Teva Clozapine

Example Titration Schedule

 Required Laboratory Testing Prior to Initiation and During Therapy
Prior to initiating treatment with Clozapine tablets, a baseline ANC must be obtained. The baseline ANC must be at least 1500/µL for the general population, and at least 1000/µL for patients with documented Benign Ethnic Neutropenia (BEN). To continue treatment, the ANC must be monitored regularly.

| EXAMPLE |
|------------------|------------------|------------------|------------------|
| WEEK 1 | AM Dose (mg) | PM Dose (mg) | Total Daily Dose (mg) |
| Day 1 | 12.5 | 12.5 (optional) | 12.5–25 |
| Day 2 | 25 | --- | 25 |
| Day 3 | 25 | 25 | 50 |
| Day 4 | 25 | 50 | 75 |
| Day 5 | 50 | 50 | 100 |
| Day 6 | 50 | 75 | 125 |
| Day 7 | 50 | 100 | 150 |

| WEEK 2 | AM Dose (mg) | PM Dose (mg) | Total Daily Dose (mg) |
| Day 8 | 75 | 100 | 175 |
| Day 9 | 100 | 100 | 200 |
| Day 10 | 100 | 125 | 225 |
| Day 11 | 100 | 150 | 250 |
| Day 12 | 125 | 150 | 275 |
| Day 13 | 150 | 150 | 300 |
| Day 14 | 150 | 150 | 300 |

INDICATIONS
Treatment-Resistant Schizophrenia
Clozapine tablets are indicated for the treatment of severely ill patients with schizophrenia who fail to respond adequately to standard antipsychotic treatment. Because of the risks of severe neutropenia and of seizure associated with their use, clozapine tablets should be used only in patients who have failed to respond adequately to standard antipsychotic treatment. The effectiveness of clozapine tablets in treatment-resistant schizophrenia was demonstrated in a 6-week, randomized, double-blind, active-controlled study comparing clozapine tablets and chlorpromazine in patients who had failed other antipsychotics.

Reduction in the Risk of Recurrent Suicidal Behavior in Schizophrenia or Schizoaffective Disorders
Clozapine tablets are indicated for reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder who are judged to be at chronic risk for re-experiencing suicidal behavior, based on history and recent clinical state. Suicidal behavior refers to actions by a patient that puts him/herself at risk for death. The effectiveness of clozapine in reducing the risk of recurrent suicidal behavior was demonstrated over a two-year treatment period in the InterSePT™ Trial.

IMPORTANT SAFETY INFORMATION

WARNING: SEVERE NEUTROPENIA; ORTHOSTATIC HYPOTENSION, BRADYCARDIA, AND SYNCOPE; SEIZURE; MYOCARDITIS AND CARDIOMYOPATHY; INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Severe Neutropenia
Clozapine treatment has caused severe neutropenia, defined as an absolute neutrophil count (ANC) less than 500/µL. Severe neutropenia can lead to serious infection and death. Prior to initiating treatment with clozapine, a baseline ANC must be at least 1500/µL for the general population; and must be at least 1000/µL for patients with documented Benign Ethnic Neutropenia (BEN). During treatment, patients must have regular ANC monitoring. Advise patients to immediately report symptoms consistent with severe neutropenia or infection (e.g., fever, weakness, lethargy, or sore throat).

Because of the risk of severe neutropenia, clozapine is available only through a restricted program under a Risk Evaluation Mitigation Strategy (REMS) called the Clozapine REMS Program.

(Boxed Warning continues on next page)

See Important Safety Information throughout and accompanying full Prescribing Information, including Boxed Warning.
Dosing Information
The starting dose is 12.5 mg once daily or twice daily. The total daily dose can be increased in increments of 25 mg to 50 mg per day, if well-tolerated, to achieve a target dose of 300 mg to 450 mg per day (administered in divided doses) by the end of 2 weeks. Subsequently, the dose can be increased once weekly or twice weekly, in increments of up to 100 mg. The maximum dose is 900 mg per day. To minimize the risk of orthostatic hypotension, bradycardia, and syncope, it is necessary to use this low starting dose, gradual titration schedule, and divided dosages.

Clozapine tablets can be taken with or without food.

Maintenance Treatment
Generally, patients responding to Clozapine tablets should continue maintenance treatment on their effective dose beyond the acute episode.

Discontinuation of Treatment
Method of treatment discontinuation will vary depending on the patient’s last ANC:

- See Tables 2 or 3 for appropriate ANC monitoring based on the level of neutropenia if abrupt treatment discontinuation is necessary because of moderate to severe neutropenia.
- Reduce the dose gradually over a period of 1 to 2 weeks if termination of Clozapine therapy is planned and there is no evidence of moderate to severe neutropenia.
- For abrupt Clozapine discontinuation for a reason unrelated to neutropenia, continuation of the existing ANC monitoring is recommended for general population patients until their ANC is ≥1500/µL and for BEN patients until their ANC is ≥1000/µL or above their baseline.
- Additional ANC monitoring is required for any patient reporting onset of fever (temperature of 38.5°C or 101.3°F, or greater) during the 2 weeks after discontinuation.
- Monitor all patients carefully for the recurrence of psychotic symptoms and symptoms related to cholinergic rebound such as profuse sweating, headache, nausea, vomiting, and diarrhea.

Re-Initiation of Treatment
When restarting Clozapine tablets in patients who have discontinued Clozapine tablets (i.e., 2 days or more since the last dose), re-initiate with 12.5 mg once daily or twice daily. This is necessary to minimize the risk of hypotension, bradycardia, and syncope. If that dose is well-tolerated, the dose may be increased to the previously therapeutic dose more quickly than recommended for initial treatment.

Please see Important Safety Information continued on next page.
IMPORTANT SAFETY INFORMATION (continued)

**Clozapine tablets are contraindicated in:** patients with a history of serious hypersensitivity to clozapine (e.g., photosensitivity, vasculitis, erythema multiforme, or Stevens-Johnson syndrome) or any other component of clozapine tablets.

**Falls:** Clozapine may cause somnolence, postural hypotension, motor and sensory instability, which may lead to falls and, consequently, fractures or other injuries. For patients with diseases, conditions, or medications that could exacerbate these effects, complete fall risk assessments when initiating antipsychotic treatment and recurrently for patients on long-term antipsychotic therapy.

**Eosinophilia:** Eosinophilia, defined as a blood eosinophil count of greater than 700/µL, has occurred with clozapine treatment. Clozapine-related eosinophilia usually occurs during the first month of treatment and has been associated with myocarditis, pancreatitis, hepatitis, colitis and nephritis. If eosinophilia develops during clozapine treatment, promptly evaluate for signs and symptoms of systemic reactions, such as rash or other allergic symptoms, myocarditis, or other organ-specific disease associated with eosinophilia. If clozapine-related systemic disease is suspected, discontinue clozapine immediately.

**QT Interval Prolongation:** QT prolongation, Torsade de Pointes and other life-threatening ventricular arrhythmias, cardiac arrest, and sudden death have occurred with clozapine treatment. Exercise caution in patients with a history of QT prolongation, long QT syndrome, family history of long QT syndrome or sudden cardiac death, significant cardiac arrhythmia, recent myocardial infarction, uncompensated heart failure, treatment with other medications that cause QT prolongation, treatment with medications that inhibit the metabolism of clozapine, and electrolyte abnormalities. Electrolyte abnormalities such as hypokalemia or hypomagnesemia increase the risk of QT prolongation and therefore should be corrected before initiating treatment with clozapine. Exercise caution when clozapine is coadministered with other medications known to prolong the QT interval or inhibit metabolism of clozapine. Discontinue clozapine if the QTc interval exceeds 500 msec. If patients experience symptoms consistent with Torsades de Pointes or other arrhythmias, (e.g., syncope, presyncope, dizziness or palpitations), obtain a cardiac evaluation, and discontinue clozapine.

**Metabolic Changes:** Atypical antipsychotic drugs, including clozapine, have been associated with metabolic changes that may increase cardiovascular and cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and body weight gain and should be monitored at baseline and have periodic follow-up monitoring during treatment with clozapine.

- **Hyperglycemia and Diabetes Mellitus:** Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics including clozapine. Patients diagnosed with diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics including clozapine should have fasting blood glucose testing at the beginning of treatment and periodically during treatment.

- **Dyslipidemia:** Undesirable alterations in lipids have occurred in patients treated with atypical antipsychotics, including clozapine. Clinical monitoring, including baseline and periodic follow-up lipid evaluations is recommended.

- **Weight Gain:** Weight gain has occurred with the use of antipsychotics, including clozapine. Monitor weight during treatment with clozapine.

**Neuroleptic Malignant Syndrome (NMS):** A potentially fatal symptom complex referred to as NMS has been reported in patients receiving clozapine alone or in combination with lithium or other CNS-active medications. Immediately discontinue antipsychotic drugs as part of the management of NMS. If a patient requires antipsychotic drug therapy after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered and monitored as NMS can recur.

**Hepatotoxicity:** Severe, life threatening, and in some cases fatal hepatotoxicity including hepatic failure, hepatic necrosis, and hepatitis have been reported in post marketing studies in patients treated with clozapine. Monitor for the appearance of signs and symptoms of hepatotoxicity such as fatigue, malaise, anorexia, nausea, jaundice, bilirubinemia, coagulopathy, and hepatic encephalopathy. Perform serum tests for liver injury and consider permanently discontinuing treatment if hepatitis or transaminase elevations combined with other systemic symptoms are due to clozapine.

**Fever:** During clozapine therapy, patients have experienced transient, clozapine-related fever. While this fever is generally benign and self-limited, it may necessitate discontinuing treatment. The fever can be associated with an increase or decrease in WBC count. Carefully evaluate patients with fever to rule out severe neutropenia or infection. Consider the possibility of NMS.

**Pulmonary Embolism:** Pulmonary embolism and deep-vein thrombosis have occurred in patients treated with clozapine tablets. Consider the possibility of pulmonary embolism in patients who present with deep-vein thrombosis, acute dyspnea, chest pain or other respiratory signs and symptoms.

**Anticholinergic Toxicity:** Treatment with clozapine can result in CNS and peripheral anticholinergic toxicity. Use with caution in the presence of narrow-angle glaucoma, concomitant anticholinergic medications, prostatic hypertrophy, or other conditions in which anticholinergic effects can lead to serious adverse reactions. Clozapine treatment can cause gastrointestinal adverse reactions such as constipation, intestinal obstruction, fecal impaction, and paralytic ileus which can be fatal. Constipation may be treated by ensuring adequate hydration and use of bulk laxatives. Consultation with a gastroenterologist is advisable in more serious cases.

Please see Important Safety Information continued on next page.
IMPORTANT SAFETY INFORMATION (continued)

Interference with Cognitive and Motor Performance: Clozapine can cause sedation and impairment of cognitive and motor performance. Caution patients about operating hazardous machinery, including automobiles, while they are taking clozapine. These reactions may be dose-related and a reduction in dose may be required.

Tardive Dyskinesia (TD): TD has occurred in patients treated with antipsychotic drugs, including clozapine. Prescribe clozapine in a manner that is most likely to minimize the risk of developing TD. Use the lowest effective dose and the shortest duration necessary to control symptoms. Periodically assess the need for continued treatment. Consider discontinuing treatment if TD occurs.

Cerebrovascular Adverse Reactions: Elderly patients with dementia-related psychosis treated with some atypical antipsychotics had an increased risk of cerebrovascular adverse reactions (e.g., stroke, transient ischemic attack), including fatalities. Clozapine should be used with caution in patients with risk factors for cerebrovascular adverse reactions.

Recurrence of Psychosis and Cholinergic Rebound after Abrupt Discontinuation of Clozapine: If abrupt discontinuation of clozapine is necessary (because of severe neutropenia or another medical condition), monitor carefully for the recurrence of psychotic symptoms and adverse reactions related to cholinergic rebound, such as profuse sweating, headache, nausea, vomiting and diarrhea.

Most common adverse reactions (≥5%) were: CNS reactions (sedation, dizziness/vertigo, headache, and tremor); cardiovascular reactions (tachycardia, hypotension, and syncope); autonomic nervous system reactions (hypersalivation, sweating, dry mouth, and visual disturbances); gastrointestinal reactions (constipation and diarrhea); and fever.

CYP1A2 Inhibitors: Concomitant use of clozapine tablets and CYP1A2 inhibitors can increase plasma levels of clozapine, potentially resulting in adverse reactions. Reduce the clozapine tablets dose to one-third of the original dose when clozapine tablets are coadministered with strong CYP1A2 inhibitors (e.g., fluvoxamine, ciprofloxacin, or enoxacin). The clozapine tablets dose should be increased to the original dose when coadministration of strong CYP1A2 inhibitors is discontinued.

CYP2D6 and CYP3A4 Inhibitors: Concomitant treatment with clozapine tablets and CYP2D6 or CYP3A4 inhibitors (e.g., cimetidine, escitalopram, erythromycin, paroxetine, bupropion, fluoxetine, quinidine, d Roxetine, terbinafine, or sertraline) can increase clozapine levels and lead to adverse reactions. Use caution and monitor patients closely when using such inhibitors. Consider reducing the clozapine tablets dosage.

CYP1A2 and CYP3A4 Inducers: Concomitant treatment with drugs that induce CYP1A2 or CYP3A4 can decrease the plasma concentration of clozapine, resulting in decreased effectiveness of clozapine tablets. Tobacco smoke is a moderate inducer of CYP1A2. Strong CYP3A4 inducers include carbamazepine, phenytoin, St. John’s wort, and rifampin. It may be necessary to increase the clozapine tablets dose if used concomitantly with inducers of these enzymes. However, concomitant use of clozapine tablets and strong CYP3A4 inducers is not recommended. Consider reducing the clozapine tablets dosage when discontinuing coadministered enzyme inducers; because discontinuation of inducers can result in increased clozapine plasma levels and an increased risk of adverse reactions.

Drugs that Cause QT Interval Prolongation: Use caution when administering concomitant medications that prolong the QT interval or inhibit the metabolism of clozapine such as: specific antipsychotics (e.g., ziprasidone, iloperidone, chlorpromazine, thioridazine, mesoridazine, droperidol, and pimozide), specific antibiotics (e.g., erythromycin, gatifloxacin, moxifloxacin, sparfloxacin), Class 1A antiarrhythmics (e.g., quinidine, procainamide) or Class III antiarrhythmics (e.g., amiodarone, sotalol), and others (e.g., pentalidine, levomethadyl acetate, methadone, halofantrine, mefloquine, dolasetron mesylate, procyclol or tacrolimus).

Pregnancy: Clozapine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. Monitor neonates for symptoms of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, and feeding difficulties. The severity of complications can vary from self-limited symptoms to some neonates requiring intensive care unit support and prolonged hospitalization.

Nursing Mothers: Clozapine is present in human milk. Because of the potential for serious adverse reactions in nursing infants from clozapine, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Renal or Hepatic Impairment: Dose reduction of clozapine may be necessary in patients with significant impairment of renal or hepatic function.

Phenylketonuric patients (PKU): PKU patients should be informed that clozapine, USP Orally Disintegrating Tablets contain phenylalanine (a component of aspartame).

Prescribers, pharmacies and patients must be enrolled with the Clozapine REMS Program. Further information is available at www.clozapinerems.com or 1-844-267-8678.

For additional safety information, please see accompanying full Prescribing Information, including Boxed Warning.
CLOZAPINE ODT (Orally Disintegrating Tablets) for oral use

**WARNINGS AND PRECAUTIONS**

- Eosinophilia: Assess for organ involvement (e.g., myocarditis, pancreatitis, hepatitis, colitis, nephritis). Discontinue if these occur (5.8).
- QT Interval Prolongation: Can be fatal. Consider additional risk factors for prolonged QT interval (disorders and drugs) (5.9).
- Metabolic Changes: Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. These metabolic changes include:
  - Hyperglycaemia and Diabetes Mellitus: Monitor for symptoms of hyperglycaemia including polydipsia, polyuria, polyphagia, and weakness. Monitor glucose regularly in patients with diabetes or at risk for diabetes (5.10).
  - Dyslipidaemia: Undesirable alterations in lipids have occurred in patients treated with atypical antipsychotics (5.10).
- Weight Gain: Significant weight gain has occurred. Monitor weight gain (5.10).
- Neuroleptic Malignant Syndrome (NMS): Immediately discontinue and monitor closely. Assess for co-morbid conditions (5.11).
- Hepatotoxicity: Can be fatal. Monitor for hepatotoxicity. Discontinue treatment if hepatotoxicity or transaminase elevations combined with other symptoms occur (5.12).
- Fever: Evaluate for infection and neutropenia, NMS (5.13).
- Pulmonary Embolism (PE): Consider PE if respiratory distress, chest pain, or deep vein thrombosis occurs (5.14).
- Anticholinergic Toxicity: Use cautiously in presence of specific conditions (e.g., narrow angle glaucoma, use of anticholinergic drugs) (5.15).
- Interference with Cognitive and Motor Performance: Advise caution when operating machinery, including automobiles (5.16).

