

Rx only

ABILIFY[®] (aripiprazole) Tablets

ABILIFY[®] DISCMELT[™] (aripiprazole) Orally

Disintegrating Tablets

ABILIFY[®] (aripiprazole) Oral Solution

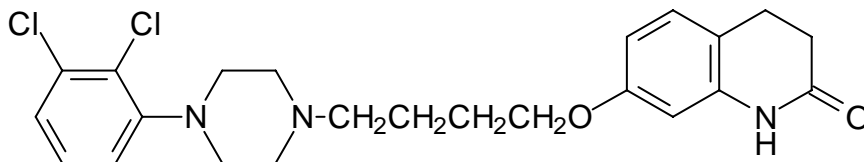
WARNING

Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. ABILIFY (aripiprazole) is not approved for the treatment of patients with dementia-related psychosis.

DESCRIPTION

Aripiprazole is a psychotropic drug that is available as ABILIFY[®] (aripiprazole) tablets, ABILIFY[®] DISCMELT[™] (aripiprazole) orally disintegrating tablets, and in solution for oral administration. Aripiprazole is 7-[4-[4-(2,3-dichlorophenyl)-1-piperazinyl]butoxy]-3,4-dihydrocarbostyryl. The empirical formula is C₂₃H₂₇Cl₂N₃O₂ and its molecular weight is 448.39. The chemical structure is:



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ABILIFY tablets are available in 2-mg, 5-mg, 10-mg, 15-mg, 20-mg, and 30-mg strengths. Inactive ingredients include cornstarch, hydroxypropyl cellulose, lactose monohydrate, magnesium stearate and microcrystalline cellulose. Colorants include ferric oxide (yellow or red) and FD&C Blue No. 2 Aluminum Lake.

ABILIFY DISCMELT orally disintegrating tablets are available in 10-mg, 15-mg, 20-mg, and 30-mg strengths. Inactive ingredients include acesulfame potassium, aspartame, calcium silicate, croscarmellose sodium, crospovidone, crème de vanilla (natural and artificial flavors), magnesium stearate, microcrystalline cellulose, silicon dioxide, tartaric acid, and xylitol. Colorants include ferric oxide (yellow or red) and FD&C Blue No. 2 Aluminum Lake.

ABILIFY is also available as a 1 mg/mL oral solution. The inactive ingredients for this solution include disodium edetate, fructose, glycerin, dl-lactic acid, methylparaben, propylene glycol, propylparaben, sodium hydroxide, sucrose, and purified water. The oral solution is flavored with natural orange cream and other natural flavors.

CLINICAL PHARMACOLOGY

Pharmacodynamics

Aripiprazole exhibits high affinity for dopamine D₂ and D₃, serotonin 5-HT_{1A} and 5-HT_{2A} receptors (K_i values of 0.34, 0.8, 1.7, and 3.4 nM, respectively), moderate affinity for dopamine D₄, serotonin 5-HT_{2C} and 5-HT₇, alpha₁-adrenergic and histamine H₁ receptors (K_i values of 44, 15, 39, 57, and 61 nM, respectively), and moderate affinity for the serotonin reuptake site (K_i=98 nM). Aripiprazole has no appreciable affinity for cholinergic muscarinic receptors (IC₅₀>1000 nM). Aripiprazole functions as a partial agonist at the dopamine D₂ and the serotonin 5-HT_{1A} receptors, and as an antagonist at serotonin 5-HT_{2A} receptor.

The mechanism of action of aripiprazole, as with other drugs having efficacy in schizophrenia and bipolar disorder, is unknown. However, it has been proposed that the efficacy of aripiprazole is mediated through a combination of partial agonist activity at D₂ and 5-HT_{1A} receptors and antagonist activity at 5-HT_{2A} receptors. Actions at

receptors other than D₂, 5-HT_{1A}, and 5-HT_{2A} may explain some of the other clinical effects of aripiprazole, eg, the orthostatic hypotension observed with aripiprazole may be explained by its antagonist activity at adrenergic alpha₁ receptors.

Pharmacokinetics

ABILIFY activity is presumably primarily due to the parent drug, aripiprazole, and to a lesser extent, to its major metabolite, dehydro-aripiprazole, which has been shown to have affinities for D₂ receptors similar to the parent drug and represents 40% of the parent drug exposure in plasma. The mean elimination half-lives are about 75 hours and 94 hours for aripiprazole and dehydro-aripiprazole, respectively. Steady-state concentrations are attained within 14 days of dosing for both active moieties. Aripiprazole accumulation is predictable from single-dose pharmacokinetics. At steady state, the pharmacokinetics of aripiprazole are dose-proportional. Elimination of aripiprazole is mainly through hepatic metabolism involving two P450 isozymes, CYP2D6 and CYP3A4.

