For the Use of a Registered Medical Practitioner Only

1. GENERIC NAME & BRAND NAME

Brivaracetam Tablets I.P. 25 mg, 50 mg, 75 mg and 100 mg

Brivetoin™ 25 / 50 / 75 / 100

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Brivetoin™ 25

Each film coated tablet contains:
Brivaracetam I.P.….25mg
Excipients……..q.s.
Colours: Black Oxide of Iron, Yellow Oxide of Iron and Titanium Dioxide I.P.

Brivetoin™ 50

Each film coated tablet contains**:**
Brivaracetam I.P.….50mg
Excipients……..q.s.
Colours: Red Oxide of Iron, Yellow Oxide of Iron and Titanium Dioxide I.P.

Brivetoin™ 75

Each film coated tablet contains**:**
Brivaracetam I.P. ….75mg
Excipients……..q.s.
Colours: Black oxide of Iron, Red Oxide of Iron, Yellow oxide of Iron and Titanium Dioxide I.P.

Brivetoin™ 100

Each film coated tablet contains:
Brivaracetam I.P.……. 100mg
Excipients q.s.
Colours: Black oxide of Iron, Yellow oxide of Iron, Red oxide of iron and Titanium Dioxide I.P.

3. DOSAGE FORM AND STRENGTH

Kindly Refer Section 1&2

4. CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATION

Brivaracetam is indicated as adjunctive therapy in the treatment of partial onset seizures in patients 16 years of age and older with epilepsy.

4.2 POSOLOGY AND METHOD OF ADMINISTRATION

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

Adults
The recommended starting dose is either 50 mg/day or 100 mg/day based on physician's assessment of required seizure reduction versus potential side effects. The dose should be administered in two equally divided doses, once in the morning and once in the evening. Based on individual patient response and tolerability, the dose may be adjusted in the dose range of 50 mg/day to 200 mg/day.

Missed doses
If patients missed one dose or more, it is recommended that they take a single dose as soon as they remember and take the following dose at the usual morning or evening time. This may avoid the brivaracetam plasma concentration falling below the efficacy level and prevent breakthrough seizures from occurring.

Discontinuation
If brivaracetam has to be discontinued it is recommended to withdraw it gradually by 50 mg/day on a weekly basis. After 1 week of treatment at 50 mg/day, a final week of treatment at the dose of 20 mg/day is recommended.

Special populations
Elderly (65 years of age and above)
No dose adjustment is needed in elderly patients.
The clinical experience in patients ≥ 65 years is limited.

Renal impairment
No dose adjustment is needed in patients with impaired renal function (see section 5.2). Brivaracetam is not recommended in end-stage renal disease patients undergoing dialysis due to lack of data. Based on data in adults, no dose adjustment is necessary in pediatric patients with impaired renal function.

Hepatic impairment
Exposure to brivaracetam was increased in adult patients with chronic liver disease. In adults, a 50 mg/day starting dose should be considered. In children and adolescents weighing 50 kg or greater, a 50 mg/day starting dose is recommended. A maximum daily dose of 150 mg administered in 2 divided doses is recommended for all stages of hepatic impairment.
In children and adolescents weighing less than 50 kg, a 1 mg/kg/day starting dose is recommended. The maximum dose should not exceed 3 mg/kg/day. No clinical data are available in pediatric patients with hepatic impairment.

Method of administration
Brivaracetam film-coated tablets must be taken orally swallowed in whole with liquid and may be taken with or without food

4.3 CONTRAINDICATIONS

Hypersensitivity to the active substance or other pyrrolidone derivatives or to any of the excipients listed in section 8.1.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Suicidal ideation and behavior

Suicidal ideation and behaviour have been reported in patients treated with anti-epileptic drugs (AEDs), including brivaracetam, in several indications. A meta-analysis of randomized placebo-controlled trials of AEDs 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 brivaracetam.

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 any signs of suicidal ideation or behaviour emerge.

