

Vimpat 100 mg film-coated tablets

Summary of Product Characteristics Updated 10-Sep-2019 | UCB Pharma Limited

1. Name of the medicinal product

Vimpat 50 mg film-coated tablets

Vimpat 100 mg film-coated tablets

Vimpat 150 mg film-coated tablets

Vimpat 200 mg film-coated tablets

2. Qualitative and quantitative composition

Vimpat 50 mg film-coated tablets

Each film-coated tablet contains 50 mg lacosamide.

Vimpat 100 mg film-coated tablets

Each film-coated tablet contains 100 mg lacosamide.

Vimpat 150 mg film-coated tablets

Each film-coated tablet contains 150 mg lacosamide.

Vimpat 200 mg film-coated tablets

Each film-coated tablet contains 200 mg lacosamide.

For the full list of excipients, see section 6.1.

3. Pharmaceutical form

Film-coated tablet

Vimpat 50 mg film-coated tablets

Pinkish, oval film-coated tablets with approximate dimensions of 10.4 mm x 4.9 mm, and debossed with 'SP' on one side and '50' on the other side.

Vimpat 100 mg film-coated tablets

Dark yellow, oval film-coated tablets with approximate dimensions of 13.2 mm x 6.1 mm, and debossed with 'SP' on one side and '100' on the other side.

Vimpat 150 mg film-coated tablets

Salmon, oval film-coated tablets with approximate dimensions of 15.1 mm x 7.0 mm, and debossed with 'SP' on one side and '150' on the other side.

Vimpat 200 mg film-coated tablets

Blue, oval film-coated tablets with approximate dimensions of 16.6 mm x 7.8 mm, and debossed with 'SP' on one side and '200' on the other side.

4. Clinical particulars

4.1 Therapeutic indications

Vimpat is indicated as monotherapy and adjunctive therapy in the treatment of partial-onset seizures with or without secondary generalisation in adults, adolescents and children from 4 years of age with epilepsy.

4.2 Posology and method of administration

Posology

Lacosamide must be taken twice a day (usually once in the morning and once in the evening).

Lacosamide may be taken with or without food.

If a dose is missed, the patient should be instructed to take the missed dose immediately, and then to take the next dose of lacosamide at the regularly scheduled time. If the patient notices the missed dose within 6 hours of the next one, he/she should be instructed to wait to take the next dose of lacosamide at the regularly scheduled time. Patients should not take a double dose.

Adolescents and children weighing 50 kg or more, and adults

The following table summarises the recommended posology for adolescents and children weighing 50 kg or more, and

for adults. More details are provided in the table below.

	Monotherapy	Adjunctive therapy
Starting dose	100 mg/day or 200 mg/day	100 mg/day
Single loading dose (if applicable)	200 mg	200 mg
Titration (incremental steps)	50 mg twice a day (100 mg/day) at weekly intervals	50 mg twice a day (100 mg/day) at weekly intervals
Maximum recommended dose	up to 600 mg/day	up to 400 mg/day

Monotherapy

The recommended starting dose is 50 mg twice a day which should be increased to an initial therapeutic dose of 100 mg twice a day after one week.

Lacosamide can also be initiated at the dose of 100 mg twice a day based on the physician's assessment of required seizure reduction versus potential side effects.

Depending on response and tolerability, the maintenance dose can be further increased at weekly intervals by 50 mg twice a day (100 mg/day), up to a maximum recommended daily dose of 300 mg twice a day (600 mg/day).

In patients having reached a dose greater than 400 mg/day and who need an additional antiepileptic medicinal product, the posology that is recommended for adjunctive therapy below should be followed.

Adjunctive therapy

The recommended starting dose is 50 mg twice a day which should be increased to an initial therapeutic dose of 100 mg twice a day after one week.

Depending on response and tolerability, the maintenance dose can be further increased at weekly intervals by 50 mg twice a day (100 mg/day), up to a maximum recommended daily dose of 400 mg (200 mg twice a day).

Initiation of lacosamide treatment with a loading dose

Lacosamide treatment may also be initiated with a single loading dose of 200 mg, followed approximately 12 hours later by a 100 mg twice a day (200 mg/day) maintenance dose regimen. Subsequent dose adjustments should be performed according to individual response and tolerability as described above. A loading dose may be initiated in patients in situations when the physician determines that rapid attainment of lacosamide steady state plasma concentration and therapeutic effect is warranted. It should be administered under medical supervision with consideration of the potential for increased incidence of serious cardiac arrhythmia and central nervous system adverse reactions (see section 4.8). Administration of a loading dose has not been studied in acute conditions such as status epilepticus.

Discontinuation

In accordance with current clinical practice, if lacosamide has to be discontinued, it is recommended this be done gradually (e.g. taper the daily dose by 200 mg/week).

In patients who develop serious cardiac arrhythmia, clinical benefit/risk assessment should be performed and if needed lacosamide should be discontinued.

Special populations

Elderly (over 65 years of age)

No dose reduction is necessary in elderly patients. Age associated decreased renal clearance with an increase in AUC levels should be considered in elderly patients (see following paragraph 'renal impairment' and section 5.2). There is limited clinical data in the elderly patients with epilepsy, particularly at doses greater than 400 mg/day (see sections 4.4, 4.8, and 5.1).

