Serious Adverse Events and the Modafinil Augmentation Study

To the Editor: ***March 2, 2006***

I have many questions regarding the completed suicide and the case of leukopenia/neutropenia in the February 2006 article by Thase and colleagues, "Modafinil Augmentation of SSRI Therapy in Patients with Major Depressive Disorder and Excessive Sleepiness and Fatigue: A 12-Week Open-Label, Extension Study."[1]

Can we get more details on these two serious adverse events?

Did either or both of these patients receive placebo before getting modafinil?

How far into the study did the events occur?

What drugs and dosages were they taking at the time?

Why did the authors conclude the suicide and the leukopenia/neutropenia were unrelated to the drug trial?

In my experience, a completed suicide and a case of leukopenia/neutropenia among 250 patients over an 8-week drug trial seems unusual. Since I supplement with modafinil, I find the partial report unsettling. I think in some fashion the article should be amended with this information.

Regards,

Jerald Block, MD
Portland, OR

REFERENCE

1. Thase ME, Fava M, DeBattista C, Arora S, Hughes RJ. Modafinil augmentation of SSRI therapy in patients with major depressive disorder and excessive sleepiness and fatigue: a 12-week, open-label, extension study. *CNS Spectr.* 2006;11(2):93-102.

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Disclosure: Dr. Block does not have an affiliation with or financial interest in any organization that might pose a conflict of interest.

The Authors respond: ***April 5, 2006***

We appreciate the opportunity to respond to Dr. Block's request for more information on our report, "Modafinil Augmentation of SSRI Therapy in Patients with Major Depressive Disorder and Excessive Sleepiness and Fatigue: A 12-Week Open-Label, Extension Study." This report was the extension study to an 8-week double-blind study in which patients taking SSRIs who had incompletely responded to therapy were randomly assigned to modafinil or matching placebo.[1] It is important to understand that all of the participants in this 12-week extension study had received at least 16 weeks of selective serotonin reuptake inhibitor therapy (with or without active modafinil for 8 weeks during the double-blind phase) prior to beginning open-label modafinil therapy.

We agree that these two serious adverse events are rare in clinical studies of patients with major depressive disorder (MDD) and, thus, warrant a closer look. The patient who experienced leukopenia/neutropenia was a 37-year-old male with MDD (since 1991) who was receiving sertraline 150 mg/day. The patient, who had a history of lower back pain and substance abuse, received placebo during the 8-week double-blind phase. At baseline of the double-blind phase, his white blood cell (WBC) count and absolute neutrophil count (ANC) were low (WBC: 3.7 x 10^9/L, normal range=3.8–10.8 x 10^9/L; ANC: 1.7 x 10^9/L, normal range=1.8–8.0 x 10^9/L). He was a responder to placebo therapy and his 17-item Hamilton Rating Scale for Depression ($HAM\text{-}D_{17}$) score decreased from 14 to 3. The patient's WBC count after 8 weeks of placebo was again low (2.9 x 10^9/L), as was his ANC (1.4 x 10^9/L).

During the open-label period, while the patient continued taking sertraline, modafinil was initiated at 100 mg/day for 3 days and then continued at an average dose of 200 mg/day. On days 33 and 42, the patient's WBC counts were clinically significantly low (2.1 x 10^9/L on both days) and his ANCs were clinically significantly

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abnormal (0.7 x 10^9/L on both). Therefore, he was withdrawn from study therapy on day 42 (last dose of modafinil was day 41) and the blind (which masked assignment in the double-blind phase) was broken. Because the pattern of low WBCs and ANCs had been present at baseline and appeared to worsen during treatment with placebo and sertraline during the double-blind phase, the investigator rated these events as unlikely to be related to modafinil. After withdrawal from the study, this patient was lost to follow-up. No further information about his outcome is available.

The patient who committed suicide was a 40-year-old white man with a history of MDD (since 1997) who was receiving sertraline 100 mg/day and bupropion 300 mg/day. The patient had a history of migraine, sinus draining, inguinal hernia repair, herniated disk, ganglion cyst, carpal tunnel syndrome, bone spur, and sensitivity to penicillin and sulfa drugs. He received modafinil 200 mg/day in the double-blind phase. The patient was a responder during the double-blind study; his HAM-D_{17} total score decreased from 15 to 5.

