

SUMMARY OF PRODUCT CHARACTERISTICS

1. Name of the medicinal product

Levetiracetam 500 mg film-coated tablets

Sycocetam

2. Qualitative and quantitative composition

Each tablet contains 500 mg of levetiracetam.

Excipient with known effect

Each tablet also contains 0.026 mg of FD&C Yellow 6 alum lake (sunset yellow). See section 4.4.

For the full list of excipients, see section 6.1.

3. Pharmaceutical form

Tablet.

Simon oblong, biconvex, film-coated tablet scored (non-functional) from two sides.

4. Clinical particulars

4.1 Therapeutic indications

Sycocetam is indicated as monotherapy in the treatment of partial-onset seizures with or without secondary generalisation in adults and adolescents from 16 years of age with newly diagnosed epilepsy.

Sycocetam is indicated as adjunctive therapy

- in the treatment of partial-onset seizures with or without secondary generalisation in adults, adolescents, children and infants from 1 month of age with epilepsy.
- in the treatment of myoclonic seizures in adults and adolescents from 12 years of age with Juvenile Myoclonic Epilepsy.
- in the treatment of primary generalised tonic-clonic seizures in adults and adolescents from 12 years of age with Idiopathic Generalised Epilepsy.

4.2 Posology and method of administration

Posology

Partial onset seizures

The recommended dosing for monotherapy (from 16 years of age) and adjunctive therapy is the same; as outlined below.

All indications

Adults (≥18 years) and adolescents (12 to 17 years) weighing 50 kg or more

The initial therapeutic dose is 500 mg of levetiracetam twice daily. This dose can be started on the first day of treatment. However, a lower initial dose of 250 levetiracetam mg twice daily may be

given based on the physician's assessment of seizure reduction versus potential side effects. This can be increased to 500 mg levetiracetam twice daily after two weeks. Depending upon the clinical response and tolerability, the daily dose can be increased up to 1,500 mg twice daily. Dose changes can be made in 250 mg or 500 mg levetiracetam twice daily increasing or decreasing every two to four weeks.

Adolescents (12 to 17 years) weighing below 50 kg and children from 1 month of age

The physician should prescribe the most appropriate pharmaceutical form, presentation and strength according to weight, age and dose. Refer to the *Paediatric population* section for dosing adjustments based on weight.

Discontinuation

If levetiracetam has to be discontinued it is recommended to withdraw it gradually (*e.g.* in adults and adolescents weighing more than 50 kg: 500 mg levetiracetam decreases twice daily every two to four weeks; in infants older than 6 months, children and adolescents weighing less than 50 kg: dose decrease should not exceed 10 mg levetiracetam /kg twice daily every two weeks; in infants (less than 6 months): dose decrease should not exceed 7 mg levetiracetam /kg twice daily every two weeks).

Special populations

Elderly (65 years and older)

Adjustment of the dose is recommended in elderly patients with compromised renal function (see “Renal impairment” below).

Renal impairment

The daily dose must be individualised according to renal function.

For adult patients, refer to the following table and adjust the dose as indicated. To use this dosing table, an estimate of the patient's creatinine clearance (CLcr) in ml/min is needed.

The CLcr in ml/min may be estimated from serum creatinine (mg/dl) determination, for adults and adolescents weighing 50 kg or more, the following formula:

$$[140 - \text{age (years)}] \times \text{weight (kg)}$$

$$\text{CLcr (ml/min)} = \text{-----} (\times 0.85 \text{ for women})$$

$$72 \times \text{serum creatinine (mg/dl)}$$

Then CLcr is adjusted for body surface area (BSA) as follows:

Dosing adjustment for adult and adolescent patients weighing more than 50 kg with impaired renal

CLcr (ml/min)

$$\text{CLcr (ml/min/1.73 m}^2\text{)} = \text{-----} \times 1.73$$

$$\text{BSA subject (m}^2\text{)}$$

function:

Group	Creatinine clearance (ml/min/1.73m ²)	Dose and frequency
Normal	≥ 80	500 to 1,500 mg levetiracetam twice daily
Mild	50-79	500 to 1,000 mg levetiracetam twice daily
Moderate	30-49	250 to 750 mg levetiracetam twice daily
Severe	< 30	250 to 500 mg levetiracetam twice daily
End-stage renal disease patients undergoing dialysis ⁽¹⁾	-	500 to 1,000 levetiracetam mg once daily ⁽²⁾

(1) A 750 mg loading dose is recommended on the first day of treatment with levetiracetam.