Renal impairment

No dose adjustment is necessary in mildly and moderately renally impaired adult and paediatric patients ($CL_{CR} > 30$ ml/min). In paediatric patients weighing 50 kg or more and in adult patients with mild or moderate renal impairment a loading dose of 200 mg may be considered, but further dose titration (> 200 mg daily) should be performed with caution. In paediatric patients weighing 50 kg or more and in adult patients with severe renal impairment ($CL_{CR} \leq 30$ ml/min) or with end-stage renal disease, a maximum dose of 250 mg/day is recommended and the dose titration should be performed with caution. If a loading dose is indicated, an initial dose of 100 mg followed by a 50 mg twice daily regimen for the first week should be used. In paediatric patients weighing less than 50 kg with severe renal impairment ($CL_{CR} \leq$

30 ml/min) and in those with end-stage renal disease, a reduction of 25 % of the maximum dose is recommended. For all patients requiring haemodialysis a supplement of up to 50 % of the divided daily dose directly after the end of haemodialysis is recommended. Treatment of patients with end-stage renal disease should be made with caution as there is little clinical experience and accumulation of a metabolite (with no known pharmacological activity).

Hepatic impairment

A maximum dose of 300 mg/day is recommended for paediatric patients weighing 50 kg or more and for adult patients with mild to moderate hepatic impairment.

The dose titration in these patients should be performed with caution considering co-existing renal impairment. In adolescents and adults weighing 50 kg or more, a loading dose of 200 mg may be considered, but further dose titration (> 200 mg daily) should be performed with caution. Based on data in adults, in paediatric patients weighing less than 50 kg with mild to moderate hepatic impairment, a reduction of 25 % of the maximum dose should be applied. The pharmacokinetics of lacosamide has not been evaluated in severely hepatic impaired patients (see section 5.2). Lacosamide should be administered to adult and paediatric patients with severe hepatic impairment only when the expected therapeutic benefits are anticipated to outweigh the possible risks. The dose may need to be adjusted while carefully observing disease activity and potential side effects in the patient.

Paediatric population

The physician should prescribe the most appropriate formulation and strength according to weight and dose.

Adolescents and children weighing 50 kg or more

Dosage in adolescents and children weighing 50 kg or more is the same as in adults (see above).

Children (from 4 years of age) and adolescents weighing less than 50 kg

The dose is determined based on body weight. It is therefore recommended to initiate treatment with the syrup and switch to tablets, if desired.

Monotherapy

The recommended starting dose is 2 mg/kg/day which should be increased to an initial therapeutic dose of 4 mg/kg/day after one week.

Depending on response and tolerability, the maintenance dose can be further increased by 2 mg/kg/day every week. The dose should be gradually increased until the optimum response is obtained. In children weighing less than 40 kg, a maximum dose of up to 12 mg/kg/day is recommended. In children weighing from 40 to under 50 kg, a maximum dose of 10 mg/kg/day is recommended.

The following table summarises the recommended posology in monotherapy for children and adolescents weighing less than 50 kg.

Starting dose	2 mg/kg/day
Single loading dose	Not recommended
Titration (incremental steps)	2 mg/kg/day every week
Maximum recommended dose in patients < 40 kg	up to 12 mg/kg/day
Maximum recommended dose in patients ≥ 40 kg to < 50 kg	up to 10 mg/kg/day

Adjunctive therapy

The recommended starting dose is 2 mg/kg/day which should be increased to an initial therapeutic dose of 4 mg/kg/day after one week.

Depending on response and tolerability, the maintenance dose can be further increased by 2 mg/kg/day every week. The dose should be gradually adjusted until the optimum response is obtained. In children weighing less than 20 kg, due to an increased clearance compared to adults, a maximum dose of up to 12 mg/kg/day is recommended. In children weighing from 20 to under 30 kg, a maximum dose of 10 mg/kg/day is recommended and in children weighing from 30 to under 50 kg, a maximum dose of 8 mg/kg/day is recommended, although in open-label studies (see sections 4.8 and 5.2), a dose up to 12 mg/kg/day has been used by a small number of these children.

The following table summarises the recommended posology in adjunctive therapy for children and adolescents weighing less than 50 kg.

Starting dose	2 mg/kg/day

Single loading dose	Not recommended
Titration (incremental steps)	2 mg/kg/day every week
Maximum recommended dose in patients < 20 kg	up to 12 mg/kg/day
Maximum recommended dose in patients ≥ 20 kg to < 30 kg	up to 10 mg/kg/day
Maximum recommended dose in patients ≥ 30 kg to < 50 kg	up to 8 mg/kg/day

Loading dose

Administration of a loading dose has not been studied in children. Use of a loading dose is not recommended in adolescents and children weighing less than 50 kg.

Children less than 4 years

The safety and efficacy of lacosamide in children aged below 4 years have not yet been established. No data are available.

Method of administration

Lacosamide film-coated tablets are for oral use. Lacosamide may be taken with or without food.

4.3 Contraindications

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

Known second- or third-degree atrioventricular (AV) block.

4.4 Special warnings and precautions for use

Suicidal ideation and behaviour

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

Therefore, patients should be monitored for signs of suicidal ideation and behaviours and appropriate treatment should be considered. Patients (and caregivers of patients) should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge (see section 4.8).

Cardiac rhythm and conduction

Dose-related prolongations in PR interval with lacosamide have been observed in clinical studies. Lacosamide should be used with caution in patients with underlying proarrhythmic conditions such as patients with known cardiac conduction problems or severe cardiac disease (e.g. myocardial ischaemia/infarction, heart failure, structural heart disease or cardiac sodium channelopathies) or patients treated with medicinal products affecting cardiac conduction, including antiarrhythmics and sodium channel blocking antiepileptic medicinal products (see section 4.5), as well as in elderly patients.