In the open-label phase, the patient received an initial dose of modafinil 100 mg/day for 3 days before titration to 200 mg/day. The patient also took paracetamol 250 mg/day for headaches and the common cold, for which he also took Alka Seltzer. The patient had also received lidocaine (local anesthesia for surgery for carpal tunnel syndrome/bone spur removal). At visit 1 of the open-label period (day 25 of the open-label period), his condition remained improved (in relation to before starting double-blind therapy). However, he did report experiencing a relationship problem that was causing an increase in depressive symptoms, according to the investigator's reporting form. The patient did not express any suicidal ideation to the investigator, and the HAM-D_{17} and Montgomery-Åsberg Depression Rating Scale items for suicidal ideation were 0, as they had been throughout the course of the study. Three days later, on day 28 of the open-label phase (day 87 since starting modafinil therapy), the patient committed suicide (by cutting his wrists and neck with a razor blade). The last day of dosing was reported as day 84. The investigator determined that the suicide was not attributable to treatment with modafinil because of the patient's overall response to treatment and because of the temporal relationship between the reported relationship problems and the suicide.

In this study, as with any clinical study, it is the treating psychiatrist, not the authors of the manuscript, who assesses the relationship of all adverse events to study drug. In reviewing the history associated with these two serious adverse events, the investigators determined that the events were not related to the study drugs and we, the authors, saw no reason to disagree with their assessment.

Nevertheless, the occurrence of relatively infrequent serious adverse events needs to be monitored carefully to ensure that a novel therapy is not associated with some relatively rare pharmacologic or behavioral toxicity. To this end, it is important to note that the safety of modafinil has been evaluated in >3,500 patients in clinical studies, of whom >2,000 were patients with excessive sleepiness associated with a disorder of sleep and wakefulness. In these studies, modafinil was not found to have a clinically significant effect on WBC count or, for that matter, on any hematologic variable. With respect to behavioral toxicity, there were no reports of suicide, suicide attempts, or suicidal ideation in randomized, double-blind clinical studies of modafinil for the treatment of excessive sleepiness associated with narcolepsy, obstructive sleep apnea/hypopnea syndrome, or shift-work sleep disorder. There are postmarketing reports of suicide, suicide attempts, and suicidal ideation in patients who were treated with modafinil. However, the number of such reports does not suggest a pattern and, in such cases, determination of causality is difficult due to the number of confounding factors that can contribute to these events.

With respect to the broader issue of suicide in patients receiving antidepressants, we agree that this is an important public health matter, and the literature offers varied findings on risk of suicide or suicidal ideation with antidepressant therapy.[2-4] The Food and Drug Administration is working with manufacturers of commonly prescribed antidepressants to increase awareness of this issue among clinicians and to evaluate whether such agents are associated with an increased risk.[5] The agency advises clinicians to monitor adult patients being treated with antidepressant medications closely for worsening of depression and increased suicidal thinking or behavior, particularly early in treatment or when the dose is either increased or decreased. It is recommended that any patient with worsening of symptoms or an increase in suicidal thinking or behavior be evaluated by a healthcare professional. Monitoring is also recommended when patients with MDD are taken off medication.

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Further information from the FDA on this topic is anticipated. As is evident, unfortunately, in the case of the patient who completed suicide, even close monitoring and an apparent response to treatment were not sufficient to negate his risk.

Sincerely,
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Dr. Thase is chief of the Division of Adult Academic Psychiatry and director of the Mood Disorders Treatment and Research Program at Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center in Pennsylvania. Dr. Fava is director of the Depression Clinical and Research Program at Massachusetts General Hospital in Boston. Dr. DeBattista is director of the Depression Research Clinic at Stanford University in California. Dr. Arora is a director in the Biostatistics Department at Cephalon, Inc., in Frazer, Pennsylvania. Dr. Hughes is vice president of the Scientific Communications Department at Cephalon, Inc., in Frazer.

