician should weigh the benefits of therapy against the risks, particularly when topiramate is considered for a condition not usually associated with permanent injury or death. If this drug is used during pregnancy or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

The risk of having an abnormal child as a result of antiepileptic medication is far outweighed by the danger to the mother and fetus of uncontrolled epilepsy.

It is recommended that:

- Women on antiepileptic drugs (AEDs) receive pregnancy counselling with regard to the risk of foetal abnormalities;
- AEDs should be continued during pregnancy and monotherapy should be used if possible at the lowest effective dose as risk of abnormality is greater in women taking combined medication;
- Folic acid supplementation (5mg) should be commenced four weeks prior to and continue for twelve weeks after conception;
- Specialist prenatal diagnosis including detailed mid-trimester ultrasound should be offered.

Topiramate is excreted in the milk of lactating rats. The excretion of topiramate in human milk has not been evaluated in controlled studies. Limited observation in patients suggests an extensive excretion of topiramate into breast milk. Since many medicines are excreted in human milk, a decision should be made whether to discontinue breastfeeding or to discontinue the medicine, taking into account the importance of the medicine to the mother.

Teratogenicity and embryotoxicity

As with other antiepileptic agents, topiramate was teratogenic in mice, rats and rabbits. Overall numbers of foetal malformations in mice were increased for all topiramate treated groups, but no significant differences or dose-response relationships were observed for overall or specific malformations, suggesting that other factors such as maternal toxicity may be involved.

The teratogenic effects seen in rats and rabbits were similar to those seen with carbonic anhydrase inhibitors, which have not been associated with malformations in humans.

Mutagenicity

In a battery of *in vitro* and *in vivo* mutagenicity assays, topiramate did not show genotoxic potential.

Carcinogenicity

In juvenile rats, daily oral administration of topiramate at doses up to 300 mg/kg/day during the period of development corresponding to infancy, childhood, and adolescence resulted in toxicities similar to those in adult animals (decreased food consumption with decreased body weight gain, centrolobular hepatocellular hypertrophy and slight urothelial hyperplasia in the urinary bladder). There were no relevant effects on long bone (tibia) growth or bone (femur) mineral density, preweaning and reproductive development, neurological development (including assessments on memory and learning), mating and fertility or hysterotomy parameters.

Effects on ability to drive and use machines

Topiramate acts on the central nervous system and may produce drowsiness, dizziness or other related symptoms. It may also cause visual disturbances and/or blurred vision. These otherwise mild or moderate adverse events are potentially dangerous in patients driving a vehicle or operating machinery, particularly until the individual patient's experience with the medicine is established.

4.5 Interaction with other medicines and other forms of interaction

Effects of topiramate on other antiepileptic agents

The addition of topiramate to other antiepileptic agents (phenytoin, carbamazepine, valproic acid, phenobarbitone, primidone) has no effect on their steady-state plasma concentrations. However, the addition of topiramate to phenytoin may occasionally result in an increase of plasma concentrations of phenytoin in some patients. This is possibly due to inhibition of a specific enzyme polymorphic

isoform (CYP2C19). Thus, any patient on phenytoin showing clinical signs or symptoms of toxicity should have phenytoin levels monitored.

Effects of other antiepileptic agents on topiramate

Topiramate is metabolised up to 50% in patients receiving concomitant antiepileptic therapy with known inducers of enzymes, which metabolise medicines.

Phenytoin and carbamazepine decrease the plasma concentration of topiramate. The addition or withdrawal of phenytoin or carbamazepine to topiramate therapy may require an adjustment in dosage of the latter. This should be done by titrating to clinical effect.

The addition or withdrawal of valproic acid does not produce clinically significant changes in plasma concentrations of topiramate and, therefore, does not warrant dosage adjustment of topiramate.

The results of these interactions are summarised as below:

Table 10: Interactions between antiepileptic agents (AEA) and topiramate

AEA co-administered	AEA plasma concentration	Topiramate plasma concentration
Phenytoin	↔ *	Decrease
Carbamazepine	↔	Decrease
Valproic Acid	↔	↔
Phenobarbitone	↔	Not studied
Primidone	↔	Not studied
Vigabartin	No data	No data

↔ = No effect on plasma concentration (< 15% change)

* Plasma concentrations increase occasionally in some patients on both phenytoin and topiramate.

Other interactions

Digoxin: In a single dose study, the serum digoxin area under plasma concentration curve (AUC) decreased 12% due to concomitant administration of topiramate. The clinical relevance of this observation has not been established. When topiramate is added or withdrawn in patients on digoxin therapy, careful attention should be given to the routine monitoring of serum digoxin.

CNS depressants: Concomitant administration of topiramate and alcohol or other CNS depressant medicines has not been evaluated in clinical studies. It is recommended that topiramate not be used concomitantly with alcohol or other CNS depressant medicines.

Oral contraceptives: In a pharmacokinetic interaction study in healthy volunteers with a concomitantly administered combination oral contraceptive product containing 1 mg norethindrone plus 35 microgram ethinyl oestradiol, topiramate given in the absence of other medications at doses of 50 to 200 mg/day was not associated with statistically significant changes in mean exposure (AUC) to either component of the oral contraceptive.

In another study, exposure to ethinyl oestradiol was statistically significantly decreased at doses of 200, 400 and 800 mg/day (18%, 21% and 30%, respectively) when given as adjunctive therapy in patients taking valproic acid. In both studies, topiramate (50 mg/day to 800 mg/day) did not significantly affect exposure to norethindrone. Although there was a dose dependent decrease in ethinyl oestradiol exposure for doses between 200 to 800 mg/day, there was no significant dose

dependent change in ethinyl oestradiol exposure for doses of 50 to 200 mg/day. The clinical significance of the changes observed is not known. The possibility of decreased contraceptive efficacy and increased breakthrough bleeding should be considered in patients taking combination oral contraceptive products with topiramate. Patients taking oestrogen containing contraceptives should be asked to report any change in their bleeding patterns. Contraceptive efficacy can be decreased even in the absence of breakthrough bleeding.