In these patients it should be considered to perform an ECG before a lacosamide dose increase above 400 mg/day and after lacosamide is titrated to steady-state.

In the placebo-controlled trials of lacosamide in epilepsy patients, atrial fibrillation or flutter were not reported; however, both have been reported in open-label epilepsy trials and in post-marketing experience.

In post-marketing experience, AV block (including second degree or higher AV block) has been reported. In patients with proarrhythmic conditions, ventricular tachyarrhythmia has been reported. In rare cases, these events have led to asystole, cardiac arrest and death in patients with underlying proarrhythmic conditions.

Patients should be made aware of the symptoms of cardiac arrhythmia (e.g. slow, rapid or irregular pulse, palpitations, shortness of breath, feeling lightheaded, fainting). Patients should be counselled to seek immediate medical advice if these symptoms occur.

Dizziness

Treatment with lacosamide has been associated with dizziness which could increase the occurrence of accidental injury or falls. Therefore, patients should be advised to exercise caution until they are familiar with the potential effects of the medicine (see section 4.8).

Potential for electro-clinical worsening in specific paediatric epilepsy syndromes

The safety and efficacy of lacosamide in paediatric patients with epilepsy syndromes in which focal and generalised

seizures may coexist have not been determined.

4.5 Interaction with other medicinal products and other forms of interaction

Lacosamide should be used with caution in patients treated with medicinal products known to be associated with PR prolongation (including sodium channel blocking antiepileptic medicinal products) and in patients treated with antiarrhythmics. However, subgroup analysis in clinical trials did not identify an increased magnitude of PR prolongation in patients with concomitant administration of carbamazepine or lamotrigine.

In vitro data

Data generally suggest that lacosamide has a low interaction potential. *In vitro* studies indicate that the enzymes CYP1A2, CYP2B6, and CYP2C9 are not induced and that CYP1A1, CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2D6, and CYP2E1 are not inhibited by lacosamide at plasma concentrations observed in clinical trials. An *in vitro* study indicated that lacosamide is not transported by P-glycoprotein in the intestine. *In vitro* data show that CYP2C9, CYP2C19 and CYP3A4 are capable of catalysing the formation of the O-desmethyl metabolite.

In vivo data

Lacosamide does not inhibit or induce CYP2C19 and CYP3A4 to a clinically relevant extent. Lacosamide did not affect the AUC of midazolam (metabolised by CYP3A4, lacosamide given 200 mg twice a day), but C_{max} of midazolam was slightly increased (30 %). Lacosamide did not affect the pharmacokinetics of omeprazole (metabolised by CYP2C19 and CYP3A4, lacosamide given 300 mg twice a day).

The CYP2C19 inhibitor omeprazole (40 mg once daily) did not give rise to a clinically significant change in lacosamide exposure. Thus, moderate inhibitors of CYP2C19 are unlikely to affect systemic lacosamide exposure to a clinically relevant extent.

Caution is recommended in concomitant treatment with strong inhibitors of CYP2C9 (e.g. fluconazole) and CYP3A4 (e.g. itraconazole, ketoconazole, ritonavir, clarithromycin), which may lead to increased systemic exposure of lacosamide. Such interactions have not been established *in vivo*, but are possible based on *in vitro* data.

Strong enzyme inducers such as rifampicin or St John's wort (*Hypericum perforatum*) may moderately reduce the systemic exposure of lacosamide. Therefore, starting or ending treatment with these enzyme inducers should be done with caution.

Antiepileptic medicinal products

In interaction trials lacosamide did not significantly affect the plasma concentrations of carbamazepine and valproic acid. Lacosamide plasma concentrations were not affected by carbamazepine and by valproic acid. Population pharmacokinetic analyses in different age groups estimated that concomitant treatment with other antiepileptic medicinal products known to be enzyme inducers (carbamazepine, phenytoin, phenobarbital, in various doses) decreased the overall systemic exposure of lacosamide by 25 % in adults and 17 % in paediatric patients.

Oral contraceptives

In an interaction trial there was no clinically relevant interaction between lacosamide and the oral contraceptives ethinylestradiol and levonorgestrel. Progesterone concentrations were not affected when the medicinal products were co-administered.

Others

Interaction trials showed that lacosamide had no effect on the pharmacokinetics of digoxin. There was no clinically relevant interaction between lacosamide and metformin.

Co-administration of warfarin with lacosamide does not result in a clinically relevant change in the pharmacokinetics and pharmacodynamics of warfarin.

Although no pharmacokinetic data on the interaction of lacosamide with alcohol are available, a pharmacodynamic effect cannot be excluded.

Lacosamide has a low protein binding of less than 15 %. Therefore, clinically relevant interactions with other medicinal products through competition for protein binding sites are considered unlikely.

4.6 Fertility, pregnancy and lactation

Pregnancy

Risk related to epilepsy and antiepileptic medicinal products in general

For all antiepileptic medicinal products, it has been shown that in the offspring of treated women with epilepsy, the prevalence of malformations is two to three times greater than the rate of approximately 3 % in the general population. In the treated population, an increase in malformations has been noted with polytherapy, however, the extent to which the treatment and/or the illness is responsible has not been elucidated.

Moreover, effective antiepileptic therapy must not be interrupted, since the aggravation of the illness is detrimental to

both the mother and the foetus.