**ADVERSE REACTIONS**

Most common adverse reactions (<25%) were: CNS reactions (sedation, dizziness/vertigo, headache, and tremor); cardiovascular reactions (tachycardia, hypotension, and syncope); autonomic nervous system reactions (hypersalivation, sweating, dry mouth, and visual disturbances); gastrointestinal reactions (constipation and nausea); and fever (6.1).

To report SUSPECTED ADVERSE REACTIONS, contact Jazz Pharmaceuticals, Inc., at 1-800-520-5568 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

**DRUG INTERACTIONS**

- Concomitant use of Strong CYP1A2 Inhibitors: Reduce Clozapine ODT dose to one third when coadministered with strong CYP1A2 inhibitors (e.g., fluvoxamine, cilostazol, esomeprazole, or omeprazole) or CYP3A4 inducers (e.g., dexamethasone, carbamazepine) are discontinued (2.7, 7.1).

**USE IN SPECIFIC POPULATIONS**

- Nursing Mothers: Discontinue drug or discontinue nursing, taking into consideration importance of drug to mother (8.3).

See 17 for PATIENT COUNSELLING INFORMATION.

Revised: 02/2017
10 OVERDOSE
10.1 Overdose Experience
10.2 Management of Overdose

11 DESCRIPTION

12 CLINICAL PHARMACOLOGY
12.1 Mechanism of Action
12.2 Pharmacodynamics
12.3 Pharmacokinetics

13 NONCLINICAL TOXICOLOGY
13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

FULL PRESCRIBING INFORMATION

WARNING: SEVERE NEUTROPENIA; ORTHOSTATIC HYPOTENSION, BRADYCARDIA, AND SYNCOPE; SEIZURE; MYOCARDITIS AND CARDIOMYOPATHY; INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

1 INDICATIONS AND USAGE
1.1 Treatment-Resistant Schizophrenia
1.2 Reduction in the Risk of Recurrent Suicidal Behavior in Schizophrenia or Schizoaffective Disorder

14 CLINICAL STUDIES
14.1 Treatment-Resistant Schizophrenia
14.2 Recurrent Suicidal Behavior in Schizophrenia or Schizoaffective Disorder

16 HOW SUPPLIED/STORAGE AND HANDLING
16.1 How Supplied
16.2 Storage and Handling

17 PATIENT COUNSELING INFORMATION

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

CLOZAPINE ODT (Orally Disintegrating Tablets) for oral use

CLOZAPINE ODT (Orally Disintegrating Tablets) for oral use is indicated for the treatment of treatment-resistant schizophrenia and for the reduction in the risk of recurrent suicidal behavior in those schizophrenia patients who fail to respond adequately to standard antipsychotic treatment.

The effectiveness of clozapine in treatment-resistant schizophrenia was demonstrated in 9-week, randomized, double-blind, placebo-controlled trials comparing clozapine and chlorpromazine in patients who had failed other antipsychotics (see Clinical Studies [14.1]).

The effectiveness of clozapine in the treatment of treatment-resistant schizophrenia was demonstrated in a 6-week, double-blind, randomized, double-blind, active-controlled study comparing clozapine and chlorpromazine in patients who had failed other antipsychotics (see Clinical Studies [14.1]).

Co-medications

Co-medication

Use one third of the Clozapine ODT dose.

Dose adjustments may be necessary in patients concomitantly treated with: strong CYP1A2 inhibitors (e.g., fluvoxamine, ciprofloxacin, or enoxacin); moderate or weak CYP1A2 inhibitors or CYP2D6, CYP3A4 Inducers

CYP3A4 inducers (e.g., phenytoin, carbamazepine, St. John's wort, and rifampin); or CYP1A2 inducers (e.g., tobacco smoking) (Table 1) (see Drug Interactions [7]).

Table 1: Dosage Adjustment in Patients Taking Concomitant Medications

<table>
<thead>
<tr>
<th>Co-medications</th>
<th>Scenarios</th>
<th>Inhibitors</th>
<th>CYP1A2, CYP2D6, CYP3A4 Inducers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiating Clozapine ODT while taking a co-medication</td>
<td>Adding a co-medication while taking Clozapine ODT</td>
<td>Discontinuing a co-medication while continuing Clozapine ODT</td>
<td></td>
</tr>
<tr>
<td>Strong CYP1A2 Inhibitors</td>
<td>Use one third of the Clozapine ODT dose.</td>
<td>Increase Clozapine ODT dose based on clinical response.</td>
<td></td>
</tr>
</tbody>
</table>

1000/L for patients with documented Benign Ethnic Neutropenia (BEN). To continue treatment, the ANC must be monitored regularly (see Warnings and Precautions [5.1]).

14.2 Recurrent Suicidal Behavior in Schizophrenia or Schizoaffective Disorder

CLOZAPINE ODT orally disintegrating tablets should be immediately placed in the mouth after removing the tablet from the blister pack or bottle. The tablet disintegrates rapidly after placement in the mouth. The tablets can be allowed to disintegrate, or they may be chewed. They may be swallowed with saliva. No water is necessary for administering the tablets.

The orally disintegrating tablets in a blister pack should be left in the unopened blister until the time of use. Just prior to use, peel the foil from the blister and gently remove the orally disintegrating tablet. Do not push the tablets through the foil, because this could damage the tablet.

2.3 Dosing Information

The starting dose is 12.5 mg once daily or twice daily. The total daily dose can be increased in increments of up to 25 mg to 50 mg per day, if well-tolerated, to achieve a target dose of 300 mg to 450 mg per day (administered in divided doses) by the end of the first week. Subsequently, the dose can be increased once weekly or twice weekly, in increments of up to 100 mg. The maximum dose is 900 mg per day. To minimize the risk of orothostatic hypotension, bradycardia, and syncope, it is necessary to use this low starting dose, gradual titration schedule, and divided dosages (see Warnings and Precautions [5.3]).

CLOZAPINE ODT can be taken with or without food (see Pharmacokinetics [12.3]).

2.4 Maintenance Treatment

Generally, patients responding to Clozapine ODT should continue maintenance treatment on their effective dose beyond the acute episode.

2.5 Discontinuation of Treatment

Method of treatment discontinuation will vary depending on the patient's last ANC:

- Neonatal Death

- Severe neutropenia

- Increased mortality in elderly patients with dementia-related psychosis

2.6 Re-initiation of Treatment

When restarting Clozapine ODT in patients who have discontinued Clozapine ODT (i.e., 2 days or more since the last dose), re-initiate with 12.5 mg once daily or twice daily. This is necessary to minimize the risk of hypotension, bradycardia, and syncope [see Warnings and Precautions (5.2)]. If that dose is well-tolerated, the dose may be increased to the previously therapeutic dose more quickly than recommended for initial treatment.

2.7 Dosage Adjustments with Concomitant use of CYP1A2, CYP2D6, CYP3A4 Inducers

Dose adjustments may be necessary in patients concomitantly treated with: strong CYP1A2 inhibitors (e.g., fluvoxamine, ciprofloxacin, or enoxacin); moderate or weak CYP1A2 inhibitors (e.g., oral contraceptives, or caffeine); CYP2D6 or CYP3A4 inhibitors (e.g., cimetidine, eslicarbazepin, erlotinib, paroxetine, fluoxetine, quinidine, valproate, topiramate, or sertraline); CYP3A4 inducers (e.g., phenytoin, carbamazepine, St. John's wort, and rifampin); or CYP1A2 inducers (e.g., tobacco smoking) (Table 1) (see Drug Interactions [7]).

Table 1: Dosage Adjustment in Patients Taking Concomitant Medications

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</tr>
<tr>
<td>Strong CYP1A2 Inhibitors</td>
<td>Use one third of the Clozapine ODT dose.</td>
<td>Increase Clozapine ODT dose based on clinical response.</td>
<td></td>
</tr>
</tbody>
</table>

1000/L for patients with documented Benign Ethnic Neutropenia (BEN). To continue treatment, the ANC must be monitored regularly (see Warnings and Precautions [5.1]).
CLOZAPINE ODT (Orally Disintegrating Tablets) for oral use

Co-medications Scenarios
Moderate or Weak CYP1A2 Inhibitors Monitor for adverse reactions. Consider reducing the Clozapine ODT dose if necessary. Monitor for lack of effectiveness. Consider increasing Clozapine ODT dose if necessary.

CYP2D6 or CYP3A4 Inhibitors Concomitant use is not recommended. However, if the inducer is necessary, it may be necessary to increase the Clozapine ODT dose. Monitor for decreased effectiveness. Reduce Clozapine ODT dose based on clinical response.

Strong CYP3A4 Inducers

Moderate or Weak CYP1A2 or CYP3A4 Inducers Monitor for decreased effectiveness. Consider increasing the Clozapine ODT dose if necessary. Monitor for adverse reactions. Consider reducing the Clozapine ODT dose if necessary.

2.8 Renal or Hepatic Impairment or CYP2D6 Poor Metabolizers

It may be necessary to reduce the Clozapine ODT dose in patients with significant renal or hepatic impairment, or in CYP2D6 poor metabolizers [see Use in Specific Populations (8.6, 8.7)].

3 DOSAGE FORMS AND STRENGTHS

Clozapine ODT is available as 12.5 mg, 25 mg, 100 mg, 150 mg and 200 mg round, yellow, orally disintegrating tablets.

4 CONTRAINDICATIONS

4.1 Hypersensitivity

Clozapine ODT is contraindicated in patients with a history of serious hypersensitivity to clozapine (e.g., photosensitivity, vasculitis, erythema multiforme, or Stevens-Johnson Syndrome) or any other component of Clozapine ODT [see Adverse Reactions (6.2)].

5 WARNINGS AND PRECAUTIONS

5.1 Severe Neutropenia

Background

Clozapine ODT can cause neutropenia (a low absolute neutrophil count [ANC]), defined as a reduction below pre-treatment normal levels of blood neutrophils. The ANC is usually available as a component of the complete blood count (CBC), including differential, and is more relevant to drug-induced neutropenia than the white blood cell (WBC) count. The ANC may also be calculated using the following formula: ANC equals the Total WBC count multiplied by the total percentage of neutrophils obtained from the differential (neutrophil “segs” plus neutrophil “bands”). Other granulocytes (basophils and eosinophils) contribute minimally to neutropenia and their measurement is not necessary (see tables 2 and 3). To improve and standardize understanding, “severe neutropenia” replaces the previous terms severe leukopenia, severe granulocytopenia, or agranulocytosis.

Severe neutropenia, ANC less than (<) 1500/μL, occurs in a small percentage of patients taking Clozapine ODT and is associated with an increase in the risk of serious and potentially fatal infections. Risk of neutropenia appears greatest during the first 18 weeks on treatment and then declines. The mechanism by which Clozapine ODT causes neutropenia is unknown and is not dose-dependent.

Two separate management algorithms are provided below, the first for patients in the general population, and the second for patients identified to have baseline neutropenia.

Clozapine ODT Treatment and Monitoring in the General Patient Population (see Table 2)

Obtain a CBC, including the ANC value, prior to initiating treatment with Clozapine ODT to ensure the presence of a normal baseline neutrophil count (equal to or greater than 1500/μL) and to permit later comparisons. Patients in the general population

Table 2: Clozapine ODT Treatment Recommendations Based on Absolute Neutrophil Count (ANC) Monitoring for the General Patient Population

<table>
<thead>
<tr>
<th>ANC Level</th>
<th>Clozapine ODT Treatment Recommendations</th>
<th>ANC Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal range (≥1500/μL)</td>
<td>• Initiate treatment</td>
<td>• Weekly from initiation to 6 months</td>
</tr>
<tr>
<td></td>
<td>• If treatment interrupted:</td>
<td>• Every 2 weeks from 6 to 12 months</td>
</tr>
<tr>
<td></td>
<td>• ≤30 days, continue monitoring as before</td>
<td>• Monthly after 12 months</td>
</tr>
<tr>
<td></td>
<td>• ≥30 days, monitor as if new patient</td>
<td></td>
</tr>
<tr>
<td>Mild Neutropenia (1000 to 1499/μL)</td>
<td>• Continue treatment</td>
<td>• See Section 2.4</td>
</tr>
</tbody>
</table>

Obtain a CBC, including the ANC value, prior to initiating treatment with Clozapine ODT to ensure the presence of a normal baseline neutrophil count (equal to or greater than 1500/μL) and to permit later comparisons. Patients in the general population

Table 3: Patients with Benign Ethnic Neutropenia (BEN); Clozapine ODT Treatment Recommendations Based on Absolute Neutrophil Count (ANC) Monitoring

<table>
<thead>
<tr>
<th>ANC Level</th>
<th>Treatment Recommendations</th>
<th>ANC Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal BEN Range (Established ANC baseline ≥1500/μL)</td>
<td>• Obtain at least two baseline ANC levels before initiating treatment</td>
<td>• Weekly from initiation to 6 months</td>
</tr>
<tr>
<td></td>
<td>• If treatment interrupted</td>
<td>• Every 2 weeks from 6 to 12 months</td>
</tr>
<tr>
<td></td>
<td>• ≤30 days, continue monitoring as before</td>
<td>• Monthly after 12 months</td>
</tr>
<tr>
<td></td>
<td>• ≥30 days, monitor as if new patient</td>
<td></td>
</tr>
<tr>
<td>BEN Neutropenia (500 to 999/μL)*</td>
<td>• Recommend hematology consultation</td>
<td>• See Section 2.4</td>
</tr>
<tr>
<td></td>
<td>• Continue treatment</td>
<td></td>
</tr>
<tr>
<td>BEN Severe Neutropenia (less than 500/μL)*</td>
<td>• Recommend hematology consultation</td>
<td>• Three times weekly until ANC ≥1000/μL or at patient's known baseline</td>
</tr>
<tr>
<td></td>
<td>• Interrupt treatment for suspected clozapine-induced neutropenia</td>
<td>• Once ANC ≥1000/μL, check ANC weekly for 4 weeks, then return to patient's last &quot;Normal Range&quot; ANC monitoring interval **</td>
</tr>
<tr>
<td></td>
<td>• Do not rechallenge unless prescriber determines benefits outweigh risks</td>
<td></td>
</tr>
</tbody>
</table>

* Confirm all initial reports of ANC less than 1500/μL with a repeat ANC measurement within 24 hours ** If clinically appropriate
5.6 Myocarditis and Cardiomyopathy

Myocarditis and cardiomyopathy have occurred with the use of clozapine. These reactions can be fatal. Discontinue Clozapine ODT and obtain a cardiac evaluation upon suspicion of myocarditis or cardiomyopathy. Generally, patients with a history of clozapine-associated myocarditis or cardiomyopathy should not be rechallenged with Clozapine ODT. However, in the absence of Clozapine ODT treatment being judged to outweigh the potential risks of recurrent myocarditis or cardiomyopathy, the clinician may consider rechallenge with Clozapine ODT in consultation with a cardiologist, after a complete cardiac evaluation, and under close monitoring.

Consider the possibility of myocarditis or cardiomyopathy in patients receiving Clozapine ODT who present with chest pain, dyspnea, persistent tachycardia at rest, palpitations, fever, flu-like symptoms, hypotension, other signs or symptoms of heart failure, or electrocardiographic findings (low voltages, ST-T abnormalities, arrhythmias, right axis deviation, and poor R wave progression). Myocarditis most frequently presents within the first two months of clozapine treatment. Symptoms of cardiomyopathy are generally more insidious than clozapine-associated myocarditis and usually after 8 weeks of treatment. However, myocarditis and cardiomyopathy can occur at any period during treatment with Clozapine ODT. It is common for nonspecific flu-like symptoms such as malaise, myalgia, pleuritic chest pain, and low-grade fevers to precede more overt signs of heart failure. Typical laboratory findings include elevated cardiac enzymes (e.g., creatine kinase, troponins), rise in C-reactive protein (CRP). Chest roentgenogram may demonstrate cardiac silhouette enlargement, and cardiac imaging (echocardiogram, radionuclide studies, or cardiac catheterization) may reveal evidence of left ventricular dysfunction.

5.7 Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Clozapine ODT is contraindicated in elderly patients with dementia-related psychosis (e.g., patients with Alzheimer’s disease, dementia of the Alzheimer type). These patients are at increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of drug-related deaths in drug-treated patients was 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 (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality risk in elderly patients, particularly those with cardiovascular conditions. The risk to benefit in such patients is unknown. This mortality in observational studies may be attributed to the antipsychotic drug as opposed to some other characteristic(s) of the patients is not clear. Clozapine ODT is not approved for the treatment of patients with dementia-related psychosis [see Boxed Warning].