Lithium: In healthy volunteers, there was an observed reduction (18% for AUC) in systemic exposure for lithium during concomitant administration with topiramate 200 mg/day. In patients with bipolar disorder, the pharmacokinetics of lithium were unaffected during treatment with topiramate at doses of 200 mg/day. However, there was an observed increase in systemic exposure (26% for AUC) following topiramate doses of up to 600 mg/day. Lithium levels should be monitored when co-administered with topiramate.

Risperidone: Drug-drug interaction studies conducted under single and multiple dose conditions in healthy volunteers and patients with bipolar disorder yielded similar results. When administered concomitantly with topiramate at escalating doses of 100, 250 and 400 mg/day, there was a reduction in risperidone (administered at doses ranging from 1 to 6 mg/day) with systemic exposure (16% and 33% for steady-state AUC at the 250 and 400 mg/day doses, respectively). Minimal alterations in the pharmacokinetics of the total active moiety (risperidone plus 9-hydroxyrisperidone) and no alterations for 9-hydroxyrisperidone were observed.

Hydrochlorothiazide (HCTZ): A drug-drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of HCTZ (25 mg 24-hourly) and topiramate (96 mg 12-hourly) when administered alone and concomitantly. The results of this study indicate that topiramate C_{max} increased by 27% and AUC increased by 29% when HCTZ was added to topiramate. The clinical significance of this change is unknown. The addition of HCTZ to topiramate therapy may require an adjustment of the topiramate dose. The steady-state pharmacokinetics of HCTZ was not significantly influenced by the concomitant administration of topiramate. Clinical laboratory results indicated decreases in serum potassium after topiramate or HCTZ administration, which were greater when HCTZ and topiramate were administered in combination.

Metformin: A drug-drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of metformin and topiramate in plasma when metformin was given alone and when metformin and topiramate were given simultaneously. The results of this study indicated that metformin mean C_{max} and mean AUC_{0-12h} increased by 18% and 25%, respectively, while mean Cl/F decreased 20% when metformin was co-administered with topiramate. Topiramate did not affect metformin T_{max} . The clinical significance of the effect of topiramate on metformin pharmacokinetics is unclear. Oral plasma clearance of topiramate appears to be reduced when administered with metformin but the extent of change in the clearance is not known. Similarly, the clinical significance of the effect of metformin on topiramate pharmacokinetics is also not clear. Thus, when topiramate is added or withdrawn in patients on metformin therapy, careful attention should be given to the routine monitoring for adequate control of their diabetic disease state.

Pioglitazone: A drug-drug interaction study conducted in healthy volunteers evaluated the steady-state pharmacokinetics of topiramate and pioglitazone when administered alone and concomitantly. A 15% decrease in the $AUC_{t,ss}$ of pioglitazone with no alteration in $C_{max,ss}$ was observed. This finding was however not statistically significant. In addition, a 13% and 16% decrease in $C_{max,ss}$ and $AUC_{t,ss}$ respectively, of the active hydroxy-metabolite was noted as well as a 60% decrease in $C_{max,ss}$ and $AUC_{t,ss}$ of the active keto-metabolite. The clinical significance of these findings is not known. When topiramate is added to pioglitazone therapy or pioglitazone is added to topiramate therapy, careful attention should be given to the routine monitoring of patients for adequate control of their diabetic disease state.

Glibenclamide: A drug-drug interaction study conducted in patients with type 2 diabetes evaluated the steady-state pharmacokinetics of glibenclamide (5 mg/day) alone and concomitantly with topiramate (150 mg/day). There was a 25% reduction in glibenclamide AUC₂₄ during topiramate administration. Systemic exposure of the active metabolites, 4-*trans*-hydroxy-glibenclamide and 3-*cis*-hydroxyglibenclamide, were also reduced by 13% and 15%, respectively. The steady-state pharmacokinetics of topiramate were unaffected by concomitant administration of glibenclamide. When topiramate is added to glibenclamide therapy or glibenclamide is added to topiramate therapy, careful attention should be given to the routine monitoring of patients for adequate control of their diabetic disease state.

Other forms of interactions

Agents predisposing to nephrolithiasis: When topiramate is used concomitantly with other agents predisposing to nephrolithiasis, the risk of nephrolithiasis may be increased. Thus, while on topiramate therapy, agents like these should be avoided, as they may create a physiological environment that increases the risk of renal stone formation.

Valproic acid: Concomitant administration of topiramate and valproic acid has been associated with hyperammonemia with or without encephalopathy in patients who have tolerated either drug alone. In most cases, symptoms and signs abated with discontinuation of either drug. This adverse event is not due to a pharmacokinetic interaction.

Hypothermia, defined as an unintentional drop in body core temperature to < 35°C, has been reported in association with the concomitant use of topiramate and valproic acid (VPA) both in conjunction with hyperammonemia and in the absence of hyperammonemia. This adverse event in patients using concomitant topiramate and valproate can occur after starting topiramate treatment or after increasing the daily dose of topiramate.

Additional pharmacokinetic drug interaction studies: Clinical studies have been conducted to assess the potential pharmacokinetic drug interaction between topiramate and other agents. The changes in C_{max} or AUC as a result of the interactions are summarized in Table 11. The second column (concomitant drug concentration) describes what happens to the concentration of the concomitant drug listed in the first column when topiramate is added. The third column (topiramate concentration) describes how the co-administration of a drug listed in the first column modifies the concentration of topiramate.