Risk related to lacosamide

There are no adequate data from the use of lacosamide in pregnant women. Studies in animals did not indicate any teratogenic effects in rats or rabbits, but embryotoxicity was observed in rats and rabbits at maternal toxic doses (see section 5.3). The potential risk for humans is unknown.

Lacosamide should not be used during pregnancy unless clearly necessary (if the benefit to the mother clearly outweighs the potential risk to the foetus). If women decide to become pregnant, the use of this product should be carefully re-evaluated.

Breastfeeding

It is unknown whether lacosamide is excreted in human breast milk. A risk to the newborns/infants cannot be excluded. Animal studies have shown excretion of lacosamide in breast milk. For precautionary measures, breast-feeding should be discontinued during treatment with lacosamide.

Fertility

No adverse reactions on male or female fertility or reproduction were observed in rats at doses producing plasma exposures (AUC) up to approximately 2 times the plasma AUC in humans at the maximum recommended human dose (MRHD).

4.7 Effects on ability to drive and use machines

Lacosamide has minor to moderate influence on the ability to drive and use machines. Lacosamide treatment has been associated with dizziness or blurred vision.

Accordingly, patients should be advised not to drive or to operate other potentially hazardous machinery until they are familiar with the effects of lacosamide on their ability to perform such activities.

4.8 Undesirable effects

Summary of safety profile

Based on the analysis of pooled placebo-controlled clinical trials in adjunctive therapy in 1,308 patients with partial-onset seizures, a total of 61.9 % of patients randomised to lacosamide and 35.2 % of patients randomised to placebo reported at least 1 adverse reaction. The most frequently reported adverse reactions (≥ 10 %) with lacosamide treatment were dizziness, headache, nausea and diplopia. They were usually mild to moderate in intensity. Some were dose-related and could be alleviated by reducing the dose. Incidence and severity of central nervous system (CNS) and gastrointestinal (GI) adverse reactions usually decreased over time.

In all of these controlled studies, the discontinuation rate due to adverse reactions was 12.2 % for patients randomised to lacosamide and 1.6 % for patients randomised to placebo. The most common adverse reaction resulting in discontinuation of lacosamide therapy was dizziness.

Incidence of CNS adverse reactions such as dizziness may be higher after a loading dose.

Based on the analysis of data from a non-inferiority monotherapy clinical trial comparing lacosamide to carbamazepine controlled release (CR), the most frequently reported adverse reactions (≥ 10 %) for lacosamide were headache and dizziness. The discontinuation rate due to adverse reactions was 10.6 % for patients treated with lacosamide and 15.6 % for patients treated with carbamazepine CR.

Tabulated list of adverse reactions

The table below shows the frequencies of adverse reactions which have been reported in clinical trials and post-marketing experience. The frequencies are defined as follows: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$) and not known (frequency cannot be estimated from available data). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

System organ class	Very common	Common	Uncommon	Not known
Blood and lymphatic disorders				Agranulocytosis ⁽¹⁾
Immune system disorders			Drug hypersensitivity ⁽¹⁾	Drug reaction with eosinophilia and systemic symptoms (DRESS) ^(1,2)
Psychiatric disorders		Depression	Aggression	

		Confusional state Insomnia ⁽¹⁾	Agitation ⁽¹⁾ Euphoric mood ⁽¹⁾ Psychotic disorder ⁽¹⁾ Suicide attempt ⁽¹⁾ Suicidal ideation Hallucination ⁽¹⁾	
Nervous system disorders	Dizziness Headache	Balance disorder Memory impairment Cognitive disorder Somnolence Tremor Nystagmus Hypoesthesia Dysarthria Disturbance in attention Paraesthesia	Syncope ⁽²⁾ Coordination abnormal	Convulsion ⁽³⁾
Eye disorders	Diplopia	Vision blurred		
Ear and labyrinth disorders		Vertigo Tinnitus		
Cardiac disorders			Atrioventricular block ^(1,2) Bradycardia ^(1,2) Atrial Fibrillation ^(1,2) Atrial Flutter ^(1,2)	Ventricular tachyarrhythmia ⁽¹⁾
Gastrointestinal disorders	Nausea	Vomiting Constipation Flatulence Dyspepsia Dry mouth Diarrhoea		
Hepatobiliary disorders			Liver function test abnormal ⁽²⁾ Hepatic enzyme increased (> 2x ULN) ⁽¹⁾	
Skin and subcutaneous tissue disorders		Pruritus Rash ⁽¹⁾	Angioedema ⁽¹⁾ Urticaria ⁽¹⁾	Stevens-Johnson syndrome ⁽¹⁾ Toxic epidermal necrolysis ⁽¹⁾
Musculoskeletal and connective tissue disorders		Muscle spasms		
General disorders and administration site		Gait disturbance Asthenia		

conditions		Fatigue Irritability Feeling drunk		
Injury, poisoning and procedural complications		Fall Skin laceration Contusion		

(1) Adverse reactions reported in post marketing experience.

(2) See Description of selected adverse reactions.

(3) Reported in open-label studies.

Description of selected adverse reactions

The use of lacosamide is associated with dose-related increase in the PR interval. Adverse reactions associated with PR interval prolongation (e.g. atrioventricular block, syncope, bradycardia) may occur.