Hepatic impairment

There are limited clinical data on the use of brivaracetam in patients with pre-existing hepatic impairment. Dose adjustments are recommended for patients with hepatic impairment Excipients

Lactose intolerance

Brivaracetam film-coated tablets contain lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

4.5 DRUGS INTERACTIONS

Formal interaction studies have only been performed in adults.

Pharmacodynamic interactions

Concomitant treatment with levetiracetam

In the clinical studies, although the numbers were limited, there was no observed benefit of Brivaracetam versus placebo in patients taking levetiracetam concurrently. No additional safety or tolerability concern was observed.

Interaction with alcohol

combining this medicine with alcohol is not recommended. If you are taking Brivaracetam the negative effects of alcohol may be increased

Pharmacokinetic interactions

Effects of other medicinal products on the pharmacokinetics of Brivaracetam In vitro data suggest that brivaracetam has a low interaction potential. The main disposition pathway of Brivaracetam is by CYP-independent hydrolysis. A second disposition pathway involves hydroxylation mediated by CYP2C19.

Brivaracetam plasma concentrations may increase when coadministered with CYP2C19 strong inhibitors (e.g. fluconazole, fluvoxamine), but the risk of a clinically relevant CYP2C19-mediated interaction is considered to be low.
Limited clinical data are available implying that coadministration of cannabidiol may increase the plasma exposure of brivaracetam, possibly through CYP2C19 inhibition, but the clinical relevance is uncertain.

Rifampicin
In healthy subjects, coadministration with the strong enzyme inducer rifampicin (600 mg/day for 5 days), decreased brivaracetam area under the plasma concentration curve (AUC) by 45 %. Prescribers should consider adjusting the brivaracetam dose in patients starting or ending treatment with rifampicin.

Strong enzyme inducing AEDs
Brivaracetam plasma concentrations are decreased when coadministered with strong enzyme inducing AEDs (carbamazepine, phenobarbital, phenytoin) but no dose adjustment is required (see table 1)

Other enzyme inducers
Other strong enzyme inducers (such as St John´s wort (Hypericum perforatum)) may also decrease the systemic exposure of brivaracetam. Therefore, starting or ending treatment with St John's wort should be done with caution.

Effects of brivaracetam on other medicinal products Brivaracetam given 50 or 150 mg/day did not affect the AUC of midazolam (metabolised by CYP3A4). The risk of clinically relevant CYP3A4 interactions is considered to be low.

In vitro studies have shown that brivaracetam exhibits little or no inhibition of CYP450 isoforms except for CYP2C19. Brivaracetam may increase plasma concentrations of medicinal products metabolised by CYP2C19 (e.g. lanzoprazole, omeprazole, diazepam). When tested in vitro brivaracetam did not induce CYP1A1/2 but induced CYP3A4 and CYP2B6. No CYP3A4 induction was found in vivo (see midazolam above). CYP2B6 induction has not been investigated in vivo and brivaracetam may decrease plasma concentrations of medicinal products metabolised by CYP2B6 (e.g. efavirenz). In vitro interaction studies to determine the potential inhibitory effects on transporters concluded that there were no clinically relevant effects, except for OAT3. In vitro, Brivaracetam inhibits OAT3 with a half maximal inhibitory concentration 42-fold higher than the C_{max} at the highest clinical dose. Brivaracetam 200mg/day may increase plasma concentrations of medicinal products transported by OAT3.

Antiepileptic drugs
Potential interactions between Brivaracetam (50 mg/day to 200 mg/day) and other AEDs were investigated in a pooled analysis of plasma drug concentrations from all phase 2-3 studies, in a population pharmacokinetic analysis of placebo-controlled phase 2-3 studies, and in dedicated drug-drug interaction studies (for the following AEDs:

carbamazepine, lamotrigine, phenytoin and topiramate). The effect of the interactions on the plasma concentration is summarised in table 1 (increase is indicated as "↑" and decrease as "↓", area under the plasma concentration versus time curve as "AUC", maximum observed concentration as C_{max}).