5.8 Eosinophilia

Eosinophilia, defined as a blood eosinophil count of greater than 700/μL, has occurred with clozapine treatment. In clinical trials, approximately 1% of patients developed eosinophilia. Clozapine-related eosinophilia usually occurs during the first month of treatment. In some patients, it has been associated with myocarditis, pancreatitis, hepatomegaly, myocardial infarction, or severe cardiac death. In clinical trials, eosinophilia associated with drug reaction with eosinophilia and systemic symptoms syndrome (DRESS), also known as drug induced hypersensitivity syndrome (DIHS), if eosinophilia develops during Clozapine ODT treatment, evaluate promptly for signs and symptoms of systemic reactions, such as rash or other allergic symptoms, myocarditis, or other organ involvement. If the patient has symptoms consistent with myopericardial signs and symptoms consistent with DIHS, discontinue Clozapine ODT immediately. If a cause of eosinophilia unrelated to clozapine is identified (e.g., asthma, allergies, collagen vascular disease, parasitic infections, and specific neoplasms), treat the underlying cause and continue Clozapine ODT.

5.9 QT Interval Prolongation

QT prolongation, torsades de pointes, and other life-threatening ventricular arrhythmias, hyperkalemia, and sudden death have occurred with clozapine treatment. When prescribing clozapine ODT, consider the presence of additional risk factors for QT prolongation and serious cardiovascular reactions. Conditions that increase these risks include the following: history of QT prolongation, long QT syndrome, family history of sudden cardiac death, significant cardiac disease, recent myocardial infarction, uncompensated heart failure, treatment with other medications that cause QT prolongation, treatment with medications that inhibit the metabolism of Clozapine ODT, and electrolyte abnormalities. Prior to initiating treatment with Clozapine ODT, perform a careful physical examination, including a baseline electrocardiogram (ECG) and serum chemistry panel. Correct electrolyte abnormalities. Discontinue Clozapine ODT if the QTc interval exceeds 500 msec. If patients experience symptoms consistent with torsades de pointes or other arrhythmias (e.g., syncope, presyncope, dizziness, or palpitations), obtain a cardiac evaluation and discontinue Clozapine ODT. Use caution when administering concomitant medications that prolong the QT interval or inhibit the metabolism of Clozapine ODT. Drugs that cause QT prolongation include:

- Specific antipsychotics (e.g., ziprasidone, iloperidone, chlorpromazine, thioridazine, mesoridazine, droperidol, pimozide), specific antibiotics (e.g., erythromycin, gentamicin, moxifloxacin, sparfloxacin), and 3A1A antiarrhythmic medications (e.g., flecainide, propafenone, bepridil, quinidine).
CLOZAPINE ODT (Orally Disintegrating Tablets) for oral use

CLOZAPINE ODT is primarily metabolized by CYP isoenzymes 1A2, 2D6, and 3A4. Concomitant treatment with inhibitors of these enzymes can increase the concentration of CLOZAPINE ODT [see Drug Interactions (7.1) and Clinical Pharmacology (12.3)]. The median duration of exposure was 42 days for clozapine and chlorpromazine. Chlorpromazine dose was 1800 mg per day (mean modal dose: 1029 mg per day). Hypokalemia and hypomagnesemia increase the risk of QT prolongation. Hypokalemia can result from diuretic therapy, diarrhea, and other causes. Use caution when treating patients at risk for significant electrolyte disturbance, particularly hypokalemia. Obtain baseline measurements of serum potassium and magnesium levels, and periodically monitor electrolytes. Correct electrolyte abnormalities before initiating treatment with CLOZAPINE ODT.

5.10 Metabolic Changes

Atypical antipsychotic drugs, including CLOZAPINE ODT, have been associated with metabolic changes that can increase cardiovascular and cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and body weight gain. While atypical antipsychotic drugs may produce some metabolic changes, each drug in the class has its own specific risk profile.

Hyperglycemia and Diabetes Mellitus

Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics including CLOZAPINE ODT. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse reactions is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent, hyperglycemia-related adverse reactions in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycemia-related adverse reactions in patients treated with atypical antipsychotics are not available. Patients with an established diagnosis of diabetes mellitus who are started on CLOZAPINE ODT should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug. In a pooled data analysis of 8 studies in adult subjects with schizophrenia, the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL respectively. A higher proportion of the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL respectively. In a pooled data analysis of 8 studies in adult subjects with schizophrenia, the treatment with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug. In a pooled data analysis of 8 studies in adult subjects with schizophrenia, the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL respectively. A higher proportion of the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL respectively. In a pooled data analysis of 8 studies in adult subjects with schizophrenia, the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL respectively. A higher proportion of the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL respectively. In a pooled data analysis of 8 studies in adult subjects with schizophrenia, the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL respectively. A higher proportion of the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL respectively.

5.11 Neuroleptic Malignant Syndrome

Antipsychotic drugs including CLOZAPINE ODT can cause a potentially fatal symptom complex referred to as Neuroleptic Malignant Syndrome (NMS). Clinical manifestations of NMS include hyperpyrexia, muscle rigidity, altered mental status, and autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmias). Associated findings can include elevated creatine phosphokinase (CPK), myoglobinuria, rhabdomyolysis, and acute renal failure.
The diagnostic evaluation of patients with this syndrome is complicated. It is important to consider the presence of other serious medical conditions (e.g., severe neutropenia, infection, heat stroke, primary CNS pathology, central anticholinergic toxicity, extrapyramidal symptoms, and drug fever).

The management of NMS should include (1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy, (2) intensive symptomatic treatment and medical monitoring, and (3) treatment of co-morbid medical conditions. There is no general agreement about specific pharmacological treatments for NMS. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. NMS can recur. Monitor closely if restarting treatment with antipsychotics.

Clozapine ODT has occurred with clozapine monotherapy and with concomitant CNS-activating medications, including lithium.

5.12 Hepatotoxicity
Severe, life-threatening, and in some cases fatal hepatotoxicity including hepatic failure, hepatic necrosis, and hepatitis have been reported in patients treated with clozapine [see Adverse Reactions (6.2)]. Monitor for the appearance of signs and symptoms of hepatotoxicity such as fatigue, malaise, anorexia, nausea, jaundice, bilirubinemia, coagulopathy, and hepatic encephalopathy. Perform serum tests for liver injury and consider permanently discontinuing treatment if hepatitis or transaminase elevations combined with other systemic symptoms are due to clozapine.

5.13 Fever
During clozapine therapy, patients have experienced transient, clozapine-related fever. The peak incidence is within the first 3 weeks of treatment. While this fever is generally benign and reversible, it may necessitate discontinuing treatment. The fever can be associated with an increase or decrease in WBC count. Carefully evaluate patients with fever to rule out severe neutropenia or infection. Consider the possibility of NMS [see Warnings and Precautions (5.11)].

5.14 Pulmonary Embolism
Pulmonary embolism and deep vein thrombosis have occurred in patients treated with clozapine. Consider the possibility of pulmonary embolism in patients who present with deep vein thrombosis, acute dyspnea, chest pain, or with other respiratory signs and symptoms. Whether pulmonary embolus and deep vein thrombosis can be attributed to clozapine or some characteristic(s) of patients is not clear.

5.15 Anticholinergic Toxicity
Clozapine ODT has potent anticholinergic effects. Treatment with Clozapine ODT can result in CNS and peripheral anticholinergic toxicity. Use with caution in the presence of narrow-angle glaucoma, concomitant anticholinergic medications, prostatic hypertrophy, or other conditions in which anticholinergic effects can lead to significant adverse or rare adverse reactions. If anticholinergic toxicity becomes severe, the anticholinergic effects are believed to increase with greater durations of treatment and higher total cumulative doses. However, the syndrome can develop after relatively brief treatment periods at low doses. Prescribe Clozapine ODT in a manner that is most likely to minimize the risk of developing TD. Use the lowest effective dose and the shortest duration necessary to control symptoms. Periodically assess the need for continued treatment. Consider discontinuing treatment if TD occurs. However, some patients may require treatment with Clozapine ODT despite the presence of the syndrome. There is no known treatment for TD. However, the syndrome may remit partially or completely if treatment is discontinued. Antipsychotic treatment, itself, may suppress or partially suppress the signs and symptoms, and it has the potential to mask the underlying process. The effect of symptom suppression on the long-term course of TD is unknown.

5.16 Interference with Cognitive and Motor Performance
Clozapine ODT can cause sedation and impairment of cognitive and motor performance. Caution patients about operating hazardous machinery, including automobiles, until they are reasonably certain that Clozapine ODT does not adversely affect them. These reactions may be dose-related. Consider reducing the dose if they occur.

5.17 Tardive Dyskinesia
Tardive dyskinesia (TD) has occurred in patients treated with antipsychotic drugs, including Clozapine ODT. The syndrome consists of potentially irreversible, involuntary, dyskinetic movements. The risk of TD and the likelihood that it will become irreversible are believed to increase with greater durations of treatment and higher total cumulative doses. However, the syndrome can develop after relatively brief treatment periods at low doses. Prescribe Clozapine ODT in a manner that is most likely to minimize the risk of developing TD. Use the lowest effective dose and the shortest duration necessary to control symptoms. Periodically assess the need for continued treatment. Consider discontinuing treatment if TD occurs. However, some patients may require treatment with Clozapine ODT despite the presence of the syndrome. There is no known treatment for TD. However, the syndrome may remit partially or completely if treatment is discontinued. Antipsychotic treatment, itself, may suppress or partially suppress the signs and symptoms, and it has the potential to mask the underlying process. The effect of symptom suppression on the long-term course of TD is unknown.

5.18 Patients with Phenylketonuria
Phenylketonuric patients should be informed that Clozapine ODT contains phenylalanine (a component of aspartame). Each 12.5 mg, orally disintegrating tablet contains 0.87 mg phenylalanine. Each 25 mg, orally disintegrating tablet contains 1.74 mg phenylalanine. Each 100 mg, orally disintegrating tablet contains 6.96 mg phenylalanine. Each 150 mg, orally disintegrating tablet contains 10.44 mg phenylalanine. Each 200 mg, orally disintegrating tablet contains 13.92 mg phenylalanine.

5.19 Cerebrovascular Adverse Reactions
In controlled trials, elderly patients with dementia-related psychosis treated with some atypical antipsychotics had an increased risk (compared to placebo) of cerebrovascular adverse reactions (e.g., stroke, transient ischemic attack), including fatalities. The mechanism for this increased risk is not known. An increased risk cannot be excluded for Clozapine ODT or other antipsychotics or other patient populations. Clozapine ODT should be used with caution in patients with risk factors for cerebrovascular adverse reactions.

6 ADVERSE REACTIONS
The following adverse reactions are discussed in more detail in other sections of the labeling:

- Severe Neutropenia [see Warnings and Precautions (5.1)].
- Orthostatic Hypotension, Bradycardia, and Syncope [see Warnings and Precautions (5.3)].
- Fails [see Warnings and Precautions (5.4)].
- Seizures [see Warnings and Precautions (5.5)].
- Myocarditis and Cardiomyopathy [see Warnings and Precautions (5.6)].
- Increased Mortality in Elderly Patients with Dementia-Related Psychosis [see Warnings and Precautions (5.7)].
- Eosinophilia [see Warnings and Precautions (5.8)].
- QT Interval Prolongation [see Warnings and Precautions (5.9)].
- Metabolic Changes (Hyperglycemia and Diabetes Mellitus, Dyslipidemia, and Weight Gain) [see Warnings and Precautions (5.10)].
- Neuroleptic Malignant Syndrome [see Warnings and Precautions (5.11)].
- Hepatotoxicity [see Warnings and Precautions (5.12)].
- Fever [see Warnings and Precautions (5.13)].
- Pulmonary Embolism [see Warnings and Precautions (5.14)].
- Anticholinergic Toxicity [see Warnings and Precautions (5.15)].
- Interference with Cognitive and Motor Performance [see Warnings and Precautions (5.16)].
- Tardive Dyskinesia [see Warnings and Precautions (5.17)].

Patients with Phenylketonuria [see Warnings and Precautions (5.18)].

Cerebrovascular Adverse Reactions [see Warnings and Precautions (5.19)].

Recurrence of Psychosis and Cholinergic Rebound after Abrupt Discontinuation [see Warnings and Precautions (5.20)].

6.1 Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The most commonly reported adverse reactions (≥5%) across clozapine clinical trials were increased weight, lethargy, dizziness, vertigo, headache, and tremor; cardiovascular reactions, including tachycardia, hypotension, and syncope; autonomic nervous system reactions, including hypersalivation, sweating, dry mouth, and visual disturbances; gastrointestinal reactions, including constipation and nausea; and fever. Table 9 summarizes the most commonly reported adverse reactions (≥5%) in clozapine-treated patients (compared to chlorpromazine-treated patients) in the pivotal, 6-week, controlled trial in treatment-resistant schizophrenia.

Table 9: Common Adverse Reactions (≥5%) in the 6-Week, Randomized, Chlorpromazine-controlled Trial in Treatment-Resistant Schizophrenia

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Clozapine (N=126) (%)</th>
<th>Chlorpromazine (N=142) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedation</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Nausea</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Constipation</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Dizziness</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Hypotension</td>
<td>13</td>
<td>38</td>
</tr>
<tr>
<td>Fever (hyperthermia)</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Hypersalivation</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Headache</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 10 summarizes the adverse reactions reported in clozapine-treated patients at a frequency of 2% or greater across all clozapine studies (excluding the 2-year InterSePT™ Study). These rates are not adjusted for duration of exposure.

Table 10: Adverse Reactions (≥2%) Reported in Clozapine-treated Patients (N=842) across all Clozapine Studies (excluding the 2-year InterSePT™ Study)

<table>
<thead>
<tr>
<th>Body System</th>
<th>Adverse Reaction</th>
<th>Clozapine N=842 Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Nervous System</td>
<td>Drowsiness/Sedation</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Dizziness/Vertigo</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Headache</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Tremor</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Syncope</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Disturbed Sleep/Nightmares</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Restlessness</td>
<td>4</td>
</tr>
</tbody>
</table>
CLOZAPINE ODT (Orally Disintegrating Tablets) for oral use

Body System

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Clozapine</th>
<th>Olanzapine</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 842</td>
<td>Percentage of Patients</td>
<td>N = 842</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypokinesia/Akinesia</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Agitation</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Seizures (convulsions)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Rigidity</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Akathisia</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Confusion</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tachycardia</td>
<td>25†</td>
<td></td>
</tr>
<tr>
<td>Hypotension</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Abdominal Discomfort/Heartburn</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Urogenital System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary Abnormalities</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Autonomic Nervous System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salivation</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Sweating</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Dry Mouth</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Visual Disturbances</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hemic/Lymphatic/Lower WBC/Neutropenia</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Weight Gain</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

1 Rate based on population of approximately 1700 exposed during premarket clinical evaluation of clozapine.

Table 11 summarizes the most commonly reported adverse reactions (≥10% of the clozapine or olanzapine group) in the InterSePT™ Study. This was an adequate and well-controlled, two-year study evaluating the efficacy of clozapine relative to olanzapine in reducing the risk of suicidal behavior in patients with schizophrenia or schizoaffective disorder. The rates are not adjusted for duration of exposure.

Table 11: Incidence of Adverse Reactions in Patients Treated with Clozapine or Olanzapine in the InterSePT™ Study (≥10% in the clozapine or olanzapine group)

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>Clozapine</th>
<th>Olanzapine</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 842</td>
<td>Percentage of Patients</td>
<td>N = 842</td>
</tr>
<tr>
<td>Salivary hypersecretion</td>
<td>48%</td>
<td>6%</td>
</tr>
<tr>
<td>Somnolence</td>
<td>46%</td>
<td>25%</td>
</tr>
<tr>
<td>Weight increased</td>
<td>31%</td>
<td>56%</td>
</tr>
<tr>
<td>Dizziness (excluding vertigo)</td>
<td>27%</td>
<td>12%</td>
</tr>
<tr>
<td>Constipation</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>20%</td>
<td>33%</td>
</tr>
<tr>
<td>Nausea</td>
<td>17%</td>
<td>10%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>14%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Dyskinesia
Class effect: Symptoms of dyskinesia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during the first few days of treatment. Dyskinetic symptoms include: spasm of the neck muscles, sometimes progressing to tightness of the throat, swallowing difficulty, difficulty breathing, and/or protrusion of the tongue. While these symptoms can occur at low doses, they occur more frequently and with greater severity with high potency and at higher doses of first generation antipsychotic drugs. An elevated rate of acute dyskinesia is observed in males and younger age groups.

6.2 Postmarketing Experience
The following adverse reactions have been identified during post-approval use of clozapine. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Central Nervous System
Delerium, EKG abnormal, myoclonus, paresthesia, possible cataplexy, status epilepticus, obsessive compulsive symptoms, and post-discontinuation cholinergic rebound adverse reactions.