Disclosure: Dr. Thase has been a consultant for AstraZeneca, Bristol-Myers Squibb, Cephalon, Cyberonics, Eli Lilly, Forest, GlaxoSmithKline, Janssen, Novartis, Organon, Pfizer, Sepracor, Shire US, and Wyeth; and he is on the speaker's bureau of AstraZeneca, Bristol-Myers Squibb, Cyberonics, Eli Lilly, GlaxoSmithKline, Sanofi Aventis, and Wyeth. Dr. Fava has been a consultant to Cephalon; has received research support from Abbott, Lichtwer, and Lorex; has received honoraria from Bayer, Biovail, BrainCells, Compellis, Cypress, Fabre-Kramer, Grunenthal, Janssen, MedAvante, Sepracor, and Somerset; and has received research support/honoraria from Aspect Medical Systems, AstraZeneca, Bristol-Myers Squibb, Cephalon, Eli Lilly, Forest, GlaxoSmithKline, Johnson & Johnson, Novartis, Organon, Pharmavite, Pfizer, Roche, Sanofi/Synthelabo, Solvay, and Wyeth. Dr. DeBattista has been a consultant for Cephalon; has received grant/research support from Cephalon, Corcept, Eli Lilly, GlaxoSmithKline, and Wyeth; and is on the speaker's bureau of Cephalon, Corcept, Cyberonics, Eli Lilly, GlaxoSmithKline, and Pfizer. Drs. Arora and Hughes do not have any affiliation or financial interested in any organization that might pose a conflict of interest.

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Rozerem™
ramelteon 8-mg tablets

Takeda

Brief Summary of Prescribing Information
05-1114

ROZEREM™
(ramelteon) Tablets

INDICATIONS AND USAGE
ROZEREM is indicated for the treatment of insomnia characterized by difficulty with sleep onset.

CONTRAINDICATIONS
ROZEREM is contraindicated in patients with a hypersensitivity to ramelteon or any components of the ROZEREM formulation.

WARNINGS
Since sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit after a reasonable period of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Worsening of insomnia, or the emergence of new cognitive or behavioral abnormalities, may be the result of an unrecognized underlying psychiatric or physical disorder and requires further evaluation of the patient. As with other hypnotics, exacerbation of insomnia and emergence of cognitive and behavioral abnormalities were seen with ROZEREM during the clinical development program.

ROZEREM should not be used by patients with severe hepatic impairment.

ROZEREM should not be used in combination with fluvoxamine (see **PRECAUTIONS: Drug Interactions**).

A variety of cognitive and behavior changes have been reported to occur in association with the use of hypnotics. In primarily depressed patients, worsening of depression, including suicidal ideation, has been reported in association with the use of hypnotics.

Patients should avoid engaging in hazardous activities that require concentration (such as operating a motor vehicle or heavy machinery) after taking ROZEREM.

After taking ROZEREM, patients should confine their activities to those necessary to prepare for bed.

PRECAUTIONS
General
ROZEREM has not been studied in subjects with severe sleep apnea or severe COPD and is not recommended for use in those populations.

Patients should be advised to exercise caution if they consume alcohol in combination with ROZEREM.

Use in Adolescents and Children
ROZEREM has been associated with an effect on reproductive hormones in adults, e.g. decreased testosterone levels and increased prolactin levels. It is not known what effect chronic or even chronic intermittent use of ROZEREM may have on the reproductive axis in developing humans (see **Pediatric Use**).

Information for Patients
Patients should be advised to take ROZEREM within 30 minutes prior to going to bed and should confine their activities to those necessary to prepare for bed.

Patients should be advised to avoid engaging in hazardous activities (such as operating a motor vehicle or heavy machinery) after taking ROZEREM.

Patients should be advised that they should not take ROZEREM with or immediately after a high fat meal.

Patients should be advised to consult their health care provider if they experience worsening of insomnia or any new behavioral signs or symptoms of concern.

Patients should consult their health care provider if they experience one of the following: cessation of menses or galactorrhea in females, decreased libido, or problems with fertility.

Laboratory Tests
No standard monitoring is required.

For patients presenting with unexplained amenorrhea, galactorrhea, decreased libido, or problems with fertility, assessment of prolactin levels and testosterone levels should be considered as appropriate.