Table 1: Pharmacokinetic interactions between Brivaracetam and other AEDs

AED coadministered	**Influence of AED on Brivaracetam plasma concentration**	**Influence of Brivaracetam on AED plasma concentration**
Carbamazepine	AUC 29 % ↓ Cmax 13 % ↓ No dose adjustment required	Carbamazepine - None Carbamazepine-epoxide ↑ (See below) No dose adjustment required.
Clobazam	No data available	None
Clonazepam	No data available	None
Lacosamide	No data available	None
Lamotrigine	None	None
Levetiracetam	None	None
Oxcarbazepine	None	None (monohydroxy derivative, MHD)
Phenobarbital	AUC 19 % ↓ No dose adjustment required	None
Phenytoin	AUC 21 % ↓ No dose adjustment required	None [a] AUC 20% ↑ [a] C_{max} 20% ↑
Pregabalin	No data available	None
Topiramate	None	None
Valproic acid	None	None
Zonisamide	No data available	None

[a] based on a study involving the administration of a supratherapeutic dose of 400 mg/day Brivaracetam.

Carbamazepine

Brivaracetam is a moderate reversible inhibitor of epoxide hydrolase resulting in an increased concentration of carbamazepine epoxide, an active metabolite of carbamazepine. In controlled studies, the carbamazepine epoxide plasma concentration increased by a mean of 37 %, 62 % and 98 % with little variability at Brivaracetam doses of 50 mg/day, 100 mg/day and 200 mg/day respectively. No safety risks were observed. There was no additive effect of Brivaracetam and valproate on the AUC of carbamazepine epoxide.

Oral contraceptives

Co-administration of brivaracetam (100 mg/day) with an oral contraceptive containing ethinylestradiol (0.03 mg) and levonorgestrel (0.15 mg) did not influence the pharmacokinetics of either substance. When brivaracetam was coadministered at a dose of 400 mg/day (twice the recommended maximum daily dose) with an oral contraceptive containing ethinylestradiol (0.03 mg) and levonorgestrel (0.15 mg), a reduction in

oestrogen and progestin AUCs of 27 % and 23 %, respectively, was observed without impact on suppression of ovulation. There was generally no change in the concentration-time profiles of the endogenous markers estradiol, progesterone, luteinizing hormone (LH), follicle stimulating hormone (FSH), and sex hormone binding globulin (SHBG).

4.6 USE IN SPECIAL POPULATIONS

Women of childbearing potential

Physicians should discuss family planning and contraception with women of childbearing potential taking Brivaracetam. If a woman decides to become pregnant, the use of Brivaracetam should be carefully re-evaluated.

Pregnancy

Risk related to epilepsy and antiepileptic medicinal products in general
For all anti-epileptic drugs, 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 underlying condition is responsible has not been elucidated. Discontinuation of anti -epileptic treatments may result in exacerbation of the disease which could be harmful to the mother and the foetus.

Risk related to Brivaracetam
There is a limited amount of data from the use of Brivaracetam in pregnant women. There is no data on placental transfer in humans, but Brivaracetam was shown to readily cross the placenta in rats. The potential risk for humans is unknown. Animal studies did not detect any teratogenic potential of Brivaracetam.
In clinical studies, Brivaracetam was used as adjunctive therapy and when it was used with carbamazepine, it induced a dose-related increase in the concentration of the active metabolite, carbamazepine-epoxide. There is insufficient data to determine the clinical significance of this effect in pregnancy.

As a precautionary measure, Brivaracetam should not be used during pregnancy unless clinically necessary i.e. (if the benefit to the mother clearly outweighs the potential risk to the foetus).