Table 11: Pharmacokinetic drug interaction studies

Concomitant drug	Concomitant drug concentration	Topiramate concentration
Amitriptyline	↔ 20% increase in C_{max} and AUC of nortriptyline metabolite	Not studied
Dihydroergotamine (oral and subcutaneous)	↔	↔
Haloperidol	↔ 31% increase in AUC of the reduced metabolite	Not studied
Propranolol	↔ 17% Increase in C_{max} for 4-OH propranolol (topiramate 50 mg 12-hourly)	16% Increase in C_{max} , 17% increase in AUC (80 mg propranolol 12-hourly)
Sumatriptan (oral and subcutaneous)	↔	Not studied
Pizotifen	↔	↔
Diltiazem	25% decrease in AUC of diltiazem and 18% decrease in DEA, and ↔ for DEM*	20% increase in AUC
Venlafaxine	↔	↔
Flunarizine	16% increase in AUC (topiramate 50 mg 12-hourly) ^b	↔

↔ = No effect on C_{max} and AUC ($\leq 15\%$ change) of the parent compound

* DEA = des acetyl diltiazem, DEM = N-demethyl diltiazem

^b Flunarizine AUC increased 14% in subjects taking flunarizine alone. Increase in exposure may be attributed to accumulation during achievement of steady state.

4.6 Fertility, pregnancy and lactation

4.7 Effects on ability to drive and use machines

4.8 Undesirable effects

The safety of topiramate was evaluated from clinical trial database consisting of 4111 patients (3182 on topiramate and 929 on placebo) who participated in 20 double-blind trials and 2847 patients who participated in 34 open-label trials, respectively, for the treatment of primary generalized tonic-clonic seizures, partial onset seizures, seizures associated with Lennox-Gastaut syndrome, newly or recently diagnosed epilepsy or migraine.

The majority of all adverse reactions were mild to moderate in severity.

Double-Blind, Placebo-Controlled Data Adjunctive Epilepsy Trials – Adult Patients

Adverse Drug Reactions (ADRs) reported in $\geq 1\%$ of topiramate-treated adult patients in double-blind, placebo-controlled adjunctive epilepsy trials are shown in Table 2. ADRs that had an incidence $>5\%$ in the recommended dose range (200 to 400 mg/day) in adults in double-blind, placebo-controlled adjunctive epilepsy studies in descending order of frequency included somnolence, dizziness, fatigue, irritability, weight decreased, bradyphrenia, paresthesias, diplopia, coordination abnormal, nausea, nystagmus, lethargy, anorexia, dysarthria, vision blurred, decreased appetite, memory impairment and diarrhoea.

Table 2: Adverse Drug Reactions Reported by $\geq 1\%$ of Topiramate-treated Adult Patients in Double-Blind, Placebo-Controlled, Adjunctive Epilepsy Trials

System/Organ Adverse Reaction	Class	Topiramate 200- 400 mg/day (N=354) %	Topiramate 600-1000 mg/day (N=437) %	Placebo (N=382) %
Metabolism and Nutrition Disorders				
Anorexia		5.4	6.2	1.8
Decreased appetite		5.1	8.7	3.7
Psychiatric Disorders				
Bradyphrenia		8.2	19.5	3.1
Expressive language disorder		4.5	9.4	1.6
Confusional state		3.1	5.0	0.8
Depression		3.1	11.7	3.4
Insomnia		3.1	6.4	4.5
Aggression		2.8	3.2	1.8
Agitation		1.7	2.3	1.3
Anger		1.7	2.1	0.5
Anxiety		1.7	6.6	2.9
Disorientation		1.7	3.2	1.0
Mood altered		1.7	4.6	1.0
Nervous System Disorders				
Somnolence		17.8	17.4	8.4
Dizziness		16.4	34.1	13.6
Paraesthesia		8.2	17.2	3.7
Coordination abnormal		7.1	11.4	4.2
Nystagmus		6.2	11.7	6.8
Lethargy		5.6	8.0	2.1
Dysarthria		5.4	6.2	1.0
Memory impairment		5.1	10.8	1.8

Disturbance in attention	4.5	11.9	1.8
Tremor	4.0	9.4	5.0
Amnesia	3.4	5.3	1.0
Balance disorder	3.4	3.9	2.4
Hypoaesthesia	3.1	5.9	1.0
Intention tremor	3.1	4.8	2.9
Dysgeusia	1.4	4.3	0.8
Mental impairment	1.4	5.0	1.3
Speech disorder	1.1	2.7	0.5
Eye Disorders			
Diplopia	7.3	12.1	5.0
Vision blurred	5.4	8.9	2.4
Visual disturbance	2.0	1.4	0.3
Gastrointestinal Disorders			
Nausea	6.8	15.1	8.4
Diarrhoea	5.1	14.0	5.2
Abdominal pain upper	3.7	3.9	2.1
Constipation	3.7	3.2	1.8
Stomach discomfort	3.1	3.2	1.3
Dyspepsia	2.3	3.0	2.1
Dry mouth	1.7	3.7	0.3
Abdominal pain	1.1	2.7	0.8
Musculoskeletal and Connective Tissue Disorders			
Myalgia	2.0	2.5	1.3
Muscle spasms	1.7	2.1	0.8
Musculoskeletal chest pain	1.1	1.8	0.3
General Disorders and Administration Site Conditions			
Fatigue	13.0	30.7	11.8
Irritability	9.3	14.6	3.7
Asthenia	3.4	3.0	1.8
Gait disturbance	1.4	2.5	1.3
Investigations			
Weight decreased	9.0	11.9	4.2

The recommended dose for adjunctive epilepsy therapy in adults is 200-400 mg/day.