Drug Interactions
ROZEREM has a highly variable inter-subject pharmacokinetic profile (approximately 100% coefficient of variation in C_{max} and AUC). As noted above, CYP1A2 is the major isozyme involved in the metabolism of ROZEREM; the CYP2C subfamily and CYP3A4 isozymes are also involved to a minor degree.

Effects of Other Drugs on ROZEREM Metabolism
Fluvoxamine (strong CYP1A2 inhibitor): When fluvoxamine 100 mg twice daily was administered for 3 days prior to single-dose co-administration of ROZEREM 16 mg and fluvoxamine, the $AUC_{0\text{-}inf}$ for ramelteon increased approximately 190-fold, and the C_{max} increased approximately 70-fold, compared to ROZEREM administered alone. ROZEREM should not be used in combination with fluvoxamine (See WARNINGS). Other less potent CYP1A2 inhibitors have not been adequately studied. ROZEREM should be administered with caution to patients taking less strong CYP1A2 inhibitors.

Rifampin (strong CYP enzyme inducer): Administration of rifampin 600 mg once daily for 11 days resulted in a mean decrease of approximately 80% (40% to 90%) in total exposure to ramelteon and metabolite M-II, (both $AUC_{0\text{-}inf}$ and C_{max}) after a single 32 mg dose of ROZEREM. Efficacy may be reduced when ROZEREM is used in combination with strong CYP enzyme inducers such as rifampin.

Ketoconazole (strong CYP3A4 inhibitor): The $AUC_{0\text{-}inf}$ and C_{max} of ramelteon increased by approximately 84% and 36%, respectively, when a single 16 mg dose of ROZEREM was administered on the fourth day of ketoconazole 200 mg twice daily administration, compared to administration of ROZEREM alone. Similar increases were seen in M-II pharmacokinetic variables. ROZEREM should be administered with caution in subjects taking strong CYP3A4 inhibitors such as ketoconazole.

Fluconazole (strong CYP2C9 inhibitor): The total and peak systemic exposure ($AUC_{0\text{-}inf}$ and C_{max}) of ramelteon after a single 16 mg dose of ROZEREM was increased by approximately 150% when administered with fluconazole. Similar increases were also seen in M-II exposure. ROZEREM should be administered with caution in subjects taking strong CYP2C9 inhibitors such as fluconazole.

Interaction studies of concomitant administration of ROZEREM with fluoxetine (CYP2D6 inhibitor), omeprazole (CYP1A2 inducer/CYP2C19 inhibitor), theophylline (CYP1A2 substrate), and dextromethorphan (CYP2D6 substrate) did not produce clinically meaningful changes in either peak or total exposures to ramelteon or the M-II metabolite.

Effects of ROZEREM on Metabolism of Other Drugs
Concomitant administration of ROZEREM with omeprazole (CYP2C19 substrate), dextromethorphan (CYP2D6 substrate), midazolam (CYP3A4 substrate), theophylline (CYP1A2 substrate), digoxin (p-glycoprotein substrate), and warfarin (CYP2C9 [S]/CYP1A2 [R] substrate) did not produce clinically meaningful changes in peak and total exposures to these drugs.

Effect of Alcohol on Rozerem
Alcohol: With single-dose, daytime co-administration of ROZEREM 32 mg and alcohol (0.6 g/kg), there were no clinically meaningful or statistically significant effects on peak or total exposure to ROZEREM. However, an additive effect was seen on some measures of psychomotor performance (i.e., the Digit Symbol Substitution Test, the Psychomotor Vigilance Task Test, and a Visual Analog Scale of sedation) at some post-dose time points. No additive effect was seen on the Delayed Word Recognition Test. Because alcohol by itself impairs performance, and the intended effect of ROZEREM is to promote sleep, patients should be cautioned not to consume alcohol when using ROZEREM.

Drug/Laboratory Test Interactions
ROZEREM is not known to interfere with commonly used clinical laboratory tests. In addition, *in vitro* data indicate that ramelteon does not cause false-positive results for benzodiazepines, opiates, barbiturates, cocaine, cannabinoids, or amphetamines in two standard urine drug screening methods *in vitro*.