Breast-feeding
It is unknown whether Brivaracetam is excreted in human breast milk. Studies in rats have shown excretion of Brivaracetam in breast milk (see section 5.3). A decision should be made whether to discontinue breastfeeding or to discontinue Brivaracetam, taking into account the benefit of the medicinal product to the mother. In case of coadministration of Brivaracetam and carbamazepine, the amount of carbamazepine-epoxide excreted in breast milk could increase. There is insufficient data to determine the clinical significance.

Fertility

No human data on the effect of Brivaracetam on fertility are available. In rats, there was no effect on fertility with Brivaracetam.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Brivaracetam has minor or moderate influence on the ability to drive and use machines. Due to possible differences in individual sensitivity some patients might experience somnolence, dizziness, and other central nervous system (CNS) related symptoms. Patients should be advised not to drive a car or to operate other potentially hazardous machines until they are familiar with the effects of Brivaracetam on their ability to perform such activities.

4.8 UNDESIRABLE EFFECTS

Summary of the safety profile
The most frequently reported adverse reactions (>10 %) with brivaracetam treatment were: somnolence (14.3 %) and dizziness (11.0 %). They were usually mild to moderate in intensity. Somnolence and fatigue (8.2 %) were reported at a higher incidence with increasing dose.

The discontinuation rate due to adverse reactions was 3.5 %, 3.4 % and 4.0 % for patients randomized to brivaracetam at respectively the dose of 50 mg/day, 100 mg/day and 200 mg/day and 1.7 % for patients randomized to placebo. The adverse reactions most frequently resulting in discontinuation of brivaracetam therapy were dizziness (0.8 %) and convulsion (0.8 %).

Tabulated list of adverse reactions
In the table below, adverse reactions, which were identified based on review of the three placebo-controlled, fixed dose studies safety database in subjects ≥ 16 years of age, are listed by System Organ Class and frequency.
The frequencies are defined as follows: very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

Infections and infestations
Common: Influenza

Blood and lymphatic system disorders
Uncommon: Neutropenia

Immune system disorders
Uncommon: Type I hypersensitivity

Metabolism and nutrition disorders
Common: Decreased appetite

Psychiatric disorders
Common: Depression, anxiety, insomnia, irritability
Uncommon: Suicidal ideation, psychotic disorder, aggression, agitation

Nervous system disorders
Very common: Dizziness, somnolence
Common: Convulsion, vertigo

Respiratory, thoracic and mediastinal disorders
Common: Upper respiratory tract infections, cough

Gastrointestinal disorders
Common: Nausea, vomiting, constipation

General disorders and administration site conditions
Common: Fatigue

4.9 OVERDOSAGE

Symptoms
There is limited clinical experience with Brivaracetam overdose in humans. Somnolence and dizziness have been reported in a healthy subject taking a single dose of 1,400 mg of Brivaracetam.

Management of overdose
There is no specific antidote for overdose with Brivaracetam. Treatment of an overdose should include general supportive measures. Since less than 10 % of Brivaracetam is excreted in urine, haemodialysis is not expected to significantly enhance Brivaracetam clearance.

5. PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES
Mechanism of action
Brivaracetam displays a high and selective affinity for synaptic vesicle protein 2A (SV2A), a transmembrane glycoprotein found at presynaptic level in neurons and in endocrine cells. Although the exact role of this protein remains to be elucidated it has been shown to modulate exocytosis of neurotransmitters. Binding to SV2A is believed to be the primary mechanism for Brivaracetam anticonvulsant activity.

5.2 PHARMACOKINETIC PROPERTIES
Brivaracetam film-coated tablets, oral solution and solution for intravenous injection show the same AUC, while the maximum plasma concentration is slightly higher after intravenous administration. Brivaracetam exhibits linear and time-independent pharmacokinetics with low intra- and inter-subject variability, and features complete absorption, very low protein binding, renal excretion following extensive biotransformation, and pharmacologically inactive metabolites.