Double-Blind, Placebo-Controlled Data, Adjunctive Epilepsy Trials – Pediatric Patients
 ADRs reported in >2% of topiramate-treated paediatric patients (2 to 16 years of age) in double-blind,

placebo-controlled adjunctive epilepsy trials are shown in Table 3. ADRs that had an incidence >5% in the recommended dose range (5 to 9 mg/kg/day) in descending order of frequency included decreased appetite, fatigue, somnolence, lethargy irritability, disturbance in attention, weight decreased, aggression, rash, abnormal behaviour, anorexia, balance disorder, and constipation.

Table 3: Adverse Drug Reactions Reported by $\geq 2\%$ of Topiramate-treated Paediatric Patients in Double-Blind, Placebo-Controlled, Adjunctive Epilepsy Trials

System/Organ Adverse Reaction	Class	Topiramate (N=104) %	Placebo (N=102) %
Metabolism and Nutrition Disorders			
Decreased appetite		19.2	12.7
Anorexia		5.8	1.0
Psychiatric Disorders			
Aggression		8.7	6.9
Abnormal behaviour		5.8	3.9
Confusional state		2.9	2.0
Mood altered		2.9	2.0
Nervous System Disorders			
Somnolence		15.4	6.9
Lethargy		13.5	8.8
Disturbance in attention		10.6	2.0
Balance disorder		5.8	2.0
Dizziness		4.8	2.9
Memory impairment		3.8	1.0
Respiratory, Thoracic and Mediastinal Disorders			
Epistaxis		4.8	1.0
Gastrointestinal Disorders			
Constipation		5.8	4.9
Skin and Subcutaneous Tissue Disorders			
Rash		6.7	5.9
General Disorders and Administration Site Conditions			
Fatigue		16.3	4.9
Irritability		11.5	8.8
Gait disturbance		4.8	2.0
Investigations			
Weight decreased		9.6	1.0

The recommended dose for adjunctive epilepsy therapy in children (2-16 years of age) is 5 to 9 mg/kg/day.

Double-Blind, Controlled Data, Monotherapy Epilepsy Trials – Adult Patients ADRs reported in $\geq 1\%$ of topiramate-treated adult patients in double-blind, controlled monotherapy epilepsy trials are shown in Table 4. ADRs that had an incidence $>5\%$ at the recommended dose (400 mg/day) in descending order of frequency included paraesthesia, weight decreased, fatigue, anorexia, depression, memory impairment, anxiety, diarrhoea, asthenia, dysgeusia, and hypoesthesia.

Table 4: Adverse Drug Reactions Reported by $\geq 1\%$ of Topiramate-treated Adult Patients in Double-Blind, Controlled Monotherapy Epilepsy Trials

System/Organ Adverse Reaction	Class	Topiramate 50 mg/day (N=257) %	Topiramate 400 mg/day (N=153) %
Blood and Lymphatic System Disorders			
Anaemia		0.8	2.0
Metabolism and Nutrition Disorders			
Anorexia		3.5	12.4
Decreased appetite		2.3	2.6
Psychiatric Disorders			
Depression		4.3	8.5
Anxiety		3.9	6.5
Bradyphrenia		2.3	4.6
Expressive language disorder		3.5	4.6
Depressed mood		0.8	2.6
Mood altered		0.4	2.0
Mood swings		1.6	2.0
Nervous System Disorders			
Paraesthesia		18.7	40.5
Memory impairment		1.2	7.2
Dysgeusia		2.3	5.9
Hypoaesthesia		4.3	5.2
Balance disorder		1.6	3.3
Dysarthria		1.6	2.6
Cognitive disorder		0.4	2.0
Lethargy		1.2	2.0
Mental impairment		0.8	2.0
Psychomotor skills impaired		0	2.0
Sedation		0	1.3
Visual field defect		0.4	1.3
Eye Disorders			

Dry Eye	0	1.3
Ear and Labyrinth Disorders		
Ear pain	0	1.3
Tinnitus	1.6	1.3
Respiratory, Thoracic and Mediastinal Disorders		
Dyspnoea	1.2	2.0
Rhinorrhoea	0	1.3
Gastrointestinal Disorders		
Diarrhoea	5.4	6.5
Paraesthesia oral	1.2	3.3
Dry mouth	0.4	2.6
Gastritis	0.8	2.6
Abdominal pain	1.2	2.0
Gastroesophageal reflux disease	0.4	2.0
Gingival bleeding	0	1.3
Skin and Subcutaneous Tissue Disorders		
Rash	0.4	3.9
Alopecia	1.6	3.3
Pruritus	0.4	3.3
Hypoaesthesia facial	0.4	2.0
Pruritus generalised	0	1.3
Musculoskeletal and Connective Tissue Disorders		
Muscle spasms	2.7	3.3
Arthralgia	1.9	2.0
Muscle twitching	0.4	1.3
Renal and Urinary Disorders		
Nephrolithiasis	0	2.6
Dysuria	0.8	2.0
Pollakiuria	0.8	2.0
Reproductive System and Breast Disorders		
Erectile dysfunction	0.8	1.3
General Disorders and Administration Site Conditions		
Fatigue	15.2	14.4
Asthenia	3.5	5.9
Irritability	3.1	3.3
Investigations		

Weight decreased	7.0	17.0
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The recommended dose for monotherapy therapy in adults is 400 mg/day.

Double-Blind, Controlled Data, Monotherapy Epilepsy Trials – Pediatric Patients ADRs reported in $\geq 2\%$ of topiramate-treated paediatric patients (10 to 16 years of age) in double-blind, controlled monotherapy epilepsy trials are shown in Table 5. ADRs that had an incidence $>5\%$ at the recommended dose (400 mg/day) in descending order of frequency included weight decreased, paraesthesia, diarrhoea, disturbance in attention, pyrexia, and alopecia.