In adjunctive clinical trials in epilepsy patients, the incidence rate of reported first-degree AV Block is uncommon, 0.7 %, 0 %, 0.5 % and 0 % for lacosamide 200 mg, 400 mg, 600 mg or placebo, respectively. No second- or higher degree AV Block was seen in these studies. However, cases with second- and third-degree AV Block associated with lacosamide treatment have been reported in post-marketing experience. In the monotherapy clinical trial comparing lacosamide to carbamazepine CR, the extent of increase in PR interval was comparable between lacosamide and carbamazepine.

The incidence rate for syncope reported in pooled adjunctive therapy clinical trials is uncommon and did not differ between lacosamide (n=944) treated epilepsy patients (0.1 %) and placebo (n=364) treated epilepsy patients (0.3 %). In the monotherapy clinical trial comparing lacosamide to carbamazepine CR, syncope was reported in 7/444 (1.6 %) lacosamide patients and in 1/442 (0.2 %) carbamazepine CR patients.

Atrial fibrillation or flutter were not reported in short term clinical trials; however, both have been reported in open-label epilepsy trials and in post-marketing experience.

Laboratory abnormalities

Abnormalities in liver function tests have been observed in placebo-controlled trials with lacosamide in adult patients with partial-onset seizures who were taking 1 to 3 concomitant antiepileptic medicinal products. Elevations of ALT to $\geq 3x$ ULN occurred in 0.7 % (7/935) of Vimpat patients and 0 % (0/356) of placebo patients.

Multiorgan hypersensitivity reactions

Multiorgan hypersensitivity reactions (also known as Drug Reaction with Eosinophilia and Systemic Symptoms, DRESS) have been reported in patients treated with some antiepileptic medicinal products. These reactions are variable in expression, but typically present with fever and rash and can be associated with involvement of different organ systems. If multiorgan hypersensitivity reaction is suspected, lacosamide should be discontinued.

Paediatric population

The safety profile of lacosamide in placebo-controlled (see study details in section 5.1) and in open-label studies (n=408) in adjunctive therapy in children from 4 years of age was consistent with the safety profile observed in adults although the frequency of some adverse reactions (somnolence, vomiting and convulsion) was increased and additional adverse reactions (nasopharyngitis, pyrexia, pharyngitis, decreased appetite, lethargy and abnormal behaviour) have been reported in paediatric patients: nasopharyngitis (15.7 %), vomiting (14.7 %), somnolence (14.0 %), dizziness (13.5 %), pyrexia (13.0 %), convulsion (7.8 %), decreased appetite (5.9 %), pharyngitis (4.7 %), lethargy (2.7 %) and abnormal behaviour (1.7 %).

A total of 67.8 % of patients randomised to lacosamide and 58.1 % of patients randomised to placebo reported at least 1 adverse reaction.

Behavioural, cognition and emotional functioning were measured by the questionnaires Achenbach CBCL and BRIEF that were applied at baseline and throughout the studies and where mainly stable during the course of the trials.

Elderly population

In the monotherapy study comparing lacosamide to carbamazepine CR, the types of adverse reactions related to lacosamide in elderly patients (≥ 65 years of age) appear to be similar to that observed in patients less than 65 years of age. However, a higher incidence (≥ 5 % difference) of fall, diarrhoea and tremor has been reported in elderly patients compared to younger adult patients. The most frequent cardiac-related adverse reaction reported in elderly compared to the younger adult population was first-degree AV block. This was reported with lacosamide in 4.8 % (3/62) in elderly patients versus 1.6 % (6/382) in younger adult patients. The discontinuation rate due to adverse events observed with lacosamide was 21.0 % (13/62) in elderly patients versus 9.2 % (35/382) in younger adult patients. These differences between elderly and younger adult patients were similar to those observed in the active comparator group.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via:

Yellow Card Scheme

Website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store

4.9 Overdose

Symptoms

Symptoms observed after an accidental or intentional overdose of lacosamide are primarily associated with CNS and gastrointestinal system.

- The types of adverse reactions experienced by patients exposed to doses above 400 mg up to 800 mg were not clinically different from those of patients administered recommended doses of lacosamide.
- Reactions reported after an intake of more than 800 mg are dizziness, nausea, vomiting, seizures (generalised tonic-clonic seizures, status epilepticus). Cardiac conduction disorders, shock and coma have also been observed. Fatalities have been reported in patients following an intake of acute single overdose of several grams of lacosamide.

Management

There is no specific antidote for overdose with lacosamide. Treatment of lacosamide overdose should include general supportive measures and may include haemodialysis if necessary (see section 5.2).

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: antiepileptics, other antiepileptics, ATC code: N03AX18

Mechanism of action

The active substance, lacosamide (R-2-acetamido-N-benzyl-3-methoxypropionamide) is a functionalised amino acid.

The precise mechanism by which lacosamide exerts its antiepileptic effect in humans remains to be fully elucidated. *In vitro* electrophysiological studies have shown that lacosamide selectively enhances slow inactivation of voltage-gated sodium channels, resulting in stabilization of hyperexcitable neuronal membranes.

Pharmacodynamic effects

Lacosamide protected against seizures in a broad range of animal models of partial and primary generalised seizures and delayed kindling development.

In non-clinical experiments lacosamide in combination with levetiracetam, carbamazepine, phenytoin, valproate, lamotrigine, topiramate or gabapentin showed synergistic or additive anticonvulsant effects.