Carcinogenesis, Mutagenesis, and Impairment of Fertility
Carcinogenesis
In a two-year carcinogenicity study, B6C3F$_1$ mice were administered ramelteon at doses of 0, 30, 100, 300, or 1000 mg/kg/day by oral gavage. Male mice exhibited a dose-related increase in the incidence of hepatic tumors at dose levels ≥100 mg/kg/day including hepatic adenoma, hepatic carcinoma, and hepatoblastoma. Female mice developed a dose-related increase in the incidence of hepatic adenomas at dose levels ≥ 300 mg/kg/day and hepatic carcinoma at the 1000 mg/kg/day dose level. The no-effect level for hepatic tumors in male mice was 30 mg/kg/day (103-times and 3-times the therapeutic exposure to ramelteon and the active metabolite M-II, respectively, at the maximum recommended human dose [MRHD] based on an area-under-the-curve [AUC] comparison). The no-effect level for hepatic tumors in female mice was 100 mg/kg/day (827-times and 12-times the therapeutic exposure to ramelteon and M-II, respectively, at the MRHD based on AUC).

In a two-year carcinogenicity study conducted in the Sprague-Dawley rat, male and female rats were administered ramelteon at doses of 0, 15, 60, 250 or 1000 mg/kg/day by oral gavage. Male rats exhibited a dose-related increase in the incidence of hepatic adenoma and benign Leydig cell tumors of the testis at dose levels ≥ 250 mg/kg/day and hepatic carcinoma at the 1000 mg/kg/day dose level. Female rats exhibited a dose-related increase in the incidence of hepatic adenoma at dose levels ≥ 60 mg/kg/day and hepatic carcinoma at the 1000 mg/kg/day dose level. The no-effect level for hepatic tumors and benign Leydig cell tumors in male rats was 60 mg/kg/day (1,429-times and 12-times the therapeutic exposure to ramelteon and M-II, respectively, at the MRHD based on AUC). The no-effect level for hepatic tumors in female rats was 15 mg/kg/day (472-times and 16-times the therapeutic exposure to ramelteon and M-II, respectively, at the MRHD based on AUC).

The development of hepatic tumors in rodents following chronic treatment with non-genotoxic compounds may be secondary to microsomal enzyme induction, a mechanism for tumor generation not thought to occur in humans. Leydig cell tumor development following treatment with non-genotoxic compounds in rodents has been linked to reductions in circulating testosterone levels with compensatory increases in luteinizing hormone release, which is a known proliferative stimulus to Leydig cells in the rat testis. Rat Leydig cells are more sensitive to the stimulatory effects of luteinizing hormone than human Leydig cells. In mechanistic studies conducted in the rat, daily ramelteon administration at 250 and 1000 mg/kg/day for 4 weeks was associated with a reduction in plasma testosterone levels. In the same study, luteinizing hormone levels were elevated over a 24 hour period after the last ramelteon treatment; however, the durability of this luteinizing hormone finding and its support for the proposed mechanistic explanation was not clearly established.

Although the rodent tumors observed following ramelteon treatment occurred at plasma levels of ramelteon and M-II in excess of mean clinical plasma concentrations at the MRHD, the relevance of both rodent hepatic tumors and benign rat Leydig cell tumors to humans is not known.

Mutagenesis
Ramelteon was not genotoxic in the following: *in vitro* bacterial reverse mutation (Ames) assay; *in vitro* mammalian cell gene mutation assay using the mouse lymphoma TK$^{+/-}$ cell line; *in vivo/in vitro* unscheduled DNA synthesis assay in rat hepatocytes; and in *in vivo* micronucleus assays conducted in mouse and rat. Ramelteon was positive in the chromosomal aberration assay in Chinese hamster lung cells in the presence of S9 metabolic activation.

Separate studies indicated that the concentration of the M-II metabolite formed by the rat liver S9 fraction used in the *in vitro* genetic toxicology studies described above, exceeded the concentration of ramelteon; therefore, the genotoxic potential of the M-II metabolite was also assessed in these studies.