Table 5: Adverse Drug Reactions Reported by $\geq 2\%$ of Topiramate-treated Paediatric Patients in Double-Blind, Controlled Monotherapy Epilepsy Trials

System/Organ Adverse Reaction	Class	Topiramate 50 mg/day (N=77) %	Topiramate 400 mg/day (N=63) %
Metabolism and Nutrition Disorders			
Decreased appetite		1.3	4.8
Psychiatric Disorders			
Bradyphrenia		0	4.8
Mood altered		1.3	4.8
Depression		0	3.2
Nervous System Disorders			
Paraesthesia		3.9	15.9
Disturbance in attention		3.9	7.9
Ear and Labyrinth Disorders			
Vertigo		0	3.2
Respiratory, Thoracic and Mediastinal Disorders			
Epistaxis		0	3.2
Gastrointestinal Disorders			
Diarrhoea		3.9	9.5
Vomiting		3.9	4.8
Skin and Subcutaneous Tissue Disorders			
Alopecia		0	6.3
General Disorders and Administration Site Conditions			
Pyrexia		0	6.3
Asthenia		0	4.8
Investigations			
Weight decreased		7.8	20.6
Social Circumstances			
Learning disability		0	3.2

The recommended dose for monotherapy therapy in children 10 years and older is 400 mg/day.

Migraine Prophylaxis

Double-Blind, Placebo-Controlled Data, Migraine Prophylaxis Trials – Adult Patients ADRs reported in $\geq 1\%$ of topiramate-treated adult patients in double-blind, placebo-controlled migraine prophylaxis trials are shown in Table 6. ADRs that had an incidence $>5\%$ at the recommended dose (100 mg/day) in descending order of frequency included paraesthesia, fatigue, nausea, diarrhoea, weight decreased, dysgeusia, anorexia, decreased appetite, insomnia, hypoesthesia, disturbance in attention, anxiety, somnolence, and expressive language disorder.

Table 6: Adverse Drug Reactions Reported by $\geq 1\%$ of Topiramate-treated Adult Patients in Double-Blind, Placebo-Controlled Migraine Prophylaxis Trials

System/Organ Adverse Reaction	Class	Topiramate 50 mg/day (N=227) %	Topiramate 100 mg/day (N=374) %	Topiramate 200 mg/day (N=501) %	Placebo (N=436) %
Metabolism and Nutrition Disorders					
Anorexia		3.5	7.5	7.2	3.0
Decreased appetite		5.7	7.0	6.8	3.0
Psychiatric Disorders					
Insomnia		4.8	7.0	5.6	3.9
Anxiety		4.0	5.3	5.0	1.8
Expressive language disorder		6.6	5.1	5.2	1.4
Depression		3.5	4.8	7.4	4.1
Depressed mood		0.4	2.9	2.0	0.9
Confusional state		0.4	1.6	2.0	1.1
Mood swings		1.8	1.3	1.0	0.2
Affect lability		0.4	1.1	0.2	0.2
Bradypnea		1.8	1.1	3.4	1.4
Nervous System Disorders					
Paraesthesia		35.7	50.0	48.5	5.0
Dysgeusia		15.4	8.0	12.6	0.9
Hypoesthesia		5.3	6.7	7.4	1.4
Disturbance in attention		2.6	6.4	9.2	2.3
Somnolence		6.2	5.1	6.8	3.0
Memory impairment		4.0	4.5	6.2	1.6
Amnesia		3.5	2.9	5.2	0.5
Tremor		1.3	1.9	2.4	1.4
Balance disorder		0.4	1.3	0.4	0
Mental impairment		0.4	1.1	1.8	0.9

Eye Disorders				
Vision blurred	4.0	2.4	4.4	2.5
Ear and Labyrinth Disorders				
Tinnitus	0.4	1.3	1.6	0.7
Respiratory, Thoracic and Mediastinal Disorders				
Dyspnoea	1.3	2.7	1.6	1.4
Epistaxis	0.4	1.1	0.6	0.5
Gastrointestinal Disorders				
Nausea	9.3	13.6	14.6	8.3
Diarrhoea	9.3	11.2	10.0	4.4
Dry mouth	1.8	3.2	5.0	2.5
Paraesthesia oral	1.3	2.9	1.6	0.5
Constipation	1.8	2.1	1.8	1.4
Abdominal distension	0	1.3	0.2	0.2
Stomach discomfort	2.2	1.3	1.0	0.2
Gastroesophageal reflux disease	0.4	1.1	1.2	0.5
Musculoskeletal and Connective Tissue Disorders				
Muscle twitching	1.8	1.3	1.8	0.7
General Disorders and Administration Site Conditions				
Fatigue	15.0	15.2	19.2	11.2
Asthenia	0.9	2.1	2.6	0.5
Irritability	3.1	1.9	2.4	0.9
Thirst	1.3	1.6	1.0	0.5
Investigations				
Weight decreased	5.3	9.1	10.8	1.4

The recommended dose for migraine prophylaxis is 100 mg/day.

Other Clinical Trial Data

ADRs reported in double-blind controlled clinical trials in <1% of topiramate-treated adult patients or at any rate in open-label clinical trials of topiramate-treated adult patients are shown in Table 7.