Cardiovascular System
Atrial or ventricular fibrillation, ventricular tachycardia, QT interval prolongation, Torsades de Pointes, myocardial infarction, cardiac arrest, and periocardial edema.

DRUG INTERACTIONS

7.1 Potential for Other Drugs to Affect Clozapine ODT
Clozapine is a substrate for many cytochrome P450 isozymes, in particular CYP1A2, CYP3A4, and CYP2D6. Use caution when administering Clozapine ODT concomitantly with drugs that are inducers or inhibitors of these enzymes.

CYP1A2 Inhibitors
Concomitant use of Clozapine ODT and CYP1A2 inhibitors can increase plasma levels of clozapine, potentially resulting in adverse reactions. Reduce the Clozapine ODT dose to one third of the original dose when Clozapine ODT is coadministered with strong CYP1A2 inhibitors (e.g., fluvoxamine, ciprofloxacin, or enoxacin). The Clozapine ODT dose should be increased to the original dose when coadministration of strong CYP1A2 inhibitors is discontinued [see Dosage and Administration (2.7), Clinical Pharmacology (12.3)].

CYP2D6 and CYP3A4 Inducers
Concomitant treatment with Clozapine ODT and CYP2D6 or CYP3A4 inhibitors (e.g., cimetidine, esclopolam, erythromycin, paroxetine, bupropion, fluoxetine, quinidine, duloxetine, terbinafine, or sertraline) can increase Clozapine ODT levels and lead to adverse reactions [see Clinical Pharmacology (12.3)]. Use caution and monitor patients closely when using such inhibitors. Consider reducing the Clozapine ODT dose if necessary [see Dosage and Administration (2.7)].

CYP3A4 Inducers
Concomitant treatment with drugs that induce CYP1A2 or CYP3A4 can decrease the plasma concentration of clozapine, resulting in decreased effectiveness of Clozapine ODT. Tobacco smoke is a moderate inducer of CYP1A2. Strong CYP3A4 inducers include carbamazepine, phenytoin, St. John’s wort, and rifampin. It may be necessary to increase the Clozapine ODT dose if used concomitantly with these enzymes. However, concomitant use of Clozapine ODT and strong CYP3A4 inducers is not recommended [see Dosage and Administration (2.7)].

Consider reducing the Clozapine ODT dosage when discontinuing coadministered enzyme inducers, because discontinuation of inducers can result in increased clozapine plasma levels and an increased risk of adverse reactions [see Dosage and Administration (2.7)].

Drugs that Cause QT Interval Prolongation
Use caution when administering concomitant medications that prolong the QT interval or inhibit the metabolism of Clozapine ODT. Drugs that cause QT prolongation include: specific antipsychotics (e.g., ziprasidone, iloperidone, chlorpromazine, thioridazine, mesoridazine, droperidol, and pimozone), specific antibiotics (e.g., erythromycin, gatifloxacin, moxifloxacin, sparfloxacin), Class Ia antiarrhythmics (e.g., quinidine, hydrochlorothiazide, and furosemide), and Class III antiarrhythmics (e.g., amiodarone, sotalol), and others (e.g., pentamidine, levemethadyl acetate, methadone, halofantrine, mefloquine, doxylamine mesylate, propranolol, or tacrolimus) [see Warnings and Precautions (5.9)].

7.2 Potential for Clozapine ODT to Affect Other Drugs
Concomitant use of Clozapine ODT with other drugs metabolized by CYP2D6 can increase levels of these CYP2D6 substrates. Use caution when coadministering Clozapine ODT with other drugs that are metabolized by CYP2D6. It may be necessary to use lower doses of such drugs than usually prescribed. Such drugs include specific antidepressants, phenothiazines, carbamazepine, and Type 1C antiarrhythmics (e.g., propafenone, flecainide, and encainide).
CLOzapine Odt (Orally Disintegrating Tablets) for oral use

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category B

Risk Summary

There are no adequate or well-controlled studies of clozapine in pregnant women. Reproduction studies have been performed in rats and rabbits at doses up to 0.4 and 0.9 times, respectively, the maximum recommended human dose (MRHD) of 900 mg/day on a mg/m² body surface area basis. The studies revealed no evidence of impaired fertility or harm to the fetus due to clozapine. Because animal reproduction studies are not always predictive of human response, Clozapine ODT should be used during pregnancy only if clearly needed.

Clinical Considerations

Consider the risk of exacerbation of psychosis when discontinuing or changing treatment with antipsychotic medications during pregnancy and postpartum. Consider early screening for gestational diabetes for patients treated with antipsychotic medications [see Warnings and Precautions (5.16)].

8.2 Lactation

Phenylketonurics: Contains phenylalanine. [see Warnings and Precautions (5.18)]. Phenylalanine is a component of aspartame. Each 12.5 mg, orally disintegrating tablet contains 1.6 mg aspartame, thus, 0.87 mg phenylalanine. Each 25 mg, orally disintegrating tablet contains 3.2 mg aspartame, thus, 1.74 mg phenylalanine. Each 50 mg, orally disintegrating tablet contains 6.4 mg aspartame, thus, 3.49 mg phenylalanine. Each 100 mg, orally disintegrating tablet contains 12.8 mg aspartame, thus, 6.96 mg phenylalanine. Each 150 mg, orally disintegrating tablet contains 19.2 mg aspartame, thus, 10.44 mg phenylalanine. Each 250 mg, orally disintegrating tablet contains 24.6 mg aspartame, thus, 13.92 mg phenylalanine. The allowable daily intake of aspartame is 50 mg per kilogram of body weight per day.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

The mechanism of action of clozapine is unknown. However, it has been proposed that the therapeutic efficacy of clozapine in schizophrenia is mediated through antagonism of the dopamine type 2 (D₂) and the serotonin type 2A (5-HT₂A) receptors. Clozapine ODT also acts as an antagonist at adrenergic, cholinergic, histaminergic and other dopaminergic and serotoninergic receptors.

12.2 Pharmacodynamics

Clozapine demonstrated binding affinity to the following receptors: histamine H₁ (Kᵢ = 5 nM), adrenergic α₁ (Kᵢ = 3 nM), serotonin 5-HT₄ (Kᵢ = 5.4 nM), muscarinic M₁ (Kᵢ = 3 nM), serotonin 5-HT₃ (Kᵢ = 6.3 nM), serotonin 5-HT₁ (Kᵢ = 9.4 nM), dopamine D₁ (Kᵢ = 24 nM), adrenergic α₂ (Kᵢ = 90 nM), serotonin 5-HT₅ (Kᵢ = 95 nM), serotonin 5-HT₁ (Kᵢ = 120 nM), dopamine D₂ (Kᵢ = 160 nM), dopamine D₃ (Kᵢ = 270 nM), dopamine D₄ (Kᵢ = 454 nM), and dopamine D₅ (Kᵢ = 555 nM).

10 OVERDOSAGE

10.1 Overdosage Experience

The most commonly reported signs and symptoms associated with clozapine overdose are: sedation, delirium, coma, tachycardia, hypotension, respiratory depression or failure; and hypersalivation. There are reports of aspiration pneumonia, cardiac arrhythmias, and seizure. Fatal overdoses have been reported with clozapine, generally at doses above 2500 mg. There have also been reports of patients recovering from overdoses well in excess of 4 g.
CLOzapine ODT (Orally Disintegrating Tablets) for oral use

For FazaClo® 200 mg tablets, food significantly increased the C max of both clozapine and its active metabolite, desmethylclozapine, were decreased by approximately 20%, compared to administration under fasting conditions, while the AUC, C ss, and C min values were similar between the chewed and non-chewed conditions.

In a food-effect study, a single dose of FazaClo® (clozapine) orally disintegrating tablets 12.5 mg was administered to healthy volunteers under fasting conditions and after a high fat meal. At 12 hours after the last dose of clozapine. The food significantly increased the C min,ss of clozapine by 21%. However, this is not clinically significant. For FazaClo® 200 mg tablets, the mean C min,ss values were similar between the chewed and non-chewed conditions.

For FazaClo® 200 mg tablets, food significantly increased the C max,ss of clozapine by 21%. However, this is not clinically significant. The mean AUC, C ss, and C min,ss values were similar between the chewed and non-chewed conditions.

In a food-effect study, a single dose of FazaClo® (clozapine) orally disintegrating tablets 12.5 mg was administered to healthy volunteers under fasting conditions and after a high fat meal. At 12 hours after the last dose.
CLOZAPINE ODT (Orally Disintegrating Tablets) for oral use

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

12.5 mg

1/4-inch diameter round yellow tablet debossed with “A05” on one side.

Bottles of 100:

100 tablets in an HDPE bottle with child-resistant cap. NDC No. 0093-3011-01

25 mg

5/16-inch diameter round yellow tablet debossed with “A06” on one side.

Bottles of 100:

100 tablets in an HDPE bottle with child-resistant cap. NDC No. 0093-3012-01

Cartons of 48 for Institutional Use Only:

8 cards, 6 non child-resistant blisters per card. NDC No. 0093-3012-84

100 mg

1/2-inch diameter round yellow tablet debossed with “A08” on one side.

Bottles of 100:

100 tablets in an HDPE bottle with child-resistant cap. NDC No. 0093-3010-01

Cartons of 48 for Institutional Use Only:

8 cards, 6 non child-resistant blisters per card. NDC No. 0093-3010-84

150 mg

9/16-inch diameter round, yellow tablet debossed with “A09” on one side.

Bottles of 100:

100 tablets in an HDPE bottle with child-resistant cap. NDC No. 0093-3086-01

Cartons of 48 for Institutional Use Only:

8 cards, 6 non child-resistant blisters per card. NDC No. 0093-3086-84

200 mg

5/8-inch diameter round, yellow tablet debossed with “A10” on one side.

Bottles of 100:

100 tablets in an HDPE bottle with child-resistant cap. NDC No. 0093-3087-01

Cartons of 48 for Institutional Use Only:

8 cards, 6 non child-resistant blisters per card. NDC No. 0093-3087-84

16.2 Storage and Handling

Store CLOZAPINE ODT at 20°C to 25°C (68° to 77°F); excursions permitted to 15°C to 30°C (59° to 86°F). (See USP Controlled Room Temperature.) Protect from moisture. KEEP OUT OF REACH OF CHILDREN.

CLOZAPINE ODT must remain in the original package until used by the patient.

Drug dispensing should not ordinarily exceed a weekly supply. If a patient is eligible for ANC testing every 2 weeks, then a 2-week supply of CLOZAPINE ODT can be dispensed. If a patient is eligible for ANC testing every 4 weeks, then a 4-week supply of CLOZAPINE ODT can be dispensed. Dispensing should be contingent upon the ANC testing results.

17 PATIENT COUNSELING INFORMATION

Discuss the following issues with patients and caregivers:

- **Severe Neutropenia:**
  - Instruct patients (and caregivers) beginning treatment with CLOZAPINE ODT about the risk of developing severe neutropenia and infection.
  - Instruct patients to immediately report to their physician any symptom or sign of infection (e.g., flu-like illness; fever; lethargy; general weakness or malaise; mucus membrane ulceration; skin, pharyngeal, vaginal, urinary, or pulmonary infection; or extreme weakness or lethargy) occurring at any time during CLOZAPINE ODT therapy, to aid in evaluation for neutropenia and to institute prompt and appropriate management. [see Warnings and Precautions (5.1)].
  - Inform patients and caregivers CLOZAPINE ODT is available only through a restricted program called the CLOZAPINE REMS Program designed to ensure the required blood monitoring, in order to reduce the risk of developing severe neutropenia. Advise patients and caregivers of the importance of having blood tested as follows:
    - Weekly blood tests are required for the first 6 months.
    - An ANC is required every 2 weeks for the next 6 months if an acceptable ANC is maintained during the first 6 months of continuous therapy.
    - An ANC is required once every 4 weeks thereafter if an acceptable ANC is maintained during the second 6 months of continuous therapy.

- **Orthostatic Hypotension, Bradycardia, and Syncope:** Inform patients and caregivers about the risk of orthostatic hypotension and syncope, especially during the period of initial dose titration. Instruct them to strictly follow the clinician’s instructions for dosage and administration. Advise patients to consult their clinician immediately if they feel faint, lose consciousness or have signs or symptoms suggestive of bradycardia or arrhythmia [see Dosage and Administration (2.2) and Warnings and Precautions (5.3)].
- **Falls:** Inform patients of the risk of falls, which may lead to fractures or other injuries [see Warnings and Precautions (4.1)].
- **Seizures:** Inform patients and caregivers about the significant risk of seizure during CLOZAPINE ODT treatment. Caution them about driving and any other potentially hazardous activity while taking CLOZAPINE ODT [see Dosage and Administration (2.2) and Warnings and Precautions (5.4)].
- **QT Interval Prolongation:** Advise patients to consult their clinician immediately if they feel faint, lose consciousness, or have signs or symptoms suggestive of arrhythmia. Instruct patients not to take CLOZAPINE ODT with other drugs that cause QT interval prolongation. Instruct patients to inform their clinicians that they are taking CLOZAPINE ODT before any new drug [see Warnings and Precautions (5.9) and Drug Interactions (7.1)].
- **Metabolic Changes (hyperglycemia and diabetes mellitus, dyslipidemia, weight gain):**
  - Educate patients and caregivers about the risk of metabolic changes and the need for specific monitoring. The risks include hyperglycemia and diabetes mellitus, dyslipidemia, weight gain, and cardiovascular reactions. Educate patients and caregivers about the symptoms of hyperglycemia (high blood sugar) and diabetes mellitus (e.g., polydipsia, polyuria, polyphagia, and weakness). Monitor all patients for these symptoms. Patients who are diagnosed with diabetes or have risk factors for diabetes (obesity, family history of diabetes) should have their fasting blood glucose monitored before beginning treatment and periodically during treatment. Patients who develop symptoms of hyperglycemia should have assessments of fasting glucose. Clinical monitoring of weight is recommended [see Warnings and Precautions (5.10)].
- **Patients with Phenylketonuria:** Inform patients and caregivers that CLOZAPINE ODT contains phenylalanine (a component of aspartame) [see Warnings and Precautions (5.18)].
- **Interference with Cognitive and Motor Performance:** Because CLOZAPINE ODT may have the potential to impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that CLOZAPINE ODT therapy does not affect them adversely adversely [see Warnings and Precautions (5.19)].
- **Hepatotoxicity:** Instruct patients to immediately report to their physician any symptom or sign of potential liver injury (e.g. fatigue, malaise, anorexia, nausea, jaundice, bilirubinemia, coagulopathy, and hepatic encephalopathy) [see Warnings and Precautions (5.20)].
- **Missed Doses and Re-Initiating Treatment:** Inform patients and caregivers that if the patient misses taking CLOZAPINE ODT for more than 2 days, he or she should not restart his or her medication at the same dosage but should contact their physician for dosing instructions [see Dosage and Administration (2.5) and Warnings and Precautions (5.1)].
- **Pregnancy:** Patients and caregivers should notify the clinician if the patient becomes pregnant or intends to become pregnant during therapy [see Use in Specific Populations (8.1)].
- **Nursing:** Advise patients and caregivers that the patient should not breast feed an infant if she is taking CLOZAPINE ODT [see Use in Specific Populations (8.3)].
- **Concomitant Medication:** Advise patients to inform their health care provider if they are taking, or plan to take, any prescription or over-the-counter drugs, there is a potential for significant drug-drug interactions [see Dosage and Administration (2.6), Drug Interactions (7.1), and Table 1].
- **Administration:** Patients should be advised that CLOZAPINE ODT should remain in the original package until immediately before use [see Dosage and Administration (2.2)].

Manufactured by:
Cephalon, Inc.
Salt Lake City, UT 84116

Manufactured for:
Teva Select Brands, Horsham, PA 19044
Division of Teva Pharmaceuticals USA

*FazaClo® is a registered trademark of Jazz Pharmaceuticals plc or its subsidiaries.

Revised: February 2017
WARNING: SEVERE NEUTROPENIA; ORTHOSTATIC HYPOTENSION, BRADYCARDIA, AND SYNCOPE; SEIZURE; MYOCARDITIS AND CARDIOMYOPATHY; INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

See full prescribing information for complete boxed warning.

- Severe Neutropenia: Clozapine can cause severe neutropenia, which can lead to serious and fatal infections. Patients initiating and continuing treatment with clozapine must have a baseline blood absolute neutrophil count (ANC) measured before treatment initiation and regular ANC monitoring during treat-

- Titration: In increments of 25 mg to 50 mg per day, by the end of 2 weeks.

- Use cautious titration and divided dosage schedule (2.2, 5.3).

- Starting Dose: 12.5 mg once daily or twice daily (2.2).

- Myocarditis, Cardiomyopathy and Mitral Valve Incompetence: Can be fatal.

- Increased Mortality in Elderly Patients with Dementia-Related Psychosis: Clozapine is not approved for this condition (5.7).