Impairment of Fertility
Ramelteon was administered to male and female Sprague-Dawley rats in an initial fertility and early embryonic development study at dose levels of 6, 60, or 600 mg/kg/day. No effects on male or female mating or fertility were observed with a ramelteon dose up to 600 mg/kg/day (786-times higher than the MRHD on a mg/m^2 basis). Irregular estrus cycles, reduction in the number of implants, and reduction in the number of live embryos were noted with dosing females at ≥ 60 mg/kg/day (79-times higher than the MRHD on a mg/m^2 basis). A reduction in the number of corpora lutea occurred at the 600 mg/kg/day dose level. Administration of ramelteon up to 600 mg/kg/day to male rats for 7 weeks had no effect on sperm quality and when the treated male rats were mated with untreated female rats there was no effect on implants or embryos. In a repeat of this study using oral administration of ramelteon at 20, 60 or 200 mg/kg/day for the same study duration, females demonstrated irregular estrus cycles with doses ≥ 60 mg/kg/day, but no effects were seen on implantation or embryo viability. The no-effect dose for fertility endpoints was 20 mg/kg/day in females (26-times the MRHD on a mg/m^2 basis) and 600 mg/kg/day in males (786-times higher than the MRHD on a mg/m^2 basis) when considering all studies.

Pregnancy: Pregnancy Category C
Ramelteon has been shown to be a developmental teratogen in the rat when given in doses 197 times higher than the maximum recommended human dose [MRHD] on a mg/m^2 basis. There are no adequate and well-controlled studies in pregnant women. Ramelteon should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

The effects of ramelteon on embryo-fetal development were assessed in both the rat and rabbit. Pregnant rats were administered ramelteon by oral gavage at doses of 0, 10, 40, 150, or 600 mg/kg/day during gestation days 6-17, which is the period of organogenesis in this species. Evidence of maternal toxicity and fetal teratogenicity was observed at doses greater than or equal to 150 mg/kg/day. Maternal toxicity was chiefly characterized by decreased body weight and, at 600 mg/kg/day, ataxia and decreased spontaneous movement. At maternally toxic doses (150 mg/kg/day or greater), the fetuses demonstrated visceral malformations consisting of diaphragmatic hernia and minor anatomical variations of the skeleton (irregularly shaped scapula). At 600 mg/kg/day, reductions in fetal body weights and malformations including cysts on the external genitalia were additionally observed. The no-effect level for teratogenicity in this study was 40 mg/kg/day (1,892-times and 45-times higher than the therapeutic exposure to ramelteon and the active metabolite M-II, respectively, at the MRHD based on an area-under-the-curve [AUC] comparison). Pregnant rabbits were administered ramelteon by oral gavage at doses of 0, 12, 60, or 300 mg/kg/day during gestation days 6-18, which is the period of organogenesis in this species. Although maternal toxicity was apparent with a ramelteon dose of 300 mg/kg/day, no evidence of fetal effects or teratogenicity was associated with any dose level. The no-effect level for teratogenicity was, therefore, 300 mg/kg/day (11,862-times and 99-times higher than the therapeutic exposure to ramelteon and M-II, respectively, at the MRHD based on AUC).

The effects of ramelteon on pre- and post-natal development in the rat were studied by administration of ramelteon to the pregnant rat by oral gavage at doses of 0, 30, 100, or 300 mg/kg/day from day 6 of gestation through parturition to postnatal (lactation) day 21, at which time offspring were weaned. Maternal toxicity was noted at doses of 100 mg/kg/day or greater and consisted of reduced body weight gain and increased adrenal gland weight. Reduced body weight during the post-weaning period was also noticed in the offspring of the groups given 100 mg/kg/day and higher. Offspring in the 300 mg/kg/day group demonstrated physical and developmental delays including delayed eruption of the lower incisors, a delayed acquisition of the righting reflex, and an alteration of emotional response. These delays are often observed in the presence of reduced offspring body weight but may still be indicative of developmental delay. An apparent decrease in the viability of offspring in the 300 mg/kg/day group was likely due to altered maternal behavior and function observed at this dose level. Offspring of the 300 mg/kg/day group also showed evidence of diaphragmatic hernia, a finding observed in the embryo-fetal development study previously described. There were no effects on the reproductive capacity of offspring and the resulting progeny were not different from those of vehicle-treated offspring. The no-effect level for pre- and postnatal development in this study was 30 mg/kg/day (39-times higher than the MRHD on a mg/m^2 basis).