(2) Following dialysis, a 250 to 500 mg levetiracetam supplemental dose is recommended.

For children with renal impairment, the levetiracetam dose needs to be adjusted based on the renal function as levetiracetam clearance is related to renal function. This recommendation is based on a study in adult renally impaired patients.

The CL_{Cr} in ml/min/1.73 m² may be estimated from serum creatinine (mg/dl) determination, for young adolescents, children and infants, using the following formula (Schwartz formula):

$$\text{Height (cm)} \times k_s$$

$$\text{CL}_{Cr} (\text{ml/min/1.73 m}^2) = \frac{\text{Height (cm)} \times k_s}{\text{Serum Creatinine (mg/dl)}}$$

Serum Creatinine (mg/dl)

$k_s = 0.45$ in Term infants to 1 year old; $k_s = 0.55$ in Children to less than 13 years and in adolescent females; $k_s = 0.7$ in adolescent males.

Dosing adjustment for infants, children and adolescent patients weighing less than 50 kg with impaired renal function:

Group	Creatinine clearance (ml/min/1.73m ²)	Dose of levetiracetam and frequency ⁽¹⁾	
		Infants 1 to less than 6 months	Infants 6 to 23 months, children and adolescents weighing less than 50 kg
Normal	≥80	7 to 21 mg/kg (0.07 to 0.21 ml/kg) twice daily	10 to 30 mg/kg (0.10 to 0.30 ml/kg) twice daily
Mild	50-79	7 to 14 mg/kg (0.07 to 0.14 ml/kg) twice daily	10 to 20 mg/kg (0.10 to 0.20 ml/kg) twice daily
Moderate	30-49	3.5 to 10.5 mg/kg (0.035 to 0.105 ml/kg) twice daily	5 to 15 mg/kg (0.05 to 0.15 ml/kg) twice daily
Severe	< 30	3.5 to 7 mg/kg (0.035 to 0.07 ml/kg) twice daily	5 to 10 mg/kg (0.05 to 0.10 ml/kg) twice daily
End-stage renal disease patients undergoing dialysis	--	7 to 14 mg/kg (0.07 to 0.14 ml/kg) once daily ⁽²⁾ ⁽⁴⁾	10 to 20 mg/kg (0.10 to 0.20 ml/kg) once daily ⁽³⁾ ⁽⁵⁾

- (1) levetiracetam oral solution or another suitable pharmaceutical product (refer to the doctor) should be used for doses under 500 mg, for doses not multiple of 250 mg when dosing recommendation is not achievable by taking multiple tablets and for patients unable to swallow tablets.
- (2) A 10.5 mg/kg (0.105 ml/kg) loading dose is recommended on the first day of treatment with levetiracetam.
- (3) A 15 mg/kg (0.15 ml/kg) loading dose is recommended on the first day of treatment with levetiracetam.
- (4) Following dialysis, a 3.5 to 7 mg/kg (0.035 to 0.07 ml/kg) supplemental dose is recommended.
- (5) Following dialysis, a 5 to 10 mg/kg (0.05 to 0.10 ml/kg) supplemental dose is recommended.

Hepatic impairment

No dose adjustment is needed in patients with mild to moderate hepatic impairment. In patients with severe hepatic impairment, the creatinine clearance may underestimate the renal insufficiency. Therefore a 50 % reduction of the daily maintenance dose is recommended when the creatinine clearance is < 60 ml/min/1.73 m².

Paediatric population

The physician should prescribe the most appropriate pharmaceutical form, presentation and strength according to age, weight and dose.

The tablet formulation is not adapted for use in infants and children under the age of 6 years. Sycocetam oral solution is the preferred formulation for use in this population. In addition, the available dose strengths of the tablets are not appropriate for initial treatment in children weighing less than 50 kg, for patients unable to swallow tablets or for the administration of doses below 500 mg. In all of the above cases, Sycocetam oral solution should be used or another suitable pharmaceutical product.

Monotherapy

The safety and efficacy of levetiracetam in children and adolescents below 16 years as monotherapy treatment have not been established.
No data are available.