ADVERSE REACTIONS

Most common adverse reactions (~5%) were: CNS reactions (sedation, dizziness/ vertigo, headache, and tremor); cardiovascular reactions (tachycardia, hypotension, and syncope); autonomic nervous system reactions (hypersalivation, sweating, dry mouth, and visual disturbances); gastrointestinal reactions (constipation and nausea); and fever (6.1).

To report SUSPECTED ADVERSE REACTIONS, contact Teva Pharmaceuticals USA, Inc. at 1-888-832-8537 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Concomitant use of Strong CYP1A2 Inhibitors: Reduce clozapine dose to one-third when coadministered with strong CYP1A2 inhibitors (e.g., fluvoxamine, ciprofloxacin, enoxacin) (2.6.7.1).

- Concomitant use of Strong CYP3A4 Inhibitors: Consider reducing clozapine dose when CYP3A4 inducers (e.g., carbamazepine) are discontinued (2.6.7.1).

USE IN SPECIFIC POPULATIONS

- Nursing Mothers: Discontinue drug or discontinue nursing, taking into consider-

See 17 for PATIENT COUNSELING INFORMATION

Revised: 03/2017
CLOzapine TABLETS

1 INDICATIONS AND USAGE
1.1 Treatment-Resistant Schizophrenia

Clozapine tablets are indicated for the treatment of severely ill patients with schizophrenia who fail to respond adequately to standard antipsychotic treatment. Because of the risks of severe neutropenia and of seizure associated with their use, clozapine tablets should be used only in patients who have failed to respond adequately to standard antipsychotic treatment (see Warnings and Precautions [5.1, 5.5]).

The effectiveness of clozapine tablets in treatment-resistant schizophrenia was demonstrated in a 6-week, randomized, double-blind, active-controlled study comparing clozapine tablets and chlorpromazine in patients who had failed other antipsychotics (see Clinical Studies [14.1]).

1.2 Reduction in the Risk of Recurrent Suicidal Behavior in Schizophrenia or Schizoaffective Disorder

Clozapine tablets are indicated for reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder who fail to respond adequately to standard antipsychotic treatment.

The effectiveness of clozapine tablets in reducing the risk of recurrent suicidal behavior was demonstrated over a two-year treatment period in the InterSePT™ trial (see Clinical Studies [14.2]).

8.7 CYP2D6 Poor Metabolizers
8.8 Hospice Patients

10 OVERDOSAGE
10.1 Overdose Experience
10.2 Management of Overdose

11 DESCRIPTION
12 CLINICAL PHARMACOLOGY
12.1 Mechanism of Action
12.2 Pharmacodynamics
12.3 Pharmacokinetics

FULL PRESCRIBING INFORMATION

WARNING: SEVERE NEUTROPIA; ORTHOSTATIC HYPOTENSION, BRADYCARDIA, AND SYCNOPE; SEIZURE; MYOCARDITIS AND CARDIOMYOPATHY; INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Severe Neutropenia

Clozapine treatment has caused severe neutropenia, defined as an absolute neutrophil count (ANC) less than 500/μL. Severe neutropenia can lead to serious infection and death. Prior to initiating treatment with clozapine, a baseline ANC must be at least 1500/μL for the general population; and must be at least 1000/μL for patients with documented Benign Ethnic Neutropenia (BEN). During treatment, patients must have regular ANC monitoring. Advise patients to immediately report symptoms consistent with severe neutropenia or infection (e.g., fever, weakness, lethargy, or sore throat) (see Dosage and Administration [2.1] and Warnings and Precautions [5.1, 5.5]).

A Because of the risk of severe neutropenia, clozapine is available only through a restricted program under a Risk Evaluation Mitigation Strategy (REMS) called the Clozapine REMS Program (see Warnings and Precautions [5.2]).

Orthostatic Hypotension, Bradycardia, Syncope

Orthostatic hypotension, bradycardia, syncope, and cardiac arrest have occurred with clozapine treatment. The risk is highest during the initial titration period, particularly with rapid dose escalation. These reactions can occur with the first dose, with doses as low as 12.5 mg per day. Initiate treatment at 12.5 mg once or twice daily; titrate slowly; and use divided dosages. Use clozapine cautiously in patients with cardiovascular or cerebrovascular disease or conditions predisposing to hypotension (e.g., dehydration, use of antihypertensive medications) (see Dosage and Administration [2.2, 2.5], Warnings and Precautions [5.2, 5.3]).

Seizures

Seizures have occurred with clozapine treatment. The risk is dose-related. Initiate treatment at 12.5 mg, titrate gradually, and use divided dosing. Use caution when administering clozapine to patients with a history of seizures or other predisposing risk factors for seizure (CNS pathology, medications that lower the seizure threshold, alcohol abuse). Caution patients about engaging in any activity where sudden loss of consciousness could cause serious risk to themselves or others (see Dosage and Administration [2.2]. Warnings and Precautions [5.8]).

Myocarditis, Cardiomyopathy and Mitral Valve Incompetence

Fatal myocarditis and cardiomyopathy have occurred with clozapine treatment. Discontinue clozapine and obtain a cardiac evaluation upon suspicion of these reactions. Generally, patients with clozapine-related myocarditis or cardiomyopathy should not be rechallenged with clozapine. Consider the possibility of myocarditis or cardiomyopathy if chest pain, tachycardia, palpitations, dyspnea, fever, flu-like symptoms, hypotension, or ECG changes occur (see Warnings and Precautions [5.6]).

Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Clozapine is not approved for use in patients with dementia-related psychosis (see Warnings and Precautions [5.7]).

17 PATIENT COUNSELING INFORMATION

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

2 DOSAGE AND ADMINISTRATION

2.1 Required Laboratory Testing Prior to Initiation and During Therapy

Prior to initiating treatment with clozapine tablets, a baseline ANC must be obtained. The baseline ANC must be at least 1500/μL for the general population, and at least 1000/μL for patients with documented Benign Ethnic Neutropenia (BEN). To continue treatment, the ANC must be monitored regularly (see Warnings and Precautions [5.1]).

2.2 Dosing Information

The initial clozapine tablets dose is 12.5 mg once or twice daily. The total daily dose can be increased in increments of 25 mg to 50 mg per day, if well-tolerated, to achieve a target dose of 300 mg to 450 mg per day (administered in divided doses) by the end of 2 weeks. Subsequently, the dose can be increased once weekly or twice weekly, in increments of up to 100 mg. The maximum dose is 900 mg per day. To minimize the risk of orthostatic hypotension, bradycardia, and syncope, it is necessary to use this low starting dose, gradual titration schedule, and divided dosages (see Warnings and Precautions [5.3]).

Clozapine tablets can be taken with or without food (see Pharmacokinetics [12.3]).

2.3 Maintenance Treatment

Generally, patients responding to clozapine tablets should continue maintenance treatment on their effective dose beyond the acute episode.

2.4 Discontinuation of Treatment

Method of treatment discontinuation will vary depending on the patient’s last ANC:

- • See Tables 2 or 3 for appropriate ANC monitoring based on the level of neutropaenia if abrupt treatment discontinuation is necessary because of moderate to severe neutropenia.
- • Reduce the dose gradually over a period of 1 to 2 weeks if termination of clozapine therapy is planned and there is no evidence of moderate to severe neutropenia.
- • For abrupt discontinuation for a reason unrelated to neutropenia, continuation of the existing ANC monitoring is recommended for general population patients until their ANC is >1500/μL and for BEN patients until their ANC is >1000/μL or above their baseline.
- • Additional ANC monitoring is required for any patient reporting onset of fever (temperature of 38.5°C or 101.3°F, or greater) during the 2 weeks after discontinuation (see Warnings and Precautions [5.1]).
- • Monitor all patients carefully for the recurrence of psychotic symptoms and symptoms related to cholinergic rebound such as profuse sweating, headache, nausea, vomiting, and diarrhea.

2.5 Re-Initiation of Treatment

When restarting clozapine tablets in patients who have discontinued clozapine tablets (i.e., 2 days or more since the last dose), re-initiate with 12.5 mg once or twice daily. This is necessary to minimize the risk of hypotension, bradycardia, and syncope (see Warnings and Precautions [5.3]). If that dose is well-tolerated, the dose may be increased to the previously therapeutic dose more quickly than recommended for initial therapy.

2.6 Dosage Adjustments with Concomitant use of CYP1A2, CYP2D6, CYP3A4 Inhibitors or CYP1A2, CYP3A4 Inducers

Dose adjustments may be necessary in patients with concomitant use of: strong CYP1A2 inhibitors (e.g., fluvoxamine, ciprofloxacin, or enoxacin); moderate or weak CYP1A2 inhibitors (e.g., oral contraceptives, or caffeine); CYP2D6 or CYP3A4 inhibitors (e.g., cimetidine, escitalopram, erythromycin, paroxetine, bupropion, fluoxetine, quinidine, duloxetine, terbinafine, or sertraline); CYP3A4 inducers (e.g., phenytoin, carbamazepine, St. John’s wort, and rifampin); or CYP1A2 inducers (e.g., tobacco smoke) (see Drug Interactions [5.7]).

Table 1: Dose Adjustment in Patients Taking Concomitant Medications

Co-medications | Scenarios
--- | ---
Initiating clozapine tablets while taking a co-medication | Adding a co-medication while taking clozapine tablets
Discontinuing a co-medication while continuing clozapine tablets

Strong CYP1A2 Inhibitors

Use one-third of the clozapine tablets dose.

Increase clozapine tablets dose based on clinical response.

Moderate or Weak CYP1A2 Inhibitors

Monitor for adverse reactions. Consider reducing the clozapine tablets dose if necessary.

Monitor for lack of effectiveness. Consider increasing clozapine tablets dose if necessary.
CLOZAPINE TABLETS

Co-medications | Scenarios | ANC Monitoring
---|---|---
Strong CYP3A4 Inducers | Concomitant use is not recommended. However, if the inducer is necessary, it may be necessary to increase the clozapine tablets dose. Monitor for decreased effectiveness. | Reduce clozapine tablets dose based on clinical response.

Moderate or weak CYP1A2 or CYP3A4 Inducers | Monitor for decreased effectiveness. Consider increasing the clozapine tablets dose if necessary. | Monitor for adverse reactions. Consider reducing the clozapine tablets dose if necessary.

2.7 Renal or Hepatic Impairment or CYP2D6 Poor Metabolizers
It may be necessary to reduce the clozapine tablets dose in patients with significant renal or hepatic impairment, or in CYP2D6 poor metabolizers [see Use in Specific Populations (8.6, 8.7)].

3 DOSAGE FORMS AND STRENGTHS
Clozapine tablets are available as 25 mg, 50 mg, 100 mg, and 200 mg pale-yellow tablets with a score on one side.

4 CONTRAINDICATIONS
4.1 Hypersensitivity
Clozapine tablets are contraindicated in patients with a history of serious hypersensitivity to clozapine (e.g., photosensitivity, vasculitis, erythema multiforme, or Stevens-Johnson Syndrome) or any other component of clozapine tablets [see Adverse Reactions (6.2)].

5 WARNINGS AND PRECAUTIONS
5.1 Severe Neutropenia
Background
Clozapine can cause neutropenia (a low absolute neutrophil count (ANC)), defined as a reduction below pre-treatment normal levels of blood neutrophils. The ANC is usually available as a component of the complete blood count (CBC), including differential, and is more relevant to drug-induced neutropenia than is the white blood cell (WBC) count. The ANC may also be calculated using the following formula: ANC equals the total WBC count multiplied by the total percentage of neutrophils obtained from the differential (neutrophil “segs” plus neutrophil “bands”). Other granulocytes (basophils and eosinophils) contribute minimally to neutropenia and are obtained from the differential (neutrophil “segs” plus neutrophil “bands”).

ANC equals the Total WBC count multiplied by the total percentage of neutrophils.

Severe neutropenia, ANC less than (<) 500/μL, occurs in a small percentage of patients taking clozapine and is associated with an increase in the risk of serious and potentially fatal infections. Risk of neutropenia appears greatest during the first 18 weeks on treatment and then declines. The mechanism by which clozapine causes neutropenia is unknown and is not dose-dependent.

Two separate management algorithms are provided below, the first for patients in the general population, and the second for patients identified to have baseline neutropenia.

Clozapine Treatment and Monitoring in Patients with Benign Ethnic Neutropenia (see Table 3)
Benign ethnic neutropenia (BEN) is a condition observed in certain ethnic groups whose average ANC values are lower than “standard” laboratory ranges for neutrophils. It is most commonly observed in individuals of African descent (approximate prevalence of 25 to 50%), some Middle Eastern ethnic groups, and in other non-Caucasian ethnic groups with darker skin. BEN is more common in men. Patients with BEN have normal hematopoietic stem-cell number and myeloid maturation, are healthy, and do not suffer from repeated or severe infections. They are not at increased risk for developing clozapine-induced neutropenia. Additional evaluation may be needed to determine if baseline neutropenia is due to BEN. Consider hematology consultation before initiating or during clozapine treatment as necessary.

Patients with BEN require a different ANC algorithm for clozapine management due to their lower baseline ANC levels. Table 3 provides guidelines for managing clozapine treatment and ANC monitoring in patients with BEN.

<table>
<thead>
<tr>
<th>ANC Level</th>
<th>Treatment Recommendations</th>
<th>ANC Monitoring</th>
</tr>
</thead>
</table>
| Normal range (<1500/μL) | • Obtain at least two baseline ANC levels before initiating treatment | • Weekly from initiation to 6 months
| | - If treatment interrupted: - < 30 days, continue monitoring as before - ≥ 30 days, monitor as if new patient | - Every 2 weeks from 6 to 12 months
| | | - Monthly after 12 months
| | • Discontinuation of treatment for reasons other than neutropenia | • See Section 2.4

BEN Neutropenia 500 to 999/μL

<table>
<thead>
<tr>
<th>ANC Level</th>
<th>Treatment Recommendations</th>
<th>ANC Monitoring</th>
</tr>
</thead>
</table>
| Normal BEN Range (Established ANC baseline ≥1000/μL) | • Obtain at least two baseline ANC levels before initiating treatment | • Three times weekly until ANC ≥1000/μL or ≥ patient’s known baseline
| | - If treatment interrupted: - < 30 days, continue monitoring as before - ≥ 30 days, monitor as if new patient | - Once ANC ≥1000/μL or at patient’s known baseline, check ANC weekly for 4 weeks, then return to patient’s last “Normal BEN Range” ANC monitoring interval
| | • Recommend hematology consultation | • Daily until ANC ≥1000/μL
| | • Recommend hematology consultation | • Daily until ANC ≥1000/μL
| | • Continue treatment | • Daily until ANC ≥1000/μL

CLOZAPINE TABLETS

<table>
<thead>
<tr>
<th>ANC Level</th>
<th>Treatment Recommendations</th>
<th>ANC Monitoring</th>
</tr>
</thead>
</table>
| Moderate Neutropenia (500 to 999/μL) | • Recommend hematology consultation | • Daily until ANC ≥1000/μL, then
| | • Interrupt treatment for suspected clozapine-induced neutropenia | • Three times weekly until ANC ≥1500/μL
| | • Resume treatment once ANC ≥1000/μL | • Once ANC ≥1500/μL, check ANC weekly for 4 weeks, then return to patient’s last “Normal Range” ANC monitoring interval
| | • Obtain at least two baseline ANC levels before initiating treatment | • Once ANC ≥1500/μL
| | • If treatment interrupted: | • If patient rechallenged, resume treatment as a new patient
| | - < 30 days, continue monitoring as before | - “Normal Range” monitoring once ANC ≥1500/μL
| | - ≥ 30 days, monitor as if new patient | - If clinically appropriate

Table 2: Clozapine Treatment Recommendations Based on Absolute Neutrophil Count (ANC) Monitoring for the General Patient Population

<table>
<thead>
<tr>
<th>ANC Level</th>
<th>Clozapine Treatment Recommendations</th>
<th>ANC Monitoring</th>
</tr>
</thead>
</table>
| Normal range (≥1500/μL) | • Initiate treatment | • Three times weekly until ANC ≥1000/μL or ≥ patient’s known baseline
| | • If treatment interrupted: | • Once ANC ≥1000/μL or at patient’s known baseline, check ANC weekly for 4 weeks, then return to patient’s last “Normal BEN Range” ANC monitoring interval
| | - < 30 days, continue monitoring as before | • Daily until ANC ≥1000/μL, then
| | - ≥ 30 days, monitor as if new patient | • Three times weekly until ANC ≥1000/μL
| | • Discontinuation of reasons other than neutropenia | • If patient rechallenged, resume treatment as a new patient under “Normal Range” monitoring once ANC ≥1000/μL or at patient’s baseline

Mild Neutropenia (1000 to 1499/μL)

<table>
<thead>
<tr>
<th>ANC Level</th>
<th>Clozapine Treatment Recommendations</th>
<th>ANC Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continue treatment</td>
<td>• Once ANC ≥1500/μL, return to patient’s last “Normal Range” ANC monitoring interval</td>
<td></td>
</tr>
</tbody>
</table>
| • Three times weekly until ANC ≥1500/μL | • Onset of ANC ≥500/μL, then
| | • Once ANC ≥1500/μL, return to patient’s last “Normal Range” ANC monitoring interval | • Confirm initial reports of ANC less than 1500/μL with a repeat ANC measurement within 24 Hours

1. Confirm initial reports of ANC less than 1500/μL with a repeat ANC measurement within 24 Hours
2. If clinically appropriate

1. Confirm all initial reports of ANC less than 1500/μL with a repeat ANC measurement within 24 Hours
2. If clinically appropriate
5.6 Myocarditis, Cardiomyopathy and Mitral Valve Incompetence

Myocarditis and cardiomyopathy have occurred with the use of clozapine. These reactions can be fatal. Discontinue clozapine and obtain a cardiac evaluation upon suspicion of myocarditis or cardiomyopathy. Generally, patients with a history of clozapine-associated myocarditis or cardiomyopathy should not be rechallenged with clozapine. However, if the benefit of clozapine treatment is judged to outweigh the potential risks of recurrent cardiomyopathy, the clinician may consider rechallenge with clozapine in consultation with a cardiologist, after a complete cardiac evaluation, and under close monitoring. Consider the possibility of myocarditis or cardiomyopathy in patients receiving clozapine who present with chest syndrome, persistent tachycardia at rest, palpitations, fever, flu-like symptoms, hypotension, other signs or symptoms of heart failure, or electrocardiographic findings (low voltages, ST-T abnormalities, arrhythmias, right axis deviation, and poor R wave progression). Myocarditis most frequently presents within the first 2 months of clozapine treatment. Symptoms of cardiomyopathy or myocarditis may be more severe than those associated with myocarditis reported earlier in the course of clozapine treatment. Although no deaths have been reported within 8 weeks of treatment, however, myocarditis and cardiomyopathy can occur at any period during treatment with clozapine. It is common for nonspecific flu-like symptoms such as malaise, myalgia, pleuritic chest pain, and low-grade fevers to precede more overt signs of heart failure. Typical laboratory findings include elevated troponin 1 or T, and can resolve without intervention. There are reports of successful rechallenge after discontinuation of clozapine, without recurrence of eosinophilia. In the absence of organ involvement, treatment should be based on the overall clinical assessment, in consultation with an intensivist or hematologist.