Labor and Delivery
The potential effects of ROZEREM on the duration of labor and/or delivery, for either the mother or the fetus, have not been studied. ROZEREM has no established use in labor and delivery.

Nursing Mothers
Ramelteon is secreted into the milk of lactating rats. It is not known whether this drug is excreted in human milk. No clinical studies in nursing mothers have been performed. The use of ROZEREM in nursing mothers is not recommended.

Pediatric Use
Safety and effectiveness of ROZEREM in pediatric patients have not been established. Further study is needed prior to determining that this product may be used safely in pre-pubescent and pubescent patients.

Geriatric Use
A total of 654 subjects in double-blind, placebo-controlled, efficacy trials who received ROZEREM were at least 65 years of age; of these, 199 were 75 years of age or older. No overall differences in safety or efficacy were observed between elderly and younger adult subjects.

ADVERSE REACTIONS
Overview
The data described in this section reflect exposure to ROZEREM in 4251 subjects, including 346 exposed for 6 months or longer, and 473 subjects for one year.

Adverse Reactions Resulting in Discontinuation of Treatment
Five percent of the 3594 individual subjects exposed to ROZEREM in clinical studies discontinued treatment owing to an adverse event, compared with 2% of the 1370 subjects receiving placebo. The most frequent adverse events leading to discontinuation in subjects receiving ROZEREM were somnolence (0.8%), dizziness (0.5%), nausea (0.3%), fatigue (0.3%), headache (0.3%), and insomnia (0.3%).

ROZEREM Most Commonly Observed Adverse Events in Phase 1-3 trials
The incidence of adverse events during the Phase 1 through 3 trials (% placebo, n=1370; % ramelteon [8 mg], n=1250) were: headache NOS (7%, 7%), somnolence (3%, 5%), fatigue (2%, 4%), dizziness (3%, 5%), nausea (2%, 3%), insomnia exacerbated (2%, 3%), upper respiratory tract infection NOS (2%, 3%), diarrhea NOS (2%, 2%), myalgia (1%, 2%), depression (1%, 2%), dysgeusia (1%, 2%), arthralgia (1%, 2%), influenza (0, 1%), blood cortisol decreased (0, 1%)

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 clinical trials of other drugs, and may not reflect the rates observed in practice. The adverse reaction information from clinical trials does, however, provide a basis for identifying the adverse events that appear to be related to drug use and for approximating rates.

DRUG ABUSE AND DEPENDENCE
ROZEREM is not a controlled substance.

Human Data: See the CLINICAL TRIALS section, Studies Pertinent to Safety Concerns for Sleep-Promoting Agents in the Complete Prescribing Information.

Animal Data. Ramelteon did not produce any signals from animal behavioral studies indicating that the drug produces rewarding effects. Monkeys did not self-administer ramelteon and the drug did not induce a conditioned place preference in rats. There was no generalization between ramelteon and midazolam. Ramelteon did not affect rotorod performance, an indicator of disruption of motor function, and it did not potentiate the ability of diazepam to interfere with rotorod performance.

Discontinuation of ramelteon in animals or in humans after chronic administration did not produce withdrawal signs. Ramelteon does not appear to produce physical dependence.

OVERDOSAGE
Signs and Symptoms
No cases of ROZEREM overdose have been reported during clinical development.

ROZEREM was administered in single doses up to 160 mg in an abuse liability trial. No safety or tolerability concerns were seen.

Recommended Treatment
General symptomatic and supportive measures should be used, along with immediate gastric lavage where appropriate. Intravenous fluids should be administered as needed. As in all cases of drug overdose, respiration, pulse, blood pressure, and other appropriate vital signs should be monitored, and general supportive measures employed.

Hemodialysis does not effectively reduce exposure to ROZEREM. Therefore, the use of dialysis in the treatment of overdosage is not appropriate.

Poison Control Center
As with the management of all overdosage, the possibility of multiple drug ingestion should be considered. The physician may contact a poison control center for current information on the management of overdosage.

Rx only

Manufactured by:
Takeda Pharmaceutical Company Limited
540-8645 Osaka, JAPAN

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Takeda Ireland Ltd.
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