Clinical efficacy and safety

Adult population

Monotherapy

Efficacy of lacosamide as monotherapy was established in a double-blind, parallel group, non-inferiority comparison to carbamazepine CR in 886 patients 16 years of age or older with newly or recently diagnosed epilepsy. The patients had to present with unprovoked partial-onset seizures with or without secondary generalisation. The patients were randomised to carbamazepine CR or lacosamide, provided as tablets, in a 1:1 ratio. The dose was based on dose-response and ranged from 400 to 1,200 mg/day for carbamazepine CR and from 200 to 600 mg/day for lacosamide. The duration of the treatment was up to 121 weeks depending on the response.

The estimated 6-month seizure freedom rates were 89.8 % for lacosamide-treated patients and 91.1 % for carbamazepine CR treated patients using the Kaplan-Meier survival analysis method. The adjusted absolute difference between treatments was -1.3 % (95 % CI: -5.5, 2.8). The Kaplan-Meier estimates of 12-month seizure freedom rates were 77.8 % for lacosamide-treated patients and 82.7 % for carbamazepine CR treated patients.

The 6-month seizure freedom rates in elderly patients of 65 and above (62 patients in lacosamide, 57 patients in carbamazepine CR) were similar between both treatment groups. The rates were also similar to those observed in the overall population. In the elderly population, the maintenance lacosamide dose was 200 mg/day in 55 patients (88.7 %), 400 mg/day in 6 patients (9.7 %) and the dose was escalated to over 400 mg/day in 1 patient (1.6 %).

Conversion to monotherapy

The efficacy and safety of lacosamide in conversion to monotherapy has been assessed in a historical-controlled,

multicentre, double-blind, randomised trial. In this study, 425 patients aged 16 to 70 years with uncontrolled partial-onset seizures taking stable doses of 1 or 2 marketed antiepileptic medicinal products were randomised to be converted to lacosamide monotherapy (either 400 mg/day or 300 mg/day in a 3:1 ratio). In treated patients who completed titration and started withdrawing antiepileptic medicinal products (284 and 99 respectively), monotherapy was maintained in 71.5 % and 70.7 % of patients respectively for 57-105 days (median 71 days), over the targeted observation period of 70 days.

Adjunctive therapy

The efficacy of lacosamide as adjunctive therapy at recommended doses (200 mg/day, 400 mg/day) was established in 3 multicenter, randomised, placebo-controlled clinical trials with a 12-week maintenance period. Lacosamide 600 mg/day was also shown to be effective in controlled adjunctive therapy trials, although the efficacy was similar to 400 mg/day and patients were less likely to tolerate this dose because of CNS- and gastrointestinal-related adverse reactions. Thus, the 600 mg/day dose is not recommended. The maximum recommended dose is 400 mg/day. These trials, involving 1,308 patients with a history of an average of 23 years of partial-onset seizures, were designed to evaluate the efficacy and safety of lacosamide when administered concomitantly with 1-3 antiepileptic medicinal products in patients with uncontrolled partial-onset seizures with or without secondary generalisation. Overall the proportion of subjects with a 50 % reduction in seizure frequency was 23 %, 34 %, and 40 % for placebo, lacosamide 200 mg/day and lacosamide 400 mg/day.

The pharmacokinetics and safety of a single loading dose of intravenous lacosamide were determined in a multicenter, open-label study designed to assess the safety and tolerability of rapid initiation of lacosamide using a single intravenous loading dose (including 200 mg) followed by twice daily oral dosing (equivalent to the intravenous dose) as adjunctive therapy in adult subjects 16 to 60 years of age with partial-onset seizures.

Paediatric population

Partial-onset seizures have a similar clinical expression in children from 4 years of age and in adults. The efficacy of lacosamide in children aged 4 years and older has been extrapolated from data of adolescents and adults with partial-onset seizures, for whom a similar response was expected provided the paediatric dose adaptations are established (see section 4.2) and safety has been demonstrated (see section 4.8).

The efficacy supported by the extrapolation principle stated above was confirmed by a double-blind, randomised, placebo-controlled study. The study consisted of an 8-week baseline period followed by a 6-week titration period. Eligible patients on a stable dose regimen of 1 to \leq 3 antiepileptic medicinal products, who still experienced at least 2 partial-onset seizures during the 4 weeks prior to screening with seizure-free phase no longer than 21 days in the 8-week period prior to entry into the baseline period, were randomised to receive either placebo (n=172) or lacosamide (n=171).

Dosing was initiated at a dose of 2 mg/kg/day in subjects weighing less than 50 kg or 100 mg/day in subjects weighing 50 kg or more in 2 divided doses. During the titration period, lacosamide doses were adjusted in 1 or 2 mg/kg/day increments in subjects weighing less than 50 kg or 50 or 100 mg/day in subjects weighing 50 kg or more at weekly intervals to achieve the target maintenance period dose range.

Subjects must have achieved the minimum target dose for their body weight category for the final 3 days of the titration period to be eligible for entry into the 10-week maintenance period. Subjects were to remain on stable lacosamide dose throughout the maintenance period or were withdrawn and entered in the blinded taper period.

Statistically significant ($p=0.0003$) and clinically relevant reduction in partial-onset seizure frequency per 28 days from baseline to the maintenance period was observed between the lacosamide and the placebo group. The percent reduction over placebo based on analysis of covariance was 31.72 % (95 % CI: 16.342, 44.277).

Overall, the proportion of subjects with at least a 50 % reduction in partial-onset seizure frequency per 28 days from baseline to the maintenance period was 52.9 % in the lacosamide group compared with 33.3 % in the placebo group.