5.7 Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at risk of death compared to placebo-treated patients. In one 10-week, randomized, placebo-controlled trial of elderly patients with dementia-related psychosis treated with 12.5 mg once daily or twice daily clozapine [see Dosage and Administration (2.5)], consider reducing the dose by 25 mg per day, if well-tolerated, to a target dose of 300 mg to 450 mg per day (administered in divided doses) by the end of 2 weeks. Subsequently, the dose can be increased weekly or twice weekly, in increments of up to 100 mg. The maximum dose is 900 mg per day. Use caution titration and a divided dosage schedule to minimize the risk of serious cardiovascular reactions. Use caution in prescribing clozapine to patients with a history of long QT syndrome or sudden cardiac death, significant cardiac arrhythmias, major adverse cardiovascular events (MACE), peripheral eosinophilia, and elevated C-reactive protein (CRP). Chest roentgenogram may demonstrate cardiac silhouette enlargement, and cardiac imaging (echocardiogram, radionucleotide studies, or cardiac catheterization) may reveal evidence of left ventricular dysfunction. In patients who are diagnosed with cardiomyopathy while taking clozapine mitral valve incompetence has been reported. Drug-induced mitral regurgitation at any period during treatment may increase mortality in this population. The extent to which the findings of increased mortality in observational studies can be attributed to the antipsychotic drug versus other causes(s) cannot be determined from these studies. Drug-induced mitral regurgitation may be reversible. It is not clear whether cases of mitral regurgitation in the placebo group were drug-related.

5.8 Eosinophilia

Eosinophilia, defined as a blood eosinophil count of greater than 700/µL, has occurred with clozapine treatment. In clinical trials, approximately 1% of patients developed eosinophilia. Clozapine-related eosinophilia usually occurs during the first month of treatment. In some patients, it has been associated with myocarditis, pancreatitis, hepatitis, colitis, and nephritis. Such organ involvement can be consistent with the antipsychotic drug as opposed to the underlying cause(s) of the patients is not clear. Clozapine is not approved for the treatment of patients with dementia-related psychosis [see Boxed Warning].

5.9 QT Interval Prolongation

QT prolongation, Torsade de Points and other life-threatening ventricular arrhythmias, cardiac arrest, and sudden death have occurred with clozapine treatment. When prescribing clozapine, consider the presence of additional risk factors for QT prolongation and serious cardiovascular reactions. Conditions that increase these risks include the following: history of QT prolongation, long QT syndrome, family history of long QT syndrome or sudden cardiac death, significant cardiac arrhythmia, recent myocardial infarction, uncompensated heart failure, treatment with other medications that cause QT prolongation, treatment with medications that inhibit the metabolism of clozapine, and electrolyte abnormalities.

Prior to initiating treatment with clozapine, perform a careful physical examination, medical history, and concomitant medication history. Consider obtaining a baseline ECG and serum chemistry panel. Correct electrolyte abnormalities. Discontinue clozapine if the QTc interval exceeds 500 msec. If patients experience symptoms consistent with Torsades de Points, or other arrhythmias (e.g., syncope, presyncope, dizziness, or palpitations), obtain a cardiac evaluation and discontinue clozapine.
CLOZAPINE TABLETS

Use caution when administering concomitant medications that prolong the QT interval or inhibit the metabolism of clozapine tablets. Drugs that cause QT prolongation include: specific antipsychotics (e.g., ziprasidone, iloperidone, chlorpromazine, thioridazine, mesoridazine, droperidol, pimozide), specific antibiotics (e.g., erythromycin, gatifloxacin, moxifloxacin, sparfloxacin), Class 1A antiarrhythmic medications (e.g., quinidine, propafenone) or Class III antiarrhythmics (e.g., amiodarone, sotalol), and others (e.g., pentamidine, levomethadyl acetate, methadone, halofantrine, mefloquine, dolasetron mesylate, procainamide or taloronic). Clozapine is primarily metabolized by CYP isozymes 1A2, 2D6, and 3A4. Concomitant treatment with inhibitors of these enzymes can increase the concentration of clozapine tablets [see Drug Interactions (7.1) and Clinical Pharmacology (12.3)].

Hypokalemia and hypomagnesemia increase the risk of QT prolongation. Hypokalemia can result from diuretic therapy, diarrhea, and other causes. Use caution when treating patients at risk for significant electrolyte disturbance, particularly hypokalemia. Obtain baseline measurements of serum potassium and magnesium levels, and periodically monitor electrolytes. Correct electrolyte abnormalities before initiating treatment with clozapine.

5.10 Metabolic Changes
Atypical antipsychotic drugs, including clozapine have been associated with metabolic changes that can increase cardiovascular and cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and body weight gain. While atypical antipsychotic drugs may produce some metabolic changes, each drug in the class has its own specific risk profile.

Hyperglycemia and Diabetes Mellitus
Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma, or death, has been reported with patients treated with atypical antipsychotics including clozapine. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounding factors, the relationship between atypical antipsychotic use and hyperglycemia-related adverse reactions is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent, hyperglycemia-related adverse reactions in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycemia-related adverse reactions in patients treated with atypical antipsychotics are not available.

Patients with an established diagnosis of diabetes mellitus who are started on clozapine should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

In a pooled data analysis of 8 studies in adult subjects with schizophrenia, the mean changes in fasting glucose concentration in the clozapine and chlorpromazine groups were +11 mg/dL and +4 mg/dL, respectively. A higher proportion of the clozapine group demonstrated categorical increases from baseline in fasting glucose concentrations, compared to the chlorpromazine group (Table 4). The clozapine doses were 100 to 900 mg per day (mean modal dose: 512 mg per day). The maximum chlorpromazine dose was 1800 mg per day (mean modal dose: 1029 mg per day). The median duration of exposure was 42 days for clozapine and chlorpromazine.

Table 4: Categorical Changes in Fasting Glucose Level in Studies in Adult Subjects with Schizophrenia

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>Category Change (at least once) from baseline</th>
<th>Treatment Arm</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting Glucose</td>
<td>Normal (&lt; 100 mg/dL) to High (&gt; 126 mg/dL)</td>
<td>Clozapine</td>
<td>198 (53)</td>
</tr>
<tr>
<td></td>
<td>to High (&gt; 126 mg/dL)</td>
<td>Chlorpromazine</td>
<td>135 (14)</td>
</tr>
<tr>
<td></td>
<td>Borderline (100 to 125 mg/dL)</td>
<td>Clozapine</td>
<td>57 (24)</td>
</tr>
<tr>
<td></td>
<td>to High (&gt; 126 mg/dL)</td>
<td>Chlorpromazine</td>
<td>43 (28)</td>
</tr>
</tbody>
</table>

Dyslipidemia
Undesirable alterations in lipids have occurred in patients treated with atypical antipsychotics, including clozapine. Clinical monitoring, including baseline and periodic follow-up lipid evaluations in patients using clozapine, is recommended.

In a pooled data analysis of 10 studies in adult subjects with schizophrenia, clozapine treatment was associated with increases in serum total cholesterol. No data were collected on LDL and HDL cholesterol. The mean increase in total cholesterol was 13 mg/dL in the clozapine group and 15 mg/dL in the chlorpromazine group. In a pooled data analysis of 2 studies in adult subjects with schizophrenia, clozapine treatment was associated with increases in fasting serum triglyceride. The mean increase in fasting triglyceride was 71 mg/dL (54%) in the clozapine group and 39 mg/dL (35%) in the chlorpromazine group (Table 5). In addition, clozapine treatment was associated with categorical increases in serum total cholesterol and triglyceride, as illustrated in Table 6. The proportion of patients with categorical increases in total cholesterol or fasting triglyceride increased with the duration of exposure. The median duration of clozapine and chlorpromazine exposure was 45 days and 38 days, respectively. The clozapine dose range was 100 mg to 900 mg daily; the maximum chlorpromazine dose was 1800 mg daily.

Table 5: Mean Changes in Total Cholesterol and Triglyceride Concentration in Studies in Adult Subjects with Schizophrenia

<table>
<thead>
<tr>
<th>Treatment Arm</th>
<th>Baseline total cholesterol concentration (mg/dL)</th>
<th>Change from baseline mg/dL (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine (N = 334)</td>
<td>184</td>
<td>+13 (7)</td>
</tr>
<tr>
<td>Chlorpromazine (N = 185)</td>
<td>182</td>
<td>+15 (8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Arm</th>
<th>Baseline triglyceride concentration (mg/dL)</th>
<th>Change from baseline mg/dL (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine (N = 6)</td>
<td>130</td>
<td>+7 (54)</td>
</tr>
<tr>
<td>Chlorpromazine (N = 7)</td>
<td>110</td>
<td>+39 (35)</td>
</tr>
</tbody>
</table>

Table 6: Categorical Changes in Lipid Concentrations in Studies in Adult Subjects with Schizophrenia

<table>
<thead>
<tr>
<th>Laboratory Parameter</th>
<th>Category Change (at least once) from baseline</th>
<th>Treatment Arm</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cholesterol (random or fasting)</td>
<td>Increase by ≥ 40 mg/dL</td>
<td>Clozapine</td>
<td>334 (111)</td>
</tr>
<tr>
<td></td>
<td>Normal (&lt; 200 mg/dL) to High (&gt; 240 mg/dL)</td>
<td>Chlorpromazine</td>
<td>185 (46)</td>
</tr>
<tr>
<td></td>
<td>Borderline (200 to 239 mg/dL) to High (&gt; 240 mg/dL)</td>
<td>Chlorpromazine</td>
<td>132 (3)</td>
</tr>
<tr>
<td></td>
<td>Increase by ≥ 50 mg/dL</td>
<td>Chlorpromazine</td>
<td>79 (30)</td>
</tr>
<tr>
<td></td>
<td>Normal (&lt; 150 mg/dL) to High (&gt; 200 mg/dL)</td>
<td>Chlorpromazine</td>
<td>34 (14)</td>
</tr>
<tr>
<td></td>
<td>Borderline (&gt; 150 mg/dL and &lt; 200 mg/dL) to High (&gt; 200 mg/dL)</td>
<td>Chlorpromazine</td>
<td>1 (100)</td>
</tr>
</tbody>
</table>

Weight Gain
Weight gain has occurred with the use of antipsychotics, including clozapine. Monitor weight during treatment with clozapine. Table 7 summarizes the data on weight gain by the duration of exposure pooled from 11 studies with clozapine and active comparators. The median duration of exposure was 609, 728, and 42 days, in the clozapine, olanzapine, and chlorpromazine group, respectively.

Table 7: Mean Change in Body Weight (kg) by Duration of Exposure from Studies in Adult Subjects with Schizophrenia

<table>
<thead>
<tr>
<th>Metabolic parameter</th>
<th>Exposure duration</th>
<th>Clozapine (N = 669)</th>
<th>Olanzapine (N = 442)</th>
<th>Chlorpromazine (N = 155)</th>
<th>n</th>
<th>Mean</th>
<th>n</th>
<th>Mean</th>
<th>n</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight change</td>
<td>2 weeks (Day 11 to 17)</td>
<td>6 +0.9</td>
<td>3 +0.7</td>
<td>2 -0.5</td>
<td></td>
<td>0.5</td>
<td></td>
<td>0.5</td>
<td></td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>4 weeks (Day 21 to 35)</td>
<td>23 +0.7</td>
<td>8 +0.8</td>
<td>17 +0.6</td>
<td></td>
<td>0.6</td>
<td></td>
<td>0.6</td>
<td></td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>8 weeks (Day 49 to 63)</td>
<td>12 +1.9</td>
<td>13 +1.8</td>
<td>16 +0.9</td>
<td></td>
<td>0.9</td>
<td></td>
<td>0.9</td>
<td></td>
<td>0.9</td>
</tr>
<tr>
<td></td>
<td>12 weeks (Day 70 to 98)</td>
<td>17 +2.8</td>
<td>5 +3.1</td>
<td>0 0</td>
<td></td>
<td>0.0</td>
<td></td>
<td>0.0</td>
<td></td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>24 weeks (Day 154 to 182)</td>
<td>42 -0.6</td>
<td>12 +5.7</td>
<td>0 0</td>
<td></td>
<td>0.0</td>
<td></td>
<td>0.0</td>
<td></td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>48 weeks (Day 322 to 350)</td>
<td>3 +3.7</td>
<td>3 +13.7</td>
<td>0 0</td>
<td></td>
<td>0.0</td>
<td></td>
<td>0.0</td>
<td></td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 8 summarizes pooled data from 11 studies in adult subjects with schizophrenia demonstrating weight gain ≥ 7% of body weight relative to baseline. The median duration of exposure was 609, 728, and 42 days, in the clozapine, olanzapine, and chlorpromazine group, respectively.

Table 8: Proportion of Adult Subjects in Schizophrenia Studies with Weight Gain ≥ 7% Relative to Baseline Body Weight

<table>
<thead>
<tr>
<th>Weight change</th>
<th>Clozapine</th>
<th>Olanzapine</th>
<th>Chlorpromazine</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>669</td>
<td>442</td>
<td>155</td>
</tr>
<tr>
<td>≥ 7% (inclusive)</td>
<td>236 (35%)</td>
<td>203 (46%)</td>
<td>13 (8%)</td>
</tr>
</tbody>
</table>

5.11 Neuroleptic Malignant Syndrome
Antipsychotic drugs including clozapine can cause a potentially fatal symptom complex referred to as Neuroleptic Malignant Syndrome (NMS). Clinical manifestations of NMS include hyperpyrexia, muscle rigidity, altered mental status, and autonomic
instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmias). Associated findings can include elevated creatine phosphokinase (CPK), myoglobinuria, rhabdomyolysis, and acute renal failure.

The diagnostic evaluation of patients with this syndrome is complicated. It is important to consider the presence of other serious medical conditions (e.g., severe neutropenia, infection, heat stroke, primary CNS pathology, central anticholinergic toxicity, extrapyramidal symptoms, and drug fever).

The management of NMS should include (1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy, (2) intensive symptomatic treatment and medical monitoring, and (3) treatment of comorbid medical conditions. There is no general agreement about specific pharmacological treatments for NMS.

If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. NMS can recur. Monitor closely if restarting treatment with antipsychotics.

NMS has occurred with clozapine monotherapy and with concomitant CNS-activating medications, including lithium.