Adolescents (16 and 17 years of age) weighing 50 kg or more with partial onset seizures with or without secondary generalisation with newly diagnosed epilepsy: Please refer to the above section on *Adults (≥18 years) and adolescents (12 to 17 years) weighing 50 kg or more.*

Add-on therapy for infants aged 6 to 23 months, children (2 to 11 years) and adolescents (12 to 17 years) weighing less than 50 kg

Sycocetam oral solution is the preferred formulation for use in infants and children under the age of 6 years.

For children 6 years and above, Sycocetam oral solution should be used for doses under 500 mg, for doses not multiple of 250 mg when dosing recommendation is not achievable by taking multiple tablets and for patients unable to swallow tablets.

The lowest effective dose should be used for all indications. The starting dose for a child or adolescent of 25 kg should be 250mg levetiracetam twice daily with a maximum dose of 750mg levetiracetam twice daily. The dose in children 50 kg or greater is the same as in adults for all indications.

Please refer to the above section on *Adults (≥ 18 years) and adolescents (12 to 17 years) weighing 50 kg or more* for all indications.

Add-on therapy for infants aged from 1 month to less than 6 months

The oral solution is the formulation to use in infants.

Method of administration

The tablet is taken without splitting or division

The film-coated tablets must be taken orally, swallowed with a sufficient quantity of liquid and may be taken with or without food. After oral administration, the bitter taste of levetiracetam may be experienced. The daily dose is administered in two equally divided doses.

4.3 Contraindications

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

4.4 Special warnings and precautions for use

Renal impairment

The administration of levetiracetam to patients with renal impairment may require dose adjustment. In patients with severely impaired hepatic function, assessment of renal function is recommended before dose selection (see section 4.2).

Acute Kidney Injury

The use of levetiracetam has been very rarely associated with acute kidney injury, with a time to onset ranging from a few days to several months.

Blood cell counts

Rare cases of decreased blood cell counts (neutropenia, agranulocytosis, leucopenia, thrombocytopenia and pancytopenia) have been described in association with levetiracetam administration, generally at the beginning of the treatment. Complete blood cell counts are advised in patients experiencing important weakness, pyrexia, recurrent infections or coagulation disorders (section 4.8).

Suicide

Suicide, suicide attempts, suicidal ideation and behaviour have been reported in patients treated with anti-epileptic agents (including levetiracetam). A meta-analysis of randomized placebo-controlled trials of anti-epileptic medicinal products has shown a small increased risk of suicidal thoughts and behaviour. The mechanism of this risk is not known.

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

Abnormal and aggressive behaviours

Levetiracetam may cause psychotic symptoms and behavioural abnormalities including irritability and aggressiveness. Patients treated with levetiracetam should be monitored for developing psychiatric signs suggesting important mood and/or personality changes. If such behaviours are noticed, treatment adaptation or gradual discontinuation should be considered. If discontinuation is considered, please refer to section 4.2.

Worsening of seizures

As with other types of antiepileptic drugs, levetiracetam may rarely exacerbate seizure frequency or severity. This paradoxical effect was mostly reported within the first month after levetiracetam initiation or increase of the dose and was reversible upon drug discontinuation or dose decrease. Patients should be advised to consult their physician immediately in case of aggravation of epilepsy.

Electrocardiogram QT interval prolongation

Rare cases of ECG QT interval prolongation have been observed during the post-marketing surveillance. Levetiracetam should be used with caution in patients with QTc-interval prolongation, in patients concomitantly treated with drugs affecting the QTc-interval, or in patients with relevant pre-existing cardiac disease or electrolyte disturbances.

Paediatric population

The tablet formulation is not adapted for use in infants and children under the age of 6 years. Available data in children did not suggest an impact on growth and puberty. However, long-term effects on learning, intelligence, growth, endocrine function, puberty and childbearing potential in children remain unknown.

Excipients

This medicine contains **FD&C Yellow 6 alum lake (sunset yellow)** and may cause allergic reactions.

4.5 Interaction with other medicinal products and other forms of interaction

Antiepileptic medicinal products

Pre-marketing data from clinical studies conducted in adults indicate that levetiracetam did not influence the serum concentrations of existing antiepileptic medicinal products (phenytoin, carbamazepine, valproic acid, phenobarbital, lamotrigine, gabapentin and primidone) and that these antiepileptic medicinal products did not influence the pharmacokinetics of levetiracetam. As in adults, there is no evidence of clinically significant medicinal product interactions in paediatric patients receiving up to 60 mg/kg/day levetiracetam.