Absorption
Brivaracetam is rapidly and completely absorbed after oral administration and the absolute bioavailability is approximately 100 %. The median t_{max} for tablets taken without food is 1 hour (t_{max} range is 0.25 to 3 h).Coadministration with a high-fat meal slowed down the absorption

rate (median t_{max} 3 h) and decreased the maximum plasma concentration (37 % lower) of Brivaracetam, while the extent of absorption remained unchanged.

Distribution
Brivaracetam is weakly bound (≤ 20 %) to plasma proteins. The volume of distribution is 0.5 L/kg, a value close to that of the total body water.Due to its lipophylicity (Log P) brivaracetam has high cell membrane permeability.

Biotransformation
Brivaracetam is primarily metabolized by hydrolysis of the amide moiety to form the corresponding carboxylic acid (approximately 60 % the elimination), and secondarily by hydroxylation on the propyl side chain (approximately 30 % the elimination). The hydrolysis of the amide moiety leading to the carboxylic acid metabolite (34 % of the dose in urine) is supported by hepatic and extra-hepatic amidase. In vitro, the hydroxylation of Brivaracetam is mediated primarily by CYP2C19. Both metabolites, are further metabolised forming a common hydroxylated acid formed predominantly by hydroxylation of the propyl side chain on the carboxylic acid metabolite (mainly by CYP2C9). In vivo, in human subjects possessing ineffective mutations of CYP2C19, production of the hydroxy metabolite is decreased 10-fold while Brivaracetam itself is increased by 22 % or 42 % in individuals with one or both mutated alleles. The three metabolites are not pharmacologically active.

Elimination
Brivaracetam is eliminated primarily by metabolism and by excretion in the urine. More than 95 % of the dose, including metabolites, is excreted in the urine within 72 hours after intake. Less than 1 % of the dose is excreted in faeces and less than 10 % of Brivaracetam is excreted unchanged in urine. The terminal plasma half-life (t1/2) is approximately 9 hours. The total plasma clearance in patients was estimated to 3.6 L/h.

Linearity
Pharmacokinetics is dose-proportional from 10 to at least 600 mg.

Interactions with medicinal products
Brivaracetam is cleared by multiple pathways including renal excretion, non-CYP-mediated hydrolysis and CYP-mediated oxidations. In vitro, Brivaracetam is not a substrate of human P-glycoprotein (P-gp), multidrug resistance proteins (MRP) 1 and 2, and likely not organic anion transporter polypeptide 1B1 (OATP1B1) and OATP1B3.

In vitro assays showed that Brivaracetam disposition should not be significantly affected by CYP (eg. CYP1A, 2C8, 2C9, 2D6 and 3A4) inhibitors.
In vitro, Brivaracetam was not an inhibitor of the CYP1A2, 2A6, 2B6, 2C8, 2C9, 2D6, 3A4, or the transporters P-gp, BCRP, BSEP MRP2, MATE-K, MATE-1, OATP1B1, OATP1B3, OAT1 and OCT1 at clinically relevant concentrations. In vitro, Brivaracetam did not induce CYP1A2.

Pharmacokinetics in special patient groups
Elderly (65 years of age and above)

In a study in elderly subjects (65 to79 years old; with creatinine clearance 53 to 98 ml/min/1.73 m^2) receiving Brivaracetam 400 mg/day in bid administration, the plasma half-life of Brivaracetam was 7.9 hours and 9.3 hours' in the 65 to 75 and >75 years' groups, respectively. The steady-state plasma clearance of Brivaracetam was similar (0.76 ml/min/kg) to young healthy male subjects (0.83 ml/min/kg).

Renal impairment
A study in subjects with severe renal impairment (creatinine clearance <30 ml/min/1.73 m^2 and not requiring dialysis) revealed that the plasma AUC of Brivaracetam was moderately increased (+21 %) relative to healthy controls, while the AUC of the acid, hydroxy and hydroxyacid metabolites were increased 3-, 4-, and 21-fold, respectively. The renal clearance of these non-active metabolites was decreased 10-fold. The hydroxyacid metabolite did not reveal anysafety concerns in nonclinical studies. Brivaracetam has not been studied in patients undergoing haemodialysis.