5.12 Hepatotoxicity
Severe, life threatening, and in some cases fatal hepatotoxicity including hepatic failure, hepatic necrosis, and hepatitis have been reported in post marketing studies in patients treated with clozapine [see Adverse Reactions (6.2)]. Monitor for the appearance of signs and symptoms of hepatotoxicity such as fatigue, malaise, anorexia, nausea, jaundice, bilirubinemia, coagulopathy, and hepatic encephalopathy. Perform serum tests for liver injury and consider permanently discontinuing treatment if hepatitis or transaminase elevations combined with other systemic symptoms are due to clozapine.

5.13 Fever
During clozapine therapy, patients have experienced transient, clozapine-related fever. The peak incidence is within the first 3 weeks of treatment. While this fever is generally benign and self-limited, it may necessitate discontinuing treatment. The fever may occur with an increase of 10% or more in WBC count. Carefully evaluate patients with fever to rule out severe neutropenia or infection. Consider the possibility of NMS [see Warnings and Precautions (5.11)].

5.14 Pulmonary Embolism
Pulmonary embolism and deep-vein thrombosis have occurred in patients treated with clozapine tablets. Consider the possibility of pulmonary embolism in patients who present with deep-vein thrombosis, acute dyspnea, chest pain, or with other respiratory signs and symptoms. Whether pulmonary embolus and deep-vein thrombosis can be attributed to clozapine or some characteristic(s) of patients is not clear.

5.15 Anticholinergic Toxicity
Clozapine has potent anticholinergic effects. Treatment with clozapine can result in CNS and peripheral anticholinergic toxicity. Use with caution in the presence of narrow-angle glaucoma, concomitant anticholinergic medications, prostatic hypertrophy, or other conditions in which anticholinergic effects can lead to significant adverse reactions.

Treatment with clozapine can result in gastrointestinal adverse reactions, including constipation, intestinal obstruction, fecal impaction, and paralytic ileus. Such reactions can be fatal. Constipation should be initially treated by ensuring adequate hydration and use of ancillary therapy such as bulk laxatives. Consultation with a gastroenterologist is advisable in more serious cases.

5.16 Interference with Cognitive and Motor Performance
Clozapine can cause sedation and impairment of cognitive and motor performance. Caution patients about operating hazardous machinery, including automobiles, until they are reasonably certain that clozapine does not affect them adversely. These reactions may be dose-related. Consider reducing the dose if they occur.

5.17 Tardive Dyskinesia
Tardive dyskinesia (TD) has occurred in patients treated with antipsychotic drugs, including clozapine. The syndrome consists of potentially irreversible, involuntary, dyskinetic movements. The risk of TD and the likelihood that it will become irreversible are believed to increase with greater durations of treatment and higher total cumulative doses. However, the syndrome can develop after relatively brief treatment periods at low doses. Prescribe clozapine in a manner that is most likely to minimize the risk of developing TD. Use the lowest effective dose and the shortest duration necessary to control symptoms. Periodically assess the need for continued treatment. Consider discontinuing treatment if TD occurs. However, some patients may require treatment with clozapine despite the presence of the syndrome.

There is no known treatment for TD. However, the syndrome may remit partially or completely if treatment is discontinued. Antipsychotic treatment, itself, may suppress (or partially suppress) the signs and symptoms, and it has the potential to mask the underlying process. The effect of symptom suppression on the long-term course of TD is unknown.

5.18 Cerebrovascular Adverse Reactions
In controlled trials, elderly patients with dementia-related psychosis treated with some atypical antipsychotic had an increased risk (compared to placebo) of cerebrovascular adverse reactions (e.g., stroke, transient ischemic attack), including fatalities. The mechanism for this increased risk is not known. An increased risk cannot be excluded for clozapine or other antipsychotics or other patient populations. Clozapine should be used with caution in patients with risk factors for cerebrovascular adverse reactions.

5.19 Recurrence of Psychosis and Cholinergic Rebound after Abrupt Discontinuation of Clozapine
If abrupt discontinuation of clozapine is necessary (because of severe neutropenia or another medical condition, for example) [see Dosage and Administration (2.4), Warnings and Precautions (5.1)], monitor carefully for the recurrence of psychotic symptoms and adverse reactions related to cholinergic rebound, such as profuse sweating, headache, nausea, vomiting and diarrhea.

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The most commonly reported adverse reactions (≥5%) across clozapine clinical trials were: CNS reactions, including sedation, dizziness/vertigo, headache, and tremor; cardiovascular reactions, including tachycardia, hypotension, and syncope; autonomic nervous system reactions, including hypersalivation, sweating, dry mouth, and visual disturbances; gastrointestinal reactions, including constipation and nausea; and fever. Table 9 summarizes the most commonly reported adverse reactions (≥5%) in clozapine-treated patients (compared to chlorpromazine-treated patients) in the pivotal, 6 week, randomized, Chlorpromazine-controlled Trial in Treatment-Resistant Schizophrenia (N = 142) across all Clozapine Studies (excluding the 2 year InterSept™ Study).

Table 9: Common Adverse Reactions (≥5%) in the 6 Week, Randomized, Chlorpromazine-controlled Trial in Treatment-Resistant Schizophrenia

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Clozapine (N = 126) (%)</th>
<th>Chlorpromazine (N = 142) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedation</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Constipation</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Dizziness</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Hypotension</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Rectus (hyperthermia)</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Hypersalivation</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Hypertension</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Headache</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Dry mouth</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 10 summarizes the adverse reactions reported in clozapine-treated patients at a frequency of ≥2% or greater across all clozapine studies (excluding the 2 year InterSept™ Study). These rates are not adjusted for duration of exposure.

Table 10: Adverse Reactions (≥2%) Reported in Clozapine-treated Patients (N = 842)

<table>
<thead>
<tr>
<th>Body System</th>
<th>Adverse Reaction*</th>
<th>Clozapine N = 842 Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Nervous System</td>
<td>Drowsiness/Sedation</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Dizziness/Vertigo</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Headache</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Tremor</td>
<td>6</td>
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<td></td>
<td>Syncope</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Disturbed Sleep/Nightmares</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Restlessness</td>
<td>4</td>
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<tr>
<td></td>
<td>Hypokinesia/Akinse</td>
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<td></td>
<td>Agitation</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Seizures (convulsions)</td>
<td>3*</td>
</tr>
<tr>
<td></td>
<td>Rigidity</td>
<td>3</td>
</tr>
</tbody>
</table>

continued
7.2 Potential for Clozapine to Affect Other Drugs

CYP1A2 Inhibitors

Concomitant use of clozapine tablets and CYP1A2 inhibitors can increase plasma levels of clozapine, potentially resulting in adverse reactions. Reduce the clozapine tablets dose to one-third of the original dose when using such inhibitors. Consider reducing the clozapine tablets dosage if necessary [see Dosage and Administration (2.6)].

CYP2D6 and CYP3A4 Inhibitors

Concomitant treatment with clozapine tablets and CYP2D6 or CYP3A4 inhibitors (e.g., cimetidine, escitalopram, erythromycin, paroxetine, bupropion, fluoxetine, quinidine, duloxetine, terbinafine, or sertraline) can increase the plasma levels and lead to adverse reactions [see Clinical Pharmacology (12.3)]. Use caution and monitor patients closely when using such inhibitors. Consider reducing the clozapine tablets dosage if necessary [see Dosage and Administration (2.6)].

CYP1A2 and CYP3A4 Inducers

Concomitant treatment with drugs that induce CYP1A2 or CYP3A4 can decrease the plasma concentration of clozapine, resulting in decreased effectiveness of clozapine tablets. Tobacco smoke is a moderate inducer of CYP1A2. Strong CYP3A4 inducers include carbamazepine, phenytoin, St. John's wort, and rifampin. It may be necessary to reduce the clozapine tablets dosage if used concomitantly with inducers of these enzymes. However, concomitant use of clozapine tablets and strong CYP3A4 inducers is not recommended [see Dosage and Administration (2.6)].

Consider reducing the clozapine tablets dosage when discontinuing coadministration of enzyme inducers, because discontinuation of inducers can result in increased clozapine plasma levels and an increased risk of adverse reactions [see Dosage and Administration (2.6)].

Drugs that Cause QT Interval Prolongation

Use caution when administering concomitant medications that prolong the QT interval or inhibit the metabolism of clozapine. Drugs that cause QT prolongation include specific antipsychotics (e.g., ziprasidone, iloperidone, chlorpromazine, thioridazine, mesoridazine, droperidol, and pimozide), specific antibiotics (e.g., erythromycin, gatifloxacin, moxifloxacin, sparfloxacin), Class 1A antiarrhythmics (e.g., quinidine, procainamide) or Class III antiarrhythmics (e.g., amiodarone, sotalol), and others (e.g., pentamidine, levomepromazine, acebutolol, halofantrine, mefloquine, doxepin, mesoridazine, droperidol, and pimozide) [see Warnings and Precautions (5.9)].

7.3 Potential for Other Drugs to Affect Clozapine

CYP1A2 and CYP3A4 inhibitors (e.g., cimetidine, escitalopram, erythromycin, paroxetine, bupropion, fluoxetine, quinidine, duloxetine, terbinafine, or sertraline) can increase plasma levels of clozapine and lead to adverse reactions [see Clinical Pharmacology (12.3)]. Use caution and monitor patients closely when using such inhibitors. Consider reducing the clozapine tablets dosage if necessary [see Dosage and Administration (2.6)].

CYP2D6 and CYP3A4 inhibitors (e.g., CYP1A2 inhibitors such as fluvoxamine, ciprofloxacin, or cimetidine) can increase the plasma levels of clozapine, resulting in decreased effectiveness of clozapine tablets. Tobacco smoke is a moderate inducer of CYP1A2. Strong CYP3A4 inducers include carbamazepine, phenytoin, St. John's wort, and rifampin. It may be necessary to reduce the clozapine tablets dosage if used concomitantly with inducers of these enzymes. However, concomitant use of clozapine tablets and strong CYP3A4 inducers is not recommended [see Dosage and Administration (2.6)].

Consider reducing the clozapine tablets dosage when discontinuing coadministration of enzyme inducers, because discontinuation of inducers can result in increased clozapine plasma levels and an increased risk of adverse reactions [see Dosage and Administration (2.6)].

Drugs that Cause QT Interval Prolongation

Use caution when administering concomitant medications that prolong the QT interval or inhibit the metabolism of clozapine. Drugs that cause QT prolongation include specific antipsychotics (e.g., ziprasidone, iloperidone, chlorpromazine, thioridazine, mesoridazine, droperidol, and pimozide), specific antibiotics (e.g., erythromycin, gatifloxacin, moxifloxacin, sparfloxacin), Class 1A antiarrhythmics (e.g., quinidine, procainamide) or Class III antiarrhythmics (e.g., amiodarone, sotalol), and others (e.g., pentamidine, levomepromazine, acebutolol, halofantrine, mefloquine, doxepin, mesoridazine, droperidol, and pimozide) [see Warnings and Precautions (5.9)].

7.4 Potential for Clozapine to Affect Other Drugs

Concomitant treatment with clozapine tablets and other drugs metabolized by CYP2D6 can increase levels of these CYP2D6 substrates. Use caution when coadministering clozapine tablets with other drugs that are metabolized by CYP2D6. It may be necessary to use lower doses of such drugs than usually prescribed. Such drugs include specific antidepressants, phenothiazines, carbamazepine, and Type 1C antiarrhythmics (e.g., propranolol, flecainide, and encainide).

7.5 Drug Interactions

CYP2D6 and CYP3A4 Inhibitors

Concomitant treatment with clozapine tablets and CYP2D6 or CYP3A4 inhibitors (e.g., cimetidine, escitalopram, erythromycin, paroxetine, bupropion, fluoxetine, quinidine, duloxetine, terbinafine, or sertraline) can increase plasma levels of clozapine and lead to adverse reactions [see Clinical Pharmacology (12.3)]. Use caution and monitor patients closely when using such inhibitors. Consider reducing the clozapine tablets dosage if necessary [see Dosage and Administration (2.6)].

CYP1A2 and CYP3A4 Inducers

Concomitant treatment with drugs that induce CYP1A2 or CYP3A4 can decrease the plasma concentration of clozapine, resulting in decreased effectiveness of clozapine tablets. Tobacco smoke is a moderate inducer of CYP1A2. Strong CYP3A4 inducers include carbamazepine, phenytoin, St. John's wort, and rifampin. It may be necessary to reduce the clozapine tablets dosage if used concomitantly with inducers of these enzymes. However, concomitant use of clozapine tablets and strong CYP3A4 inducers is not recommended [see Dosage and Administration (2.6)].

Consider reducing the clozapine tablets dosage when discontinuing coadministration of enzyme inducers, because discontinuation of inducers can result in increased clozapine plasma levels and an increased risk of adverse reactions [see Dosage and Administration (2.6)].

Drugs that Cause QT Interval Prolongation

Use caution when administering concomitant medications that prolong the QT interval or inhibit the metabolism of clozapine. Drugs that cause QT prolongation include specific antipsychotics (e.g., ziprasidone, iloperidone, chlorpromazine, thioridazine, mesoridazine, droperidol, and pimozide), specific antibiotics (e.g., erythromycin, gatifloxacin, moxifloxacin, sparfloxacin), Class 1A antiarrhythmics (e.g., quinidine, procainamide) or Class III antiarrhythmics (e.g., amiodarone, sotalol), and others (e.g., pentamidine, levomepromazine, acebutolol, halofantrine, mefloquine, doxepin, mesoridazine, droperidol, and pimozide) [see Warnings and Precautions (5.9)].

7.6 Potential for Clozapine to Affect Other Drugs

Concomitant use of clozapine tablets with other drugs metabolized by CYP2D6 can increase levels of these CYP2D6 substrates. Use caution when coadministering clozapine tablets with other drugs that are metabolized by CYP2D6. It may be necessary to use lower doses of such drugs than usually prescribed. Such drugs include specific antidepressants, phenothiazines, carbamazepine, and Type 1C antiarrhythmics (e.g., propranolol, flecainide, and encainide).
CLOZAPINE TABLETS

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category B

Risk Summary

There are no adequate or well-controlled studies of clozapine in pregnant women. Reproduction studies have been performed in rats and rabbits at doses up to 0.4 and 0.9 times, respectively, the maximum recommended human dose (MRHD) of 900 mg/day on a mg/m² body surface area basis. The studies revealed no evidence of impaired fertility or harm to the fetus due to clozapine. Because animal reproduction studies are not always predictive of human response, clozapine tablets should be used during pregnancy only if clearly needed.

Clinical Considerations

Consider the risk of exacerbation of psychosis when discontinuing or changing treatment with antipsychotic medications during pregnancy and postpartum. Consider early screening for gestational diabetes for patients treated with antipsychotic medications (see Warnings and Precautions (5.10)). Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. Monitor neonates for symptoms of agitation, hypotonia, hyperpnea, tremor, somnolence, respiratory distress, and feeding difficulties. The severity of complications can vary from self-limited symptoms to some neonates requiring intensive care unit support and prolonged hospitalization.

Animal Data

In embryofetal developmental studies, clozapine had no effects on maternal parameters, litter sizes, or fetal parameters when administered orally to pregnant rats and rabbits during the period of organogenesis at doses up to 0.4 and 0.9 times, respectively, the MRHD of 900 mg/day on a mg/m² body surface area basis. In peri/postnatal developmental studies, pregnant female rats were administered clozapine over the last third of pregnancy and until day 21 postpartum. Observations were made on fetuses at birth and during the postnatal period; the offspring were allowed to reach sexual maturity and mated. Clozapine caused a decrease in maternal body weight and had no effects on litter size or body weights of either F1 or F2 generations at doses up to 0.4 times the MRHD of 900 mg/day on a mg/m² body surface area basis.

8.3 Nursing Mothers

Clozapine is present in human milk. Because of the potential for serious adverse reactions in nursing infants from clozapine, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.5 Geriatric Use

There have not been sufficient numbers of geriatric patients in clinical studies utilizing clozapine to determine whether those over 65 years of age differ from younger subjects in their response to clozapine. Orthostatic hypotension and tachycardia can occur with clozapine treatment (see Boxed Warning and Warnings and Precautions (5.3)). Elderly patients, particularly those with compromised cardiovascular functioning, may be more susceptible to these effects.

Elderly patients may be particularly susceptible to the anticholinergic effects of clozapine, such as urinary retention and constipation (see Warnings and Precautions (5.15)). Carefully select clozapine doses in elderly patients, taking into consideration their greater frequency of decreased hepatic, renal, or cardiac function, as well as other concomitant disease and other drug therapy. Clinical experience suggests that the prevalence of tardive dyskinesia appears to be highest among the elderly; especially elderly women (see Warnings and Precautions (5.2)). Carefully monitor elderly patients for extrapyramidal and/or antipsychotic effects.

8.6 Patients with Renal or Hepatic Impairment

Dose reduction may be necessary in patients with significant impairment of renal or hepatic function. Clozapine concentrations may be increased in these patients, because clozapine is almost completely metabolized and then excreted (see Dosage and Administration (2.7), Clinical Pharmacology (12.3)).