A retrospective assessment of pharmacokinetic interactions in children and adolescents with epilepsy (4 to 17 years) confirmed that adjunctive therapy with orally administered levetiracetam did not influence the steady-state serum concentrations of concomitantly administered carbamazepine and valproate. However, data suggested a 20 % higher levetiracetam clearance in children taking enzyme-inducing antiepileptic medicinal products. Dose adjustment is not required.

Probenecid

Probenecid (500 mg four times daily), a renal tubular secretion blocking agent, has been shown to inhibit the renal clearance of the primary metabolite, but not of levetiracetam. Nevertheless, the concentration of this metabolite remains low.

Methotrexate

Concomitant administration of levetiracetam and methotrexate has been reported to decrease methotrexate clearance, resulting in increased/prolonged blood methotrexate concentration to potentially toxic levels. Blood methotrexate and levetiracetam levels should be carefully monitored in patients treated concomitantly with the two drugs.

Oral contraceptives and other pharmacokinetics interactions

Levetiracetam 1,000 mg daily did not influence the pharmacokinetics of oral contraceptives (ethinylestradiol and levonorgestrel); endocrine parameters (luteinizing hormone and progesterone) were not modified. Levetiracetam 2,000 mg daily did not influence the pharmacokinetics of digoxin and warfarin; prothrombin times were not modified. Co-administration with digoxin, oral contraceptives and warfarin did not influence the pharmacokinetics of levetiracetam.

Laxatives

There have been isolated reports of decreased levetiracetam efficacy when the osmotic laxative macrogol has been concomitantly administered with oral levetiracetam. Therefore, macrogol should not be taken orally for one hour before and for one hour after taking levetiracetam.

Food and alcohol

The extent of absorption of levetiracetam was not altered by food, but the rate of absorption was slightly reduced. No data on the interaction of levetiracetam with alcohol are available.

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Specialist advice should be given to women who are of childbearing potential. Treatment with levetiracetam should be reviewed when a woman is planning to become pregnant. As with all antiepileptic medicines, sudden discontinuation of levetiracetam should be avoided as this may lead to breakthrough seizures that could have serious consequences for the woman and the unborn child. Monotherapy should be preferred whenever possible because therapy with multiple antiepileptic medicines AEDs could be associated with a higher risk of congenital malformations than monotherapy, depending on the associated antiepileptics.

Pregnancy

A large amount of postmarketing data on pregnant women exposed to levetiracetam monotherapy (more than 1800, among which more than 1500 exposure occurred during the 1st trimester) do not suggest an increase in the risk for major congenital malformations. Only limited evidence is available on the neurodevelopment of children exposed to levetiracetam monotherapy in utero. However, current epidemiological studies (on about 100 children) do not suggest an increased risk of neurodevelopmental disorders or delays.

Levetiracetam can be used during pregnancy if after careful assessment it is considered clinically needed. In such cases, the lowest effective dose is recommended. Physiological changes during pregnancy may affect levetiracetam concentration. A decrease in levetiracetam plasma concentrations has been observed during pregnancy. This decrease is more pronounced during the third trimester (up to 60% of baseline concentration before pregnancy). Appropriate clinical management of pregnant women treated with levetiracetam should be ensured.

Breastfeeding

Levetiracetam is excreted in human breast milk. Therefore, breast-feeding is not recommended. However, if levetiracetam treatment is needed during breastfeeding, the benefit/risk of the treatment should be weighed considering the importance of breastfeeding.

Fertility

No clinical data are available, and potential risk for humans is unknown.

4.7 Effects on the ability to drive and use machines

Levetiracetam has a minor or moderate influence on the ability to drive and use machines. Due to possible different individual sensitivity, some patients might experience somnolence or other central nervous system-related symptoms, especially at the beginning of treatment or following a dose increase. Therefore, caution is recommended in those patients when performing skilled tasks, e.g., driving vehicles or operating machinery. Patients are advised not to drive or use machines until it is established that their ability to perform such activities is not affected.