Table 7: Adverse Drug Reactions Reported in Double-Blind Controlled Clinical Trials in <1% of Topiramate-treated Adult Patients or at Any Rate in Open-Label Clinical Trials of Topiramate-treated Adult Patients

Blood and Lymphatic System Disorders
Leukopenia, lymphadenopathy, thrombocytopenia
Immune System Disorders
Hypersensitivity
Metabolism and Nutrition Disorders
Acidosis hyperchloreaemic, hypokalaemia, increased appetite, metabolic acidosis, polydipsia
Psychiatric Disorders
Abnormal behaviour, anorgasmia, apathy, crying, distractibility, disturbance in sexual arousal, dysphemia, early morning awakening, elevated mood, euphoric mood, flat affect, hallucination, hallucination--auditory, hallucination--visual, hypomania, initial insomnia, lack of spontaneous speech, libido decreased, listless, loss of libido, mania, middle insomnia, orgasmic sensation decreased, panic attack, panic disorder, panic reaction, paranoia, perseveration, reading disorder, restlessness, sleep disorder, suicidal ideation, suicide attempt, tearfulness, thinking abnormal
Nervous System Disorders
Ageusia, akinesia, anosmia, aphasia, apraxia, aura, burning sensation, cerebellar syndrome, circadian rhythm sleep disorder, clumsiness, complex partial seizure, convulsion, depressed level of consciousness, dizziness postural, drooling, dysaesthesia, dysgraphia, dyskinesia, dysphasia, dystonia, essential tremor, formication, grand mal convulsion, hyperaesthesia, hypersomnia, hypogeusia, hypokinesia, hyposmia, neuropathy peripheral, parosmia, poor quality sleep, presyncope, repetitive speech, sensory disturbance, sensory loss, stupor, syncope, unresponsive to stimuli
Eye Disorders
Accommodation disorder, altered visual depth perception, amblyopia, blepharospasm, blindness transient, blindness unilateral, glaucoma, lacrimation increased, mydriasis, night blindness, photopsia, presbyopia, scintillating scotoma, scotoma, visual acuity reduced
Ear and Labyrinth Disorders
Deafness, deafness neurosensory, deafness unilateral, ear discomfort, hearing impaired
Cardiac Disorders
Bradycardia, sinus bradycardia, palpitations
Vascular Disorders
Flushing, hot flush, orthostatic hypotension, Raynaud's phenomenon
Respiratory, Thoracic, and Mediastinal Disorders

Dysphonia, dyspnoea exertional, nasal congestion, paranasal sinus hypersecretion
Gastrointestinal Disorders
Abdominal discomfort, abdominal pain lower, abdominal tenderness, breath odour, epigastric discomfort, flatulence, glossodynia, hypoaesthesia oral, oral pain, pancreatitis, salivary hypersecretion
Skin and Subcutaneous Tissue Disorders
Anhidrosis, dermatitis allergic, erythema, rash macular, skin discolouration, skin odour abnormal, swelling face, urticaria, urticaria localised
Musculoskeletal and Connective Tissue Disorders
Flank pain, muscle fatigue, muscular weakness, musculoskeletal stiffness
Renal and Urinary Disorders
Calculus ureteric, calculus urinary, haematuria, incontinence, micturition urgency, renal colic, renal pain, urinary incontinence
Reproductive System and Breast Disorders
Sexual dysfunction
General Disorders
Calcinosis, face oedema, feeling abnormal, feeling drunk, feeling jittery, malaise, peripheral coldness, sluggishness
Investigations
Blood bicarbonate decreased, crystal urine present, tandem gait test abnormal, white blood cell count decreased

ADRs reported in double-blind controlled clinical trials in <2% of topiramate-treated paediatric patients or at any rate in open-label clinical trials of topiramate-treated paediatric patients are shown in Table 8.

Table 8: Adverse Drug Reactions Reported in Double-Blind Controlled Clinical Trials in <2% of Topiramate-treated Paediatric Patients or at Any Rate in Open-Label Clinical Trials of Topiramate-Treated Paediatric Patients

Blood and Lymphatic System Disorders
Eosinophilia, leukopenia, lymphadenopathy, thrombocytopenia
Immune System Disorders
Hypersensitivity
Metabolism and Nutrition Disorders
Acidosis hyperchloraemic, hypokalaemia, increased appetite

Psychiatric Disorders
Anger, apathy, crying, distractibility, expressive language disorder, initial insomnia, insomnia, middle insomnia, mood swings, perseveration, sleep disorder, suicidal ideation, suicide attempt
Nervous System Disorders
Circadian rhythm sleep disorder, convulsion, dysarthria, dysgeusia, grand mal convulsion, hypoaesthesia, mental impairment, nystagmus, parosmia, poor quality sleep, psychomotor hyperactivity, psychomotor skills impaired, syncope, tremor
Eye Disorders
Diplopia, lacrimation increased, vision blurred
Ear and Labyrinth Disorders
Ear pain
Cardiac Disorders
Palpitations, sinus bradycardia
Vascular Disorders
Orthostatic hypotension
Respiratory, Thoracic, and Mediastinal Disorders
Nasal congestion, paranasal sinus hypersecretion, rhinorrhoea
Gastrointestinal Disorders
Abdominal discomfort, abdominal pain, dry mouth, flatulence, gastritis, gastroesophageal reflux disease, gingival bleeding, glossodynia, pancreatitis, paraesthesia oral, stomach discomfort
Musculoskeletal and Connective Tissue Disorders
Arthralgia, musculoskeletal stiffness, myalgia
Renal and Urinary Disorders
Incontinence, micturition urgency, pollakiuria
General Disorders
Feeling abnormal, hyperthermia, malaise, sluggishness

Postmarketing Data

Adverse events first identified as ADRs during postmarketing experience with topiramate, presented by frequency category based on incidence in clinical trials, are included in Table 9. The frequencies are provided according to the following convention:

Very common $\geq 1/10$

Common $\geq 1/100$ to $< 1/10$

Uncommon $\geq 1/1,000$ to $< 1/100$

Rare $\geq 1/10,000$ to $< 1/1,000$

Very rare $< 1/10,000$, including isolated reports

Table 9: Adverse Drug Reactions Identified During Postmarketing Experience with Topiramate by Frequency Category Estimated from Clinical Trials