Hepatic impairment
A pharmacokinetic study in subjects with hepatic cirrhosis (Child-Pugh classes A, B, and C) showed similar increases in exposure to Brivaracetam irrespective of disease severity (50 %, 57 % and 59 %), relative to matched healthy controls.

Body weight
A 40 % decrease in steady-state plasma concentration has been estimated across a body weight range from 46 kg to 115 kg. However, this is not considered to be a clinically relevant difference.

Gender
There are no clinically relevant differences in the pharmacokinetics of Brivaracetam by gender.

Race
The pharmacokinetics of Brivaracetam was not significantly affected by race (Caucasian, Asian) in a population pharmacokinetic modelling from epilepsy patients. The number of patients with other ethnic background was limited.

Pharmacokinetic/pharmacodynamics relationship
The EC50 (Brivaracetam plasma concentration corresponding to 50 % of the maximum effect) was estimated to be 0.57 mg/L. This plasma concentration is slightly above the median exposure obtained after Brivaracetam doses of 50 mg/day. Further seizure frequency reduction is obtained by increasing the dose to 100 mg/day and reaches a plateau at 200 mg/day.

Pediatric population
In a pharmacokinetic study with a 3-week evaluation period and weekly fixed 3-step up-titration using the Brivaracetam oral solution, 99 subjects aged 1 month to <16 years were evaluated. Brivaracetam was administered at weekly increasing doses of approximately 1 mg/kg/day, 2 mg/kg/day, and 4 mg/kg/day. All doses were adjusted by body weight and did not exceed a maximum of 50 mg/day, 100 mg/day, and 200 mg/day. At the end of the evaluation period, subjects may have been eligible for entry into a long-term follow-up study continuing

on their last received dose. Plasma concentrations were shown to be dose-proportional in all age groups. Population pharmacokinetics modeling indicated that the dose of 2.0 mg/kg twice a day provides the same steady-state average plasma concentration as in adults receiving 100 mg twice daily. The estimated plasma clearance was 1.61 L/h, 2.18 L/h and 3.19 L/h for children weighing 20 kg, 30 kg and 50 kg, respectively. In comparison, plasma clearance was estimated at 3.58 L/h in adult patients (70 kg body weight). Currently, no clinical data are available in neonates.

6. NONCLINICAL PROPERTIES

Decreased spontaneous locomotor activity) seen at multiples (greater than 50-fold) of the pharmacologically active dose of Brivaracetam, 2 mg/kg. Learning and memory function were not affected. Findings not observed in clinical studies but seen in the repeated-dose toxicology dog studies at exposure similar to the clinical plasma AUC, were hepatotoxic effects (mainly porphyria). However, toxicological data accumulated on Brivaracetam and on a structurally-related compound indicate that the dog liver changes have developed through mechanisms not relevant for humans. No adverse liver changes were seen in rats and monkeys following chronic administration of Brivaracetam at 5- and 42-fold the clinical AUC exposure. In monkeys, CNS signs (prostrate, loss of balance, clumsy movements) occurred at 64-fold the clinical C_{max}, these effects being less apparent over time.

Genotoxicity studies have not detected any mutagenic or clastogenic activity. Carcinogenicity studies did not indicate any oncogenic potential in rats, whereas increased incidences of hepatocellular tumors in male mice are considered to result of a non-genotoxic, mode of action linked to a phenobarbitone -like liver enzyme induction, which is a known rodent specific phenomenon.

Brivaracetam did not affect male or female fertility and has demonstrated no teratogenic potential in either rat or rabbit. Embryotoxicity was observed in rabbits at a maternal toxic dose of Brivaracetam with an exposure level 8-fold the clinical AUC exposure at the maximum recommended dose. In rats, Brivaracetam was shown to readily cross the placenta and to be excreted in milk of lactating rats with concentrations similar to maternal plasma levels. Brivaracetam did not show any dependence potential in rats.