4.8 Undesirable effects

Summary of the safety profile

The most frequently reported adverse reactions were nasopharyngitis, somnolence, headache, fatigue and dizziness. The adverse reaction profile presented below is based on the analysis of pooled placebo-controlled clinical trials with all indications studied, with a total of 3,416 patients treated with levetiracetam. These data are supplemented with the use of levetiracetam in corresponding open-label extension studies, as well as post-marketing experience. The safety profile of levetiracetam is generally similar across age groups (adult and paediatric patients) and the approved epilepsy indications.

Tabulated list of adverse reactions

Adverse reactions reported in clinical studies (adults, adolescents, children and infants > 1 month) and from post-marketing experience are listed in the following table per System Organ Class and per frequency. Adverse reactions are presented in the order of decreasing seriousness and their frequency is defined as follows: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$) and very rare ($< 1/10,000$).

<u>MedDRA SOC</u>	<u>Frequency category</u>			
	<u>Very common</u>	<u>Common</u>	<u>Uncommon</u>	<u>Rare</u>

<u>Infections and infestations</u>	Nasopharyngitis			Infection
<u>Blood and lymphatic system disorders</u>			Thrombocytopenia, leukopenia	Pancytopenia, neutropenia, agranulocytosis
<u>Immune system disorders</u>				Drug reaction with eosinophilia and systemic symptoms (DRESS), Hypersensitivity (including angioedema and anaphylaxis)
<u>Metabolism and nutrition disorders</u>		Anorexia	Weight decreased, weight increase	Hyponatraemia

<u>Psychiatric disorders</u>		Depression, hostility/aggression, anxiety, insomnia, nervousness/irritability	Suicide attempt, suicidal ideation, psychotic disorder, abnormal behaviour, hallucination, anger, confusional state, panic attack, affect lability/mood swings, agitation	Completed suicide, personality disorder, thinking abnormal, delirium
<u>Nervous system disorders</u>	Somnolence, headache	Convulsion, balance disorder, dizziness, lethargy, tremor	Amnesia, memory impairment, coordination abnormal/ataxia, paraesthesia, disturbance in attention	Choreoathetosis, dyskinesia, hyperkinesia, gait disturbance, encephalopathy, seizures aggravated
<u>Eye disorders</u>			Diplopia, vision blurred	
<u>Ear and labyrinth disorders</u>		Vertigo		
<u>Cardiac disorders</u>				Electrocardiogram QT prolonged

<u>Respiratory, thoracic and mediastinal disorders</u>		Cough		
<u>Gastrointestinal disorders</u>		Abdominal pain, diarrhoea, dyspepsia, vomiting, nausea		Pancreatitis
<u>Hepatobiliary disorders</u>			Liver function test abnormal	Hepatic failure, hepatitis
<u>Renal and Urinary Disorders</u>				Acute Kidney Injury
<u>Skin and subcutaneous tissue disorders</u>		Rash	Alopecia, eczema, pruritus,	Toxic epidermal necrolysis, Stevens-Johnson syndrome, erythema multiforme
<u>Musculoskeletal and connective tissue disorders</u>			Muscular weakness, myalgia	Rhabdomyolysis and blood creatine phosphokinase increased*
<u>General disorders and administration site conditions</u>		Asthenia/fatigue		
<u>Injury, poisoning and procedural complications</u>			Injury	

* Prevalence is significantly higher in Japanese patients when compared to non-Japanese patients.

Description of selected adverse reactions

The risk of anorexia is higher when levetiracetam is coadministered with topiramate. In several cases of alopecia, recovery was observed when levetiracetam was discontinued. Bone marrow suppression was identified in some of the cases of pancytopenia. Cases of encephalopathy generally occurred at the beginning of the treatment (a few days to a few months) and were reversible after treatment discontinuation.

Paediatric population

No new safety concerns for levetiracetam were identified for infants less than 12 months of age with epilepsy.

The adverse reaction profile of levetiracetam is generally similar across age groups and the approved

epilepsy indications. Safety results in paediatric patients in placebo-controlled clinical studies were consistent with the safety profile of levetiracetam in adults except for behavioural and psychiatric adverse reactions which were more common in children than in adults. In children and adolescents aged 4 to 16 years, vomiting (very common, 11.2%), agitation (common, 3.4%), mood swings (common, 2.1%), affect lability (common, 1.7%), aggression (common, 8.2%), abnormal behaviour (common, 5.6%), and lethargy (common, 3.9%) were reported more frequently than in other age ranges or the overall safety profile. In infants and children aged 1 month to less than 4 years, irritability (very common, 11.7%) and coordination abnormal (common, 3.3%) were reported more frequently than in other age groups or the overall safety profile.