The quality of life assessed by the Pediatric Quality of Life Inventory indicated that subjects in both lacosamide and placebo groups had a similar and stable health-related quality of life during the entire treatment period.

5.2 Pharmacokinetic properties

Absorption

Lacosamide is rapidly and completely absorbed after oral administration. The oral bioavailability of lacosamide tablets is approximately 100 %. Following oral administration, the plasma concentration of unchanged lacosamide increases rapidly and reaches C_{max} about 0.5 to 4 hours post-dose. Vimpat tablets and oral syrup are bioequivalent. Food does not affect the rate and extent of absorption.

Distribution

The volume of distribution is approximately 0.6 L/kg. Lacosamide is less than 15 % bound to plasma proteins.

Biotransformation

95 % of the dose is excreted in the urine as lacosamide and metabolites. The metabolism of lacosamide has not been completely characterised.

The major compounds excreted in urine are unchanged lacosamide (approximately 40 % of the dose) and its O-desmethyl metabolite less than 30 %.

A polar fraction proposed to be serine derivatives accounted for approximately 20 % in urine, but was detected only in small amounts (0-2 %) in human plasma of some subjects. Small amounts (0.5-2 %) of additional metabolites were found in the urine.

In vitro data show that CYP2C9, CYP2C19 and CYP3A4 are capable of catalysing the formation of the O-desmethyl metabolite but the main contributing isoenzyme has not been confirmed *in vivo*. No clinically relevant difference in lacosamide exposure was observed comparing its pharmacokinetics in extensive metabolisers (EMs, with a functional CYP2C19) and poor metabolisers (PMs, lacking a functional CYP2C19). Furthermore an interaction trial with omeprazole (CYP2C19-inhibitor) demonstrated no clinically relevant changes in lacosamide plasma concentrations indicating that the importance of this pathway is minor. The plasma concentration of O-desmethyl-lacosamide is approximately 15 % of the concentration of lacosamide in plasma. This major metabolite has no known pharmacological activity.

Elimination

Lacosamide is primarily eliminated from the systemic circulation by renal excretion and biotransformation. After oral and intravenous administration of radiolabeled lacosamide, approximately 95 % of radioactivity administered was recovered in the urine and less than 0.5 % in the faeces. The elimination half-life of lacosamide is approximately 13 hours. The pharmacokinetics is dose-proportional and constant over time, with low intra- and inter-subject variability. Following twice daily dosing, steady state plasma concentrations are achieved after a 3 day period. The plasma concentration increases with an accumulation factor of approximately 2.

A single loading dose of 200 mg approximates steady-state concentrations comparable to 100 mg twice daily oral administration.

Pharmacokinetics in special patient groups

Gender

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

Renal impairment

The AUC of lacosamide was increased by approximately 30 % in mildly and moderately and 60 % in severely renal impaired patients and patients with end-stage renal disease requiring haemodialysis compared to healthy subjects, whereas C_{max} was unaffected.

Lacosamide is effectively removed from plasma by haemodialysis. Following a 4-hour haemodialysis treatment, AUC of lacosamide is reduced by approximately 50 %. Therefore, dosage supplementation following haemodialysis is recommended (see section 4.2). The exposure of the O-desmethyl metabolite was several-fold increased in patients with moderate and severe renal impairment. In absence of haemodialysis in patients with end-stage renal disease, the levels were increased and continuously rising during the 24-hour sampling. It is unknown whether the increased metabolite exposure in end-stage renal disease subjects could give rise to adverse effects but no pharmacological activity of the metabolite has been identified.

Hepatic impairment

Subjects with moderate hepatic impairment (Child-Pugh B) showed higher plasma concentrations of lacosamide (approximately 50 % higher AUC_{norm}). The higher exposure was partly due to a reduced renal function in the studied subjects. The decrease in non-renal clearance in the patients of the study was estimated to give a 20 % increase in the AUC of lacosamide. The pharmacokinetics of lacosamide has not been evaluated in severe hepatic impairment (see section 4.2).

Elderly (over 65 years of age)

In a study in elderly men and women including 4 patients > 75 years of age, AUC was about 30 and 50 % increased compared to young men, respectively. This is partly related to lower body weight. The body weight normalized difference is 26 and 23 %, respectively. An increased variability in exposure was also observed. The renal clearance of lacosamide was only slightly reduced in elderly subjects in this study.

A general dose reduction is not considered to be necessary unless indicated due to reduced renal function (see section 4.2).

Paediatric population

The paediatric pharmacokinetic profile of lacosamide was determined in a population pharmacokinetic analysis using sparse plasma concentration data obtained in one placebo-controlled randomised study and three open-label studies in 414 children with epilepsy aged 6 months to 17 years. The administered lacosamide doses ranged from 2 to 17.8 mg/kg/day in twice daily intake, with a maximum of 600 mg/day for children weighing 50 kg or more.

The typical plasma clearance was estimated to be 1.04 L/h, 1.32 L/h and 1.86 L/h for children weighing 20 kg, 30 kg and

50 kg respectively. In comparison, plasma clearance was estimated at 1.92 L/h in adults (70 kg body weight).

5.3 Preclinical safety data

In the toxicity studies, the plasma concentrations of lacosamide obtained were similar or only marginally higher than those observed in patients, which leaves low or non-existing margins to human exposure.