Infections and Infestations	
<i>Very Common</i>	Nasopharyngitis*
Blood and Lymphatic System Disorders	
<i>Rare</i>	Neutropenia
Immune System Disorders	
<i>Unknown</i>	Allergic oedema
<i>Unknown</i>	Conjunctival oedema
Psychiatric Disorders	
<i>Rare</i>	Feeling of despair
Eye Disorders	
<i>Rare</i>	Abnormal sensation in eye
<i>Rare</i>	Eyelid oedema
<i>Rare</i>	Myopia
<i>Unknown</i>	Angle closure glaucoma
<i>Unknown</i>	Eye movement disorder
<i>Unknown</i>	Maculopathy
Skin and Subcutaneous Tissue Disorders	
<i>Rare</i>	Erythema multiforme
<i>Rare</i>	Periorbital oedema
<i>Rare</i>	Stevens-Johnson syndrome
<i>Unknown</i>	Toxic epidermal necrolysis
Musculoskeletal and Connective Tissue Disorders	
<i>Uncommon</i>	Joint swelling

<i>Rare</i>	Limb discomfort
Renal and Urinary Disorders	
<i>Rare</i>	Renal tubular acidosis
General Disorders and Administration Site Conditions	
<i>Uncommon</i>	Influenza like illness
<i>Unknown</i>	Generalised oedema
Investigations	
<i>Common</i>	Weight increased

*Nasopharyngitis in the clinical trial database was attributed to infectious or other causes, and was deemed a non-ADR.

4.9 Overdose

Signs and symptoms

Ingestion of between 6 and 40 g topiramate have been reported in a few patients. Signs and symptoms included: headache, agitation, drowsiness, lethargy, convulsions, speech disturbances, blurred vision, diplopia, impaired mentation, abnormal coordination, stupor, hypotension, abdominal pain, dizziness, depression and hypokalaemia. The clinical consequences were not severe in most cases, but deaths have been reported after polydrug overdoses involving topiramate.

Topiramate overdose can result in severe metabolic acidosis (see **Metabolic acidosis** under **Warnings and Precautions**).

A patient who ingested a dose calculated to be between 96 and 110 g topiramate was admitted to hospital with coma lasting 20 to 24 hours, followed by full recovery after 3 to 4 days.

Treatment

In acute topiramate overdose, if the ingestion is recent, the stomach should be emptied immediately by lavage or by induction of emesis. Activated charcoal has been shown to adsorb topiramate *in vitro*. Treatment should be appropriately supportive. Haemodialysis has been shown to be an effective means of removing topiramate from the body. The patient should be well hydrated.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Topiramate is classified as a sulfamate-substituted monosaccharide.

The precise mechanism by which topiramate exerts its antiseizure effect is unknown. Electrophysiological and biochemical studies on cultured neurons have identified three properties that may contribute to the antiepileptic efficacy of topiramate.

Action potentials elicited repetitively by a sustained depolarisation of the neurons were blocked by topiramate in a time-dependent manner, suggestive of a state-dependent sodium channel blocking action. Topiramate increased the frequency at which gamma-aminobutyrate (GABA) activated GABA_A receptors, and enhanced the ability of GABA to induce a flux of chloride ions into neurons, suggesting that topiramate potentiates the activity of this inhibitory neurotransmitter.

This effect was not blocked by flumazenil, a benzodiazepine antagonist, nor did topiramate increase the duration of the channel open time, differentiating topiramate from barbiturates that modulate GABA_A receptors.

Because the antiepileptic profile of topiramate differs markedly from that of the benzodiazepines, it may modulate a benzodiazepine-insensitive subtype of GABA_A receptor. Topiramate antagonised the ability of kainate to activate the kainate/AMPA (α-amino-3-hydroxy-5-methylisoxazole-4-propionic acid) subtype of excitatory amino acid (glutamate) receptor, but had no apparent effect on the activity of N-methyl-D-aspartate (NMDA) at the NMDA receptor subtype. These effects of topiramate were concentration-dependent over a range of 1 micromol to 200 micromols, with minimum activity observed at 1 micromol to 10 micromols.

In addition, topiramate inhibits some isoenzymes of carbonic anhydrase. This pharmacologic effect is much weaker than that of acetazolamide, a known carbonic anhydrase inhibitor, and is not thought to be a major component of topiramate's antiepileptic activity.

In animal studies, topiramate exhibits anticonvulsant activity in rat and mouse maximal electroshock seizure (MES) tests and is effective in rodent models of epilepsy, which include tonic and absence like seizures in the spontaneous epileptic rat (SER) and tonic and clonic seizures induced in rats by kindling of the amygdala or by global ischemia. Topiramate is only weakly effective in blocking clonic seizures induced by the GABA_A receptor antagonist, pentylentetrazole.

Studies in mice receiving concomitant administration of topiramate and carbamazepine or phenobarbital showed synergistic anticonvulsant activity, while combination with phenytoin showed additive anticonvulsant activity. In well controlled add-on trials, no correlation has been demonstrated between trough plasma concentrations of topiramate and its clinical efficacy. No evidence of tolerance has been demonstrated in humans.

5.2 Pharmacokinetic properties

The pharmacokinetic profile of topiramate compared to other antiepileptic medicines shows a long plasma half-life, linear pharmacokinetics, predominantly renal clearance, absence of significant protein binding, and lack of clinically relevant active metabolites.

Topiramate is not a potent inducer of drug metabolising enzymes. It can be administered without regard to meals, and routine monitoring of plasma topiramate concentrations is not necessary. In clinical studies, there was no consistent relationship between plasma concentrations and efficacy or adverse events.

Absorption

Topiramate is rapidly and well absorbed. Following oral administration of 100 mg topiramate to healthy subjects, a mean peak plasma concentration (C_{max}) of 1.5 micrograms/mL was achieved within 2 to 3 hours (T_{max}). Based on the recovery of radioactivity from the urine the mean extent of absorption of a 100 mg oral dose of ¹⁴C-topiramate was at least 81%. There was no clinically significant effect of food on the bioavailability of topiramate.