A double-blind, placebo-controlled paediatric safety study with a non-inferiority design has assessed the cognitive and neuropsychological effects of levetiracetam in children 4 to 16 years of age with partial onset seizures. It was concluded that Sycocetam was not different (non-inferior) from the placebo in the change from baseline of the Leiter-R Attention and Memory, Memory Screen Composite score in the per-protocol population. Results related to behavioural and emotional functioning indicated a worsening in levetiracetam-treated patients on aggressive behaviour as measured in a standardised and systematic way using a validated instrument (CBCL – Achenbach Child Behavior Checklist). However, subjects, who took levetiracetam in the long-term open-label follow-up study, did not experience a worsening, on average, in their behavioural and emotional functioning; in particular measures of aggressive behaviour were not worse than baseline.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the e-PV desktop applications (https://drive.google.com/file/d/16hwTz0587ZWtSWadbBAMwQPOD_KSExZP/view) or search for e-PV Mobile applications on the Google Play or Apple App Store.

4.9 Overdose

Symptoms

Somnolence, agitation, aggression, depressed level of consciousness, respiratory depression and coma were observed with levetiracetam overdoses.

Management of overdose

After an acute overdose, the stomach may be emptied by gastric lavage or by induction of emesis. There is no specific antidote for levetiracetam. Treatment of an overdose will be symptomatic and may include haemodialysis. The dialyser extraction efficiency is 60 % for levetiracetam and 74 % for the primary metabolite.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacological classification: 13.1 Anticonvulsants.

The active substance, levetiracetam, is a pyrrolidone derivative (S-enantiomer of α -ethyl- 2-oxo-1-pyrrolidine acetamide), chemically unrelated to existing antiepileptic active substances.

Mechanism of action

The mechanism of action of levetiracetam remains to be fully elucidated. *In vitro* and *in vivo* experiments suggest that levetiracetam does not alter basic cell characteristics and normal neurotransmission.

In vitro studies show that levetiracetam affects intraneuronal Ca^{2+} levels by partial inhibition of N-type Ca^{2+} currents and by reducing the release of Ca^{2+} from intraneuronal stores. In addition, it partially reverses the reductions in GABA- and glycine-gated currents induced by zinc and β -carbolines. Furthermore, levetiracetam has been shown in *in vitro* studies to bind to a specific site in rodent brain tissue. This binding site is the synaptic vesicle protein 2A, believed to be involved in vesicle fusion and neurotransmitter exocytosis. Levetiracetam and related analogues show a rank order of affinity for binding to the synaptic vesicle protein 2A which correlates with the potency of their anti-seizure protection in the mouse audiogenic model of epilepsy. This finding suggests that the interaction between levetiracetam and the synaptic vesicle protein 2A seems to contribute to the antiepileptic mechanism of action of the medicinal product.

Pharmacodynamic effects

Levetiracetam induces seizure protection in a broad range of animal models of partial and primary generalised seizures without having a pro-convulsant effect. The primary metabolite is inactive. In man, activity in both partial and generalised epilepsy conditions (epileptiform discharge/photo paroxysmal response) has confirmed the broad-spectrum pharmacological profile of levetiracetam.

5.2 Pharmacokinetic properties

Levetiracetam is a highly soluble and permeable compound. The pharmacokinetic profile is linear with low intra- and inter-subject variability. There is no modification of the clearance after repeated administration. There is no evidence for any relevant gender, race or circadian variability. The pharmacokinetic profile is comparable in healthy volunteers and patients with epilepsy. Due to its complete and linear absorption, plasma levels can be predicted from the oral dose of levetiracetam expressed as mg/kg body weight. Therefore, there is no need for plasma-level monitoring of levetiracetam.

A significant correlation between saliva and plasma concentrations has been shown in adults and children (the ratio of saliva/plasma concentrations ranged from 1 to 1.7 for oral tablet formulation and after 4 hours post-dose for oral solution formulation).

Adults' and adolescents' Absorption

Levetiracetam is rapidly absorbed after oral administration. Oral absolute bioavailability is close to 100 %.

Peak plasma concentrations (C_{max}) are achieved at 1.3 hours after dosing. A steady-state is achieved after two days of a twice-daily administration schedule.