Juvenile animal's studies

In juvenile rats, Brivaracetam exposure levels 6- to 15-fold the clinical AUC exposure at the maximum recommended dose induced developmental adverse effects (i.e. mortality, clinical signs, decreased body weight and lower brain weight). There were no adverse effects on CNS function, neuropathological and brain histopathological examination. In juvenile dogs, the Brivaracetam-induced changes at the exposure level 6- fold the clinical AUC were similar to those observed in adult animals. There were no adverse effects in any of the standard developmental or maturation endpoints.

7. DESCRIPTION

BRIVETOIN is supplied for oral administration, as a film-coated tablet. Each film coated tablet of Brivetoin contains Brivaracetam 25 mg, 50 mg, 75 mg, 100 mg.

8. PHARMACEUTICAL PARTICULARS

8.1 INCOMPATIBILITIES
None

8.2 SHELF LIFE
Refer Pack

8.3 PACKAGING INFORMATION
Refer Pack

8.4 STORAGE AND HANDING INSTRUCTIONS
Refer Pack

9. PATIENT COUNSELING INFORMATION

Suicidal Behaviour and Ideation
Counsel patients, their caregivers, and/or families that antiepileptic drugs, including Brivaracetam, may increase the risk of suicidal thoughts and behavior, and advise patients to be alert for the emergence or worsening of symptoms of depression; unusual changes in mood or behavior; or suicidal thoughts, behavior, or thoughts about self-harm. Advise patients, their caregivers, and/or families to report behaviors of concern immediately to a healthcare provider

Neurological Adverse Reactions Counsel patients that Brivaracetam causes somnolence, fatigue, dizziness, and gait disturbance. These adverse reactions, if observed, are more likely to occur early in treatment but can occur at any time. Advise patients not to drive or operate machinery until they have gained sufficient experience on Brivaracetam to gauge whether it adversely affects their ability to drive or operate machinery.

Psychiatric Adverse Reactions
Advise patients that Brivaracetam causes changes in behavior (e.g., aggression, agitation, anger, anxiety, and irritability) and psychotic symptoms. Instruct patients to report these symptoms immediately to their healthcare provider.

Hypersensitivity: Bronchospasm and Angioedema
Advise patients that symptoms of hypersensitivity including bronchospasm and angioedema can occur with BRIVAJOY. Instruct them to seek immediate medical care should they experience signs and symptoms of hypersensitivity.

Withdrawal of Antiepileptic Drugs
Advise patients not to discontinue use of Brivaracetam without consulting with their healthcare provider. Brivaracetam should normally be gradually withdrawn to reduce the potential for increased seizure frequency and status epilepticus
Pregnancy Advise patients to notify their healthcare provider if they become pregnant or intend to become pregnant during Brivaracetam therapy. Encourage patients to enroll in the North American Antiepileptic Drug Pregnancy Registry if they become pregnant. This registry is collecting information about the safety of antiepileptic drugs during pregnancy. Dosing Instructions Counsel patients that Brivaracetam may be taken with or without food. Instruct

patients that Brivaracetam tablets should be swallowed whole with liquid and not chewed or crushed.

10. DETAILS OF MANUFACTURER
Refer Pack for manufacturer details.

Marketed By:
Abbott India Limited
Angel Space, Lifestyle Bldg. No. D-4,
Gala No. 7 to 10 & 17 to 20 Ground Floor,
107 to 110 & 117 to 120 First Floor,
Pimplas Village, Dist. Thane,
Bhiwandi - 421 302, India.

11. DETAILS OF PERMISSION OR LICENSE NUMBER WITH DATE
Refer Pack for Permission/License details.

12. DATE OF REVISION
Version 3.0 dated 30/05/2024

For Product Complaints/Adverse events or Queries please write to
webmasterindia@abbott.com