8.7 CYP2D6 Poor Metabolizers

Dose reduction may be necessary in patients who are CYP2D6 poor metabolizers. Clozapine concentrations may be increased in these patients, because clozapine is almost completely metabolized and then excreted (see Dosage and Administration (2.7), Clinical Pharmacology (12.3)).

8.8 Hospice Patients

For hospice patients (i.e., terminally ill patients with an estimated life expectancy of six months or less), the prescriber may reduce the ANC monitoring frequency to once every 6 months, after a discussion with the patient and his/her caregiver. Individual treatment decisions should weigh the importance of monitoring ANC in the context of the need to control psychiatric symptoms and the patient’s terminal illness.

10 OVERDOSAGE

10.1 Overdosage Experience

The most commonly reported signs and symptoms associated with clozapine overdose are: sedation, delirium, coma, tachycardia, hypotension, respiratory depression or failure, and hyperthermia. There are reports of aspiration pneumonia, cardiac arrhythmias, and seizure. Fatal overdoses have been reported with clozapine, generally at doses above 2500 mg. There have also been reports of patients recovering from overdoses well in excess of 4 g.

10.2 Management of Overdosage

For the most up-to-date information on the management of clozapine overdose, contact a certified Regional Poison Control Center (1-800-222-1222). Telephone numbers of certified Regional Poison Control Centers are listed in the Physicians’ Desk Reference®. Establish and maintain an airway; ensure adequate oxygenation and ventilation. Monitor cardiac status and vital signs. Use general symptomatic and supportive measures. There are no specific antidotes for clozapine.

In managing overdose, consider the possibility of multiple-drug involvement.

11 DESCRIPTION

Clozapine tablets USP, an atypical antipsychotic drug, is a tricyclic dibenzoazepine derivative. The chemical name of clozapine, USP is 8-chloro-11-(4-methyl-1-piperazinyl)-5H-dibenzo[b,e][1,4] diazepine and it has the following structural formula:

Clozapine, USP is a yellow, crystalline powder, very slightly soluble in water. Each tablet, for oral administration, contains 25 mg, 50 mg, 100 mg, or 200 mg clozapine, USP. In addition, each tablet contains the following inactive ingredients: colloidal silicon dioxide, corn starch, magnesium stearate, povidone, pregelatinized corn starch, and talc. Additionally, the 25 mg and 100 mg tablets contain lactose monohydrate and the 50 mg and 200 mg tablets contain anhydrous lactose and croscopovidone.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

The mechanism of action of clozapine is unknown. However, it has been proposed that the therapeutic efficacy of clozapine in schizophrenia is mediated through antagonism of the dopamine type 2 (D₂) and the serotonin type 2A (5-HT₂A) receptors. Clozapine tablets also act as an antagonist at adrenergic, cholinergic, histaminergic and other dopaminergic and serotonergic receptors.

12.2 Pharmacodynamics

Clozapine demonstrated binding affinity to the following receptors: histamine H₁ (Kᵢ 1.1 nM), adrenergic α₁ (Kᵢ 1.6 nM), serotonin 5-HT₂ (Kᵢ 4 nM), serotonin 5-HT₃a (Kᵢ 5.4 nM), muscarinic M₁ (Kᵢ 6.2 nM), serotonin 5-HT₄ (Kᵢ 6.3 nM), serotonin 5-HT₅c (Kᵢ 9.4 nM), dopamine D₁ (Kᵢ 24 nM), adrenergic α₂ (Kᵢ 90 nM), serotonin 5-HT₃ (Kᵢ 90 nM), serotonin 5-HT₄ (Kᵢ 120 nM), dopamine D₂ (Kᵢ 160 nM), dopamine D₃ (Kᵢ 270 nM), dopamine D₄ (Kᵢ 454 nM), and dopamine D₅ (Kᵢ 555 nM).

Clozapine causes little or no prolactin elevation.

Clinical electroencephalogram (EEG) studies demonstrated that clozapine increases delta and theta activity and slows dominant alpha frequencies. Enhanced synchronisation occurs. Sharp wave activity and spike and wave complexes may also develop. Patients have reported an intensification of dream activity during clozapine therapy. REM sleep was found to be increased to 85% of the total sleep time. In these patients, the onset of REM sleep occurred almost immediately after falling asleep.

12.3 Pharmacokinetics

Absorption

Clozapine is approximately 97% bound to serum proteins. The interaction between clozapine and other highly protein-bound drugs has not been fully evaluated but may be important (see Drug Interactions (7)).

Metabolism and Excretion

Clozapine is almost completely metabolized prior to excretion, and only trace amounts of unchanged drug are detected in the urine and feces. Clozapine is a substrate for many cytochrome P450 isozymes, in particular CYP1A2, CYP2D6, and CYP3A4. Approximately 50% of the administered dose is excreted in the urine and 30% in the feces. The demethylated, hydroxylated, and N-oxide derivatives are components in both urine and feces. Pharmacological testing has shown the desmethyl metabolite (norclozapine) to have only limited activity, while the hydroxylated and N-oxide derivatives were inactive. The mean elimination half-life of clozapine after a single 75 mg dose was 8 hours (range: 4 to 12 hours), compared to a mean elimination half-life of 12 hours (range: 4 to 66 hours), after achieving steady state with 100 mg twice daily dosing. A comparison of single-dose and multiple-dose administration of clozapine demonstrated that the elimination half-life increased significantly after multiple dosing relative to that after single-dose administration, suggesting the possibility of concentration-dependent pharmacokinetics. However, at steady state, approximately doubling the dose resulted in a 1.2-fold increase in the AUC (area under the curve), peak, and minimum clozapine plasma concentrations were observed after administration of 37.5, 75, and 150 mg twice daily.
A pharmacokinetic study was conducted in 16 schizophrenic patients who received clozapine under steady-state conditions. After coadministration of fluvoxamine for 14 days, mean trough concentrations of clozapine and its metabolites, N-desmethyl-clozapine and clozapine N-oxide, were elevated about three-fold compared to baseline steady-state concentrations.

Paroxetine, Fluoxetine, and Sertraline

In a study of schizophrenic patients (n = 14) who received clozapine under steady-state conditions, coadministration of paroxetine produced only minor changes in the levels of clozapine and its metabolites. However, other published reports describe modest elevations (less than two-fold) of clozapine and metabolite concentrations when clozapine was taken with paroxetine, fluoxetine, and sertraline.

Cryptomegalic Plasma

Carcinogenesis

Carcinogenesis, Mutagenesis, Impairment of Fertility

No carcinogenic potential was demonstrated in long-term studies in mice and rats. No specific pharmacokinetic studies were conducted to investigate the effects of renal or hepatic impairment on the pharmacokinetics of clozapine. Higher clozapine plasma concentrations are likely in patients with significant renal or hepatic impairment when given usual doses.

Specific Population Studies

Renal or Hepatic Impairment

No specific pharmacokinetic studies were conducted to investigate the effects of renal or hepatic impairment on the pharmacokinetics of clozapine. Approximately 88% of patients received clozapine or olanzapine in this study, there was extensive use of concomitant psychotropics; 64% with antipsychotics, 65% with anxiolytics, 53% with antidepressants, and 28% with mood stabilizers. There was significantly greater use of concomitant psychotropic medications among the patients in the olanzapine group.

The primary efficacy measure was time to (1) a significant suicide attempt, including a completed suicide; (2) hospitalization due to imminent suicide risk, including increased level of surveillance for suicidality for patients already hospitalized; or (3) worsening of suicidality severity as demonstrated by “much worsening” or “very much worsening” from baseline in the Clinical Global Impressions of Severity of Suicidality as assessed by the Blinded Psychiatrist (CGI-SS-BP) scale. A determination of whether or not a reported event met criterion 1 or 2 above was made by the Suicide Monitoring Board (SMB), a group of experts blinded to patient data. A total of 980 patients were randomized to the study and 956 received study medication. Sixty-two percent of the patients were diagnosed with schizophrenia, and the remainder (38%) were diagnosed with schizoaffective disorder. Only about one-fourth of the total patients (27%) was identified as “treatment-resistant” at baseline. There were more males than females in the study (61% of all patients were male). The mean age of patients entering the study was 37 years of age (range 18 to 69). Most patients were Caucasian (71%), 15% were Black, 1% were Asian, and 13% were classified as being of “other” races.

Patients treated with clozapine had a statistically significant longer delay in the time to recurrent suicidal behavior in comparison with olanzapine. This result should be interpreted only as evidence of the effectiveness of clozapine in delaying time to recurrent suicidal behavior and not a demonstration of the superior efficacy of clozapine over olanzapine.

The probability of experiencing (1) a significant suicide attempt, including a completed suicide; (2) hospitalization because of imminent suicide risk, including increased level of surveillance for suicidality for patients already hospitalized, was lower for clozapine patients than for olanzapine patients at Week 104: clozapine 24% versus olanzapine 32%; 95% CI of the difference: 2%, 14% (Figure 1).

Figure 1: Cumulative Probability of a Significant Suicide Attempt or Hospitalization to Prevent Suicide in Patients with Schizophrenia or Schizoaffective Disorder at High Risk of Suicidality

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

Clozapine Tablets USP are available as pale yellow, round tablets, debossed “Ivax hourglass logo” and “4393” on one side and “25” and a bisect on the other side, containing 5 mg clozapine, USP.

NDC 0093-4393-01 25 mg packaged in bottles of 100 tablets
NDC 0093-4393-05 25 mg packaged in bottles of 500 tablets
NDC 0093-4393-93 25 mg packaged in unit-dose boxes of 100 tablets

Clozapine Tablets USP are available as pale yellow, round, flat-faced, beveled-edge tablets, debossed “Ivax hourglass logo” and “4404” on one side and “50” and a bisect on the other side, containing 50 mg clozapine, USP.

NDC 0093-4404-01 50 mg packaged in bottles of 100 tablets
NDC 0093-4404-05 50 mg packaged in bottles of 500 tablets
NDC 0093-4404-93 50 mg packaged in unit-dose boxes of 100 tablets

with schizophrenia or schizoaffective disorder (DSM-IV) who were judged to be at risk for recurrent suicidal behavior. Only about one-fourth of these patients (27%) were considered resistant to standard antipsychotic drug treatment. To enter the trial, patients must have met at least 1 of the following criteria:

- They had attempted suicide within the three years prior to their baseline evaluation.
- They had been hospitalized to prevent a suicide attempt within the three years prior to their baseline evaluation.
- They demonstrated moderate-to-severe suicidal ideation with a depressive component within one week prior to their baseline evaluation.
- They demonstrated moderate-to-severe suicidal ideation accompanied by command hallucinations to do self-harm within one week prior to their baseline evaluation.
- They had attempted suicide within the three years prior to their baseline evaluation.
- They had been hospitalized to prevent a suicide attempt within the three years prior to their baseline evaluation.
- They demonstrated moderate-to-severe suicidal ideation with a depressive component within one week prior to their baseline evaluation.
- They demonstrated moderate-to-severe suicidal ideation accompanied by command hallucinations to do self-harm within one week prior to their baseline evaluation.
- They had attempted suicide within the three years prior to their baseline evaluation.
- They had been hospitalized to prevent a suicide attempt within the three years prior to their baseline evaluation.
- They demonstrated moderate-to-severe suicidal ideation with a depressive component within one week prior to their baseline evaluation.
- They demonstrated moderate-to-severe suicidal ideation accompanied by command hallucinations to do self-harm within one week prior to their baseline evaluation.
- They had attempted suicide within the three years prior to their baseline evaluation.
- They had been hospitalized to prevent a suicide attempt within the three years prior to their baseline evaluation.

The primary efficacy measure was time to (1) a significant suicide attempt, including a completed suicide; (2) hospitalization due to imminent suicide risk, including increased level of surveillanc...
CLOZAPINE TABLETS

Clozapine Tablets USP are available as pale yellow, round, flat-faced, beveled-edge tablets, debossed “Ivax hourglass logo” and “4405” on one side and “200” and a deep bisect on the other side, containing 200 mg clozapine, USP.
NDC 0093-4405-01 200 mg packaged in bottles of 100 tablets
NDC 0093-4405-05 200 mg packaged in bottles of 500 tablets
NDC 0093-4405-93 200 mg packaged in unit-dose boxes of 100 tablets

16.2 Storage and Handling
Store at 20° to 25°C (68° to 77°F) [See USP Controlled Room Temperature]. Dispense in a tight container as defined in the USP, with a child-resistant closure (as required).

KEEP THIS AND ALL MEDICATIONS OUT OF THE REACH OF CHILDREN.

17 PATIENT COUNSELING INFORMATION
Discuss the following issues with patients and caregivers:

• Severe Neutropenia:
  - Instruct patients (and caregivers) beginning treatment with clozapine about the risk of developing severe neutropenia and infection.
  - Instruct patients to immediately report to their physician any symptom or sign of infection e.g., flu-like illness; fever; lethargy; general weakness or malaise; mucus membrane ulceration; skin, pharyngeal, vaginal, urinary, or pulmonary infection; or extreme weakness or lethargy occurring at any time during clozapine therapy, to aid in evaluation for neutropenia and to institute prompt and appropriate management [see Warnings and Precautions (5.1), (5.11), and (5.13)].
  - Inform patients and caregivers clozapine is available only through a restricted program called the Clozapine REMS Program designed to ensure the required blood monitoring, in order to reduce the risk of developing severe neutropenia. Advise patients and caregivers of the importance of having blood tested as follows:
    • Weekly blood tests are required for the first 6 months.
    • An ANC is required every 2 weeks for the next 6 months if an acceptable ANC is maintained during the first 6 months of continuous therapy.
    • An ANC is required once every 4 weeks thereafter if an acceptable ANC is maintained during the second 6 months of continuous therapy.
  - Clozapine is available only from certified pharmacies participating in the program. Provide patients (and caregivers) with website information and the telephone number on how to obtain the product (www.clozapinerems.com or 1-844-267-8678) [see Dosage and Administration (2.2) and Warnings and Precautions (5.3)].
  - Orthostatic Hypotension, Bradycardia, and Syncope: Inform patients and caregivers about the risk of orthostatic hypotension and syncope, especially during the period of initial dose titration. Instruct them to strictly follow the clinician’s instructions for dosage and administration. Advise patients to consult their clinician immediately if they feel faint, lose consciousness or have signs or symptoms suggestive of bradycardia or arrhythmia [see Dosage and Administration (2.2) and Warnings and Precautions (5.3)].
  - Seizures: Inform patients and caregivers about the significant risk of seizure during clozapine treatment. Caution them about driving and any other potentially hazardous activity while taking clozapine [see Warnings and Precautions (5.5)].
  - QT Interval Prolongation: Advise patients to consult their clinician immediately if they feel faint, lose consciousness or have signs or symptoms suggestive of arrhythmia. Instruct patients not to take clozapine with other drugs that cause QT interval prolongation. Instruct patients to inform their clinicians that they are taking clozapine before any new drug [see Warnings and Precautions (5.9) and Drug Interactions (7.1)].
  - Metabolic Changes (hyperglycemia and diabetes mellitus, dyslipidemia, weight gain): Educate patients and caregivers about the risk of metabolic changes and the need for specific monitoring. The risks include hyperglycemia and diabetes mellitus, dyslipidemia, weight gain, and cardiovascular reactions. Educate patients and caregivers about the symptoms of hyperglycemia (high blood sugar) and diabetes mellitus (e.g., polydipsia, polyuria, polyphagia, and weakness). Monitor all patients for these symptoms. Patients who are diagnosed with diabetes or have risk factors for diabetes (obesity, family history of diabetes) should have their fasting blood glucose monitored before beginning treatment and periodically during treatment. Patients who develop symptoms of hyperglycemia should have assessments of fasting glucose. Clinical monitoring of weight is recommended [see Warnings and Precautions (5.10)].
  - Interference with Cognitive and Motor Performance: Because clozapine may have the potential to impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that clozapine therapy does not affect them adversely [see Warnings and Precautions (5.16)].
  - Missed Doses and Re-initiating Treatment: Inform patients and caregivers that if the patient misses taking clozapine for more than 2 days, they should not restart their medication at the same dosage but should contact their physician for dosing instructions [see Dosage and Administration (2.5) and Warnings and Precautions (5.1, 5.3)].

• Pregnancy: Patients and caregivers should notify the clinician if the patient becomes pregnant or intends to become pregnant during therapy [see Use in Specific Populations (8.1)].
• Nursing: Advise patients and caregivers that the patient should not breastfeed an infant if they are taking clozapine [see Use in Specific Populations (8.3)].
• Concomitant Medication: Advise patients to inform their healthcare provider if they are taking, or plan to take, any prescription or over-the-counter drugs; there is a potential for significant drug-drug interactions [see Dosage and Administration (2.6), Drug Interactions (7.1), and Table 1].

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