Peak concentrations (C_{max}) are typically 31 and 43 µg/ml following a single 1,000 mg dose and repeated 1,000 mg twice daily dose, respectively.

The extent of absorption is dose-independent and is not altered by food.

Distribution

No tissue distribution data are available in humans.

Neither levetiracetam nor its primary metabolite is significantly bound to plasma proteins (< 10 %). The volume of distribution of levetiracetam is approximately 0.5 to 0.7 l/kg, a value close to the total body water volume.

Biotransformation

Levetiracetam is not extensively metabolised in humans. The major metabolic pathway (24 % of the dose) is an enzymatic hydrolysis of the acetamide group. Production of the primary metabolite, ucb L057, is not supported by liver cytochrome P450 isoforms.

Hydrolysis of the acetamide group was measurable in a large number of tissues including blood cells. The metabolite ucb L057 is pharmacologically inactive.

Two minor metabolites were also identified. One was obtained by hydroxylation of the pyrrolidone ring (1.6 % of the dose) and the other one by opening the pyrrolidone ring (0.9 % of the dose). Other unidentified components accounted only for 0.6 % of the dose.

No enantiomeric interconversion was evidenced *in vivo* for either levetiracetam or its primary metabolite.

In vitro, levetiracetam and its primary metabolite have been shown not to inhibit the major human liver cytochrome P450 isoforms (CYP3A4, 2A6, 2C9, 2C19, 2D6, 2E1 and 1A2), glucuronyl transferase (UGT1A1 and UGT1A6) and epoxide hydroxylase activities. In addition, levetiracetam does not affect the *in vitro* glucuronidation of valproic acid.

In human hepatocytes in culture, levetiracetam had little or no effect on CYP1A2, SULT1E1 or UGT1A1. Levetiracetam caused mild induction of CYP2B6 and CYP3A4.

The *in vitro* data and *in vivo* interaction data on oral contraceptives, digoxin and warfarin indicate that no significant enzyme induction is expected *in vivo*. Therefore, the interaction of Sycocetam with other substances, or *vice versa*, is unlikely.

Elimination

The plasma half-life in adults was 7±1 hours and did not vary either with dose, route of administration or repeated administration. The mean total body clearance was 0.96 ml/min/kg. The major route of excretion was via urine, accounting for a mean of 95 % of the dose (approximately 93 % of the dose was excreted within 48 hours). Excretion *via* faeces accounted for only 0.3 % of the dose.

The cumulative urinary excretion of levetiracetam and its primary metabolite accounted for 66 % and 24 % of the dose, respectively during the first 48 hours.

The renal clearance of levetiracetam and ucb L057 is 0.6 and 4.2 ml/min/kg respectively indicating that levetiracetam is excreted by glomerular filtration with subsequent tubular reabsorption and that the primary metabolite is also excreted by active tubular secretion in addition to glomerular filtration. Levetiracetam elimination is correlated to creatinine clearance.

Elderly

In the elderly, the half-life is increased by about 40 % (10 to 11 hours). This is related to the decrease in renal function in this population (see section 4.2).

Renal impairment

The apparent body clearance of both levetiracetam and its primary metabolite is correlated to the creatinine clearance. It is therefore recommended to adjust the maintenance daily dose of Sycocetam, based on creatinine clearance in patients with moderate and severe renal impairment (see section 4.2).

In anuric end-stage renal disease adult subjects the half-life was approximately 25 and 3.1 hours during interdialytic and intradialytic periods, respectively.

The fractional removal of levetiracetam was 51 % during a typical 4-hour dialysis session.

Hepatic impairment

In subjects with mild and moderate hepatic impairment, there was no relevant modification of the clearance of levetiracetam. In most subjects with severe hepatic impairment, the clearance of levetiracetam was reduced by more than 50 % due to a concomitant renal impairment (see section 4.2).

Paediatric population

Children (4 to 12 years)

Following single oral dose administration (20 mg/kg) to epileptic children (6 to 12 years), the half-life of levetiracetam was 6.0 hours. The apparent body weight-adjusted clearance was approximately 30 % higher than in epileptic adults.