A safety pharmacology study with intravenous administration of lacosamide in anaesthetised dogs showed transient increases in PR interval and QRS complex duration and decreases in blood pressure most likely due to a cardiodepressant action. These transient changes started in the same concentration range as after maximum recommended clinical dosing. In anaesthetised dogs and Cynomolgus monkeys, at intravenous doses of 15-60 mg/kg, slowing of atrial and ventricular conductivity, atrioventricular block and atrioventricular dissociation were seen.

In the repeated dose toxicity studies, mild reversible liver changes were observed in rats starting at about 3 times the clinical exposure. These changes included an increased organ weight, hypertrophy of hepatocytes, increases in serum concentrations of liver enzymes and increases in total cholesterol and triglycerides. Apart from the hypertrophy of hepatocytes, no other histopathologic changes were observed.

In reproductive and developmental toxicity studies in rodents and rabbits, no teratogenic effects but an increase in numbers of stillborn pups and pup deaths in the peripartum period, and slightly reduced live litter sizes and pup body weights were observed at maternal toxic doses in rats corresponding to systemic exposure levels similar to the expected clinical exposure. Since higher exposure levels could not be tested in animals due to maternal toxicity, data are insufficient to fully characterise the embryofetotoxic and teratogenic potential of lacosamide.

Studies in rats revealed that lacosamide and/or its metabolites readily crossed the placental barrier.

In juvenile rats and dogs, the types of toxicity do not differ qualitatively from those observed in adult animals. In juvenile rats, a reduced body weight was observed at systemic exposure levels similar to the expected clinical exposure. In juvenile dogs, transient and dose-related CNS clinical signs started to be observed at systemic exposure levels below the expected clinical exposure.

6. Pharmaceutical particulars

6.1 List of excipients

Tablet core

microcrystalline cellulose

hydroxypropylcellulose

hydroxypropylcellulose (low substituted)

silica, colloidal, anhydrous

crospovidone (polyplasdone XL-10 Pharmaceutical Grade)

magnesium stearate

Tablet coat

Vimpat 50 mg film-coated tablets

polyvinyl alcohol

polyethylene glycol 3350

talc

titanium dioxide (E171)

red iron oxide (E172)

black iron oxide (E172)

indigo carmine aluminium lake (E132)

Vimpat 100 mg film-coated tablets

polyvinyl alcohol

polyethylene glycol 3350

talc

titanium dioxide (E171)

yellow iron oxide (E172)

Vimpat 150 mg film-coated tablets

polyvinyl alcohol
polyethylene glycol 3350
talc
titanium dioxide (E171)
yellow iron oxide (E172), red iron oxide (E172), black iron oxide (E172)

Vimpat 200 mg film-coated tablets

polyvinyl alcohol
polyethylene glycol 3350
talc
titanium dioxide (E171)
indigo carmine aluminium lake (E132)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

5 years.

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

Vimpat 50 mg film-coated tablets

Packs of 14, 28, 56 and 168 film-coated tablets in PVC/PVDC blister sealed with an aluminium foil.
Packs of 14 x 1 and 56 x 1 film-coated tablet in PVC/PVDC perforated unit dose blisters sealed with an aluminium foil.
Packs of 60 film-coated tablets in HDPE bottle with a child-resistant closure.

Vimpat 100 mg film-coated tablets

Packs of 14, 28, 56 and 168 film-coated tablets in PVC/PVDC blister sealed with an aluminium foil.
Packs of 14 x 1 and 56 x 1 film-coated tablet in PVC/PVDC perforated unit dose blisters sealed with an aluminium foil.
Packs of 60 film-coated tablets in HDPE bottle with a child-resistant closure.

Vimpat 150 mg film-coated tablets

Packs of 14, 28 and 56 film-coated tablets in PVC/PVDC blister sealed with an aluminium foil.
Multipacks containing 168 (3 packs of 56 tablets) film-coated tablets in PVC/PVDC blister sealed with an aluminium foil.
Packs of 14 x 1 and 56 x 1 film-coated tablet in PVC/PVDC perforated unit dose blisters sealed with an aluminium foil.
Packs of 60 film-coated tablets in HDPE bottle with a child-resistant closure.

Vimpat 200 mg film-coated tablets

Packs of 14, 28 and 56 film-coated tablets in PVC/PVDC blister sealed with an aluminium foil.
Multipacks containing 168 (3 packs of 56 tablets) film-coated tablets in PVC/PVDC blister sealed with an aluminium foil.
Packs of 14 x 1 and 56 x 1 film-coated tablet in PVC/PVDC perforated unit dose blisters sealed with an aluminium foil.
Packs of 60 film-coated tablets in HDPE bottle with a child-resistant closure.
Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

No special requirements for disposal.

7. Marketing authorisation holder

UCB Pharma S.A.

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B-1070 Bruxelles

Belgium

8. Marketing authorisation number(s)

EU/1/08/470/001

EU/1/08/470/002

EU/1/08/470/003

EU/1/08/470/004

EU/1/08/470/005

EU/1/08/470/006

EU/1/08/470/007

EU/1/08/470/008

EU/1/08/470/009

EU/1/08/470/010

EU/1/08/470/011

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EU/1/08/470/031

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EU/1/08/470/034

EU/1/08/470/035

9. Date of first authorisation/renewal of the authorisation

Date of first authorisation: 29 August 2008

Date of latest renewal: 31 July 2013

10. Date of revision of the text

09/2019

Detailed information on this medicine is available on the European Medicines Agency web site:
<http://www.ema.europa.eu/>

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