Pharmacokinetic studies showed that ABILIFY DISCMELT orally disintegrating tablets are bioequivalent to ABILIFY tablets.

Absorption

Tablet

Aripiprazole is well absorbed after administration of the tablet, with peak plasma concentrations occurring within 3 to 5 hours; the absolute oral bioavailability of the tablet formulation is 87%. ABILIFY can be administered with or without food. Administration of a 15-mg ABILIFY tablet with a standard high-fat meal did not significantly affect the C_{max} or AUC of aripiprazole or its active metabolite, dehydro-aripiprazole, but delayed T_{max} by 3 hours for aripiprazole and 12 hours for dehydro-aripiprazole.

Oral Solution

Aripiprazole is well absorbed when administered orally as the solution. At equivalent doses, the plasma concentrations of aripiprazole from the solution were higher than that from the tablet formulation. In a relative bioavailability study comparing the pharmacokinetics of 30 mg aripiprazole as the oral solution to 30 mg aripiprazole tablets in healthy subjects, the solution to tablet ratios of geometric mean C_{max} and AUC values

were 122% and 114%, respectively (see **DOSAGE AND ADMINISTRATION**). The single-dose pharmacokinetics of aripiprazole were linear and dose-proportional between the doses of 5 to 30 mg.

Distribution

The steady-state volume of distribution of aripiprazole following intravenous administration is high (404 L or 4.9 L/kg), indicating extensive extravascular distribution. At therapeutic concentrations, aripiprazole and its major metabolite are greater than 99% bound to serum proteins, primarily to albumin. In healthy human volunteers administered 0.5 to 30 mg/day aripiprazole for 14 days, there was dose-dependent D₂ receptor occupancy indicating brain penetration of aripiprazole in humans.

Metabolism and Elimination

Aripiprazole is metabolized primarily by three biotransformation pathways: dehydrogenation, hydroxylation, and N-dealkylation. Based on *in vitro* studies, CYP3A4 and CYP2D6 enzymes are responsible for dehydrogenation and hydroxylation of aripiprazole, and N-dealkylation is catalyzed by CYP3A4. Aripiprazole is the predominant drug moiety in the systemic circulation. At steady state, dehydro-aripiprazole, the active metabolite, represents about 40% of aripiprazole AUC in plasma.

Approximately 8% of Caucasians lack the capacity to metabolize CYP2D6 substrates and are classified as poor metabolizers (PM), whereas the rest are extensive metabolizers (EM). PMs have about an 80% increase in aripiprazole exposure and about a 30% decrease in exposure to the active metabolite compared to EMs, resulting in about a 60% higher exposure to the total active moieties from a given dose of aripiprazole compared to EMs. Coadministration of ABILIFY with known inhibitors of CYP2D6, like quinidine in EMs, results in a 112% increase in aripiprazole plasma exposure, and dosing adjustment is needed (see **PRECAUTIONS: Drug-Drug Interactions**). The mean elimination half-lives are about 75 hours and 146 hours for aripiprazole in EMs and PMs, respectively. Aripiprazole does not inhibit or induce the CYP2D6 pathway.

Following a single oral dose of [¹⁴C]-labeled aripiprazole, approximately 25% and 55% of the administered radioactivity was recovered in the urine and feces, respectively. Less than 1% of unchanged aripiprazole was excreted in the urine and approximately 18% of the oral dose was recovered unchanged in the feces.

Special Populations

In general, no dosage adjustment for ABILIFY is required on the basis of a patient's age, gender, race, smoking status, hepatic function, or renal function (see **DOSAGE AND ADMINISTRATION: Dosage in Special Populations**). The pharmacokinetics of aripiprazole in special populations are described below.

Hepatic Impairment

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

Renal Impairment

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

Elderly

In formal single-dose pharmacokinetic studies (with aripiprazole given in a single dose of 15 mg), aripiprazole clearance was 20% lower in elderly (≥65 years) subjects compared to younger adult subjects (18 to 64 years). There was no detectable age effect, however, in the population pharmacokinetic analysis in schizophrenia patients. Also, the pharmacokinetics of aripiprazole after multiple doses in elderly patients appeared similar to that observed in young, healthy subjects. No dosage adjustment is recommended for elderly patients (see **Boxed WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis**, and **PRECAUTIONS: Geriatric Use**).

Gender

C_{max} and AUC of aripiprazole and its active metabolite, dehydro-aripiprazole, are 30 to 40% higher in women than in men, and correspondingly, the apparent oral clearance of

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