Distribution

Generally, 13 to 17% of topiramate is bound to plasma protein. A low capacity binding site for topiramate in/on erythrocytes that is saturable above plasma concentrations of 4 micrograms/mL has been observed. The volume of distribution varied inversely with the dose. The mean apparent volume of distribution was 0.80 to 0.55 L/kg for a single dose range of 100 to 1200 mg. There is an effect of gender on the volume of distribution. Values for females are about 50% lower than those for males.

This was attributed to the higher percentage body fat in female patients and is of no clinical consequence.

Metabolism

It is metabolised up to 50% in patients receiving concomitant antiepileptic therapy with known inducers of drug metabolising enzymes. Six metabolites, formed through hydroxylation, hydrolysis and glucuronidation, have been isolated, characterised and identified from plasma, urine and faeces of humans. Each metabolite represents less than 3% of the total radioactivity excreted following administration of ¹⁴C-topiramate. Two metabolites, which retained most of the structure of topiramate, were tested and found to have little or no anticonvulsant activity.

Elimination

In humans, the major route of elimination of unchanged topiramate and its metabolites is *via* the kidney (at least 81% of the dose). Approximately 66% of a dose of ¹⁴C-topiramate was excreted unchanged in the urine within four days. Following twice a day dosing with 50 mg and 100 mg of topiramate the mean renal clearance was approximately 18 mL/min and 17 mL/min, respectively. There is evidence of renal tubular reabsorption of topiramate. This is supported by studies in rats where topiramate was co-administered with probenecid, and a significant increase in renal clearance of topiramate was observed. Overall, plasma clearance is approximately 20 to 30 mL/min in humans following oral administration.

Topiramate exhibits low intersubject variability in plasma concentrations and therefore has predictable pharmacokinetics. The pharmacokinetics of topiramate are linear with plasma clearance remaining constant and area under the plasma concentration curve increasing in a dose proportional manner over a 100 to 400 mg single oral dose range in healthy subjects. Patients with normal renal function may take 4 to 8 days to reach steady state plasma concentrations. The mean C_{max} following multiple, twice a day oral doses of 100 mg to healthy subjects was 6.76 micrograms/mL. Following administration of multiple doses of 50 mg and 100 mg of topiramate twice a day, the mean plasma elimination half-life was approximately 21 hours.

Concomitant multiple dose administration of topiramate, 100 to 400 mg twice a day, with phenytoin or carbamazepine shows dose proportional increases in plasma concentrations of topiramate.

Patients with renal impairment

The plasma and renal clearance of topiramate decreased in patients with moderate and severe impaired renal function (CL_{CR} < 70 mL/min). As a result, higher steady state topiramate plasma concentrations are expected for a given dose in renal impaired patients as compared to those with normal renal function. In addition, patients with renal impairment will require a longer time to reach steady-state at each dose. In patients with moderate and severe renal impairment, half of the usual starting and maintenance dose is recommended (see **DOSAGE and ADMINISTRATION**).

Topiramate is effectively removed from plasma by haemodialysis. A prolonged period of hemodialysis may cause topiramate concentration to fall below levels that are required to maintain an anti-seizure effect. To avoid rapid drops in topiramate plasma concentration during hemodialysis, a supplemental dose of topiramate may be required. The actual adjustment should take into account 1) the duration of dialysis period, 2) the clearance rate of the dialysis system being used, and 3) the effective renal clearance of topiramate in the patient being dialysed.

Patients with hepatic impairment

Plasma clearance of topiramate decreased a mean of 26% in patients with moderate to severe hepatic impairment. Therefore, topiramate should be administered with caution in patients with hepatic impairment.

Elderly

Plasma clearance of topiramate is unchanged in elderly subjects in the absence of underlying renal disease.

Paediatric pharmacokinetics up to 12 years of age

The pharmacokinetics of topiramate in children, as in adults receiving add-on therapy, are linear, with clearance independent of dose and steady state plasma concentrations increasing in proportion to dose. Children, however, have a higher clearance and a shorter elimination half-life. Consequently, the plasma concentrations of topiramate for the same mg/kg dose may be lower in children compared to adults. As in adults, hepatic enzyme inducing antiepileptic medicines decrease the steady state plasma concentrations.

5.3 Preclinical safety data

Nil

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Topiramate Actavis Tablets contain the following excipients: mannitol, microcrystalline cellulose, pregelatinised maize starch, magnesium stearate, croscarmellose sodium, and the colouring Opadry II White 85F18422 for 25 mg Tablets, Opadry II Yellow 85G32312 for 50 mg Tablets, Opadry II Yellow 85G32313 for 100 mg Tablets, and Opadry II Pink 85G34776 for 200 mg Tablets.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years for both blister packs and bottles.

6.4 Special precautions for storage

Store at or below 25°C.

6.5 Nature and contents of container

Topiramate Actavis Tablets are available in opaque bottles and foil blister packs of 10, 60 and 200 tablets.

Topiramate Actavis 25 mg tablets are also available as a sample pack of 20 tablets in an opaque bottle.

Not all pack types and sizes may be marketed.

6.6 Special precautions for disposal

No special requirements for disposal.

7. MEDICINE SCHEDULE

Prescription medicine

8. SPONSOR

Teva Pharma (New Zealand) Limited

P O Box 128 244

Remuera

Auckland 1541

Telephone: 0800 800 097

9. DATE OF FIRST APPROVAL

03 April 2014

10. DATE OF REVISION OF THE TEXT

30th May 2017

SUMMARY TABLE OF CHANGES

Section changed	Summary of new information
	-Data sheet reformatted as per SPC style
1, 31 4.1, 4.2, 5.2, 6.1, 6.3, 6.5	-Data sheet revised to remove details related to capsules
8	-Sponsor details updated from Actavis to Teva
9	Date of first approval included
10	Date of revision updated