Following repeated oral dose administration (20 to 60 mg/kg/day) to epileptic children (4 to 12 years), levetiracetam was rapidly absorbed. Peak plasma concentration was observed 0.5 to 1.0 hours after dosing. Linear and dose-proportional increases were observed for peak plasma concentrations and area under the curve. The elimination half-life was approximately 5 hours. The apparent body clearance was 1.1 ml/min/kg.

Infants and children (1 month to 4 years)

Following single-dose administration (20 mg/kg) of a 100 mg/ml oral solution to epileptic children (1 month to 4 years), levetiracetam was rapidly absorbed and peak plasma concentrations were

observed approximately 1 hour after dosing. The pharmacokinetic results indicated that half-life was shorter (5.3 h) than for adults (7.2 h) and apparent clearance was faster (1.5 ml/min/kg) than for adults (0.96 ml/min/kg).

In the population pharmacokinetic analysis conducted in patients from 1 month to 16 years of age, body weight was significantly correlated to apparent clearance (clearance increased with an increase in body weight) and apparent volume of distribution. Age also influenced both parameters. This effect was pronounced for the younger infants, and subsided as age increased, to become negligible around 4 years of age.

In both population pharmacokinetic analyses, there was about a 20 % increase in apparent clearance of levetiracetam when it was co-administered with an enzyme-inducing antiepileptic medicinal product.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, genotoxicity and carcinogenic potential.

Adverse effects not observed in clinical studies but seen in the rat and to a lesser extent in the mouse at exposure levels similar to human exposure levels and with possible relevance for clinical use were liver changes, indicating an adaptive response such as increased weight and centrilobular hypertrophy, fatty infiltration and increased liver enzymes in plasma.

No adverse reactions on male or female fertility or reproduction performance were observed in rats at doses up to 1800 mg/kg/day (x 6 the MRHD on a mg/m² or exposure basis) in parents and F1 generation.

Two embryo-foetal development (EFD) studies were performed in rats at 400, 1200 and 3600 mg/kg/day. At 3600 mg/kg/day, in only one of the 2 EFD studies, there was a slight decrease in foetal weight associated with a marginal increase in skeletal variations/minor anomalies. There was no effect on embryo mortality and no increased incidence of malformations. The NOAEL (No Observed Adverse Effect Level) was 3600 mg/kg/day for pregnant female rats (x 12 the MRHD on a mg/m² basis) and 1200 mg/kg/day for foetuses.

Four embryo-foetal development studies were performed in rabbits covering doses of 200, 600, 800, 1200 and 1800 mg/kg/day. The dose level of 1800 mg/kg/day induced a marked maternal toxicity and a decrease in foetal weight associated with increased incidence of foetuses with cardiovascular/skeletal anomalies. The NOAEL was < 200 mg/kg/day for the dams and 200 mg/kg/day for the foetuses (equal to the MRHD on a mg/m² basis).

A peri- and post-natal development study was performed in rats with levetiracetam doses of 70, 350 and 1800 mg/kg/day. The NOAEL was ≥ 1800 mg/kg/day for the F0 females and the survival, growth and development of the F1 offspring up to weaning (x 6 the MRHD on a mg/m² basis).

Neonatal and juvenile animal studies in rats and dogs demonstrated that there were no adverse effects seen in any of the standard developmental or maturation endpoints at doses up to 1800 mg/kg/day (x 6 – 17 the MRHD on a mg/m² basis).

6. Pharmaceutical particulars

6.1 List of excipients

Maize starch
Microcrystalline cellulose
Copovidone
Croscarmellose sodium
Colloidal anhydrous silica
Magnesium stearate
Opadry II 85F18422 white
FD&C Yellow 6 Alum Lake (sunset yellow)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 months.

6.4 Special precautions for storage

Store below 30°C.

6.5 Nature and contents of the container

The tablets are packed in PVC/PVDC/Alu blister strips.

Pack sizes: 2 x 10 tablets.

6.6 Special precautions for disposal and handling

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. APPLICANT

Orange Health
26 Kenmark Crescent
Bluffhill Industrial Park
Harare

8. MANUFACTURERS

Marcyrl Pharmaceutical Industries
El Obour City, The West Extension
Block 20005
Egypt

9. REGISTRATION DETAILS

Zimbabwe registration number: 2023/13.1/6454

Zimbabwe category for distribution: Prescription Preparations Tenth Schedule (P.P.10)

10. DATE OF REVISION OF TEXT

November 2023