



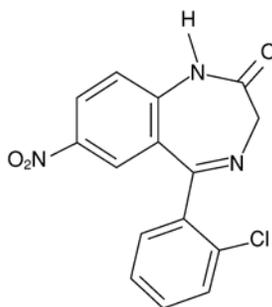
## KLONOPIN<sup>®</sup> TABLETS (clonazepam)

### Rx only

### DESCRIPTION

Klonopin, a benzodiazepine, is available as scored tablets with a K-shaped perforation containing 0.5 mg of clonazepam and unscored tablets with a K-shaped perforation containing 1 mg or 2 mg of clonazepam. Each tablet also contains lactose, magnesium stearate, microcrystalline cellulose and corn starch, with the following colorants: 0.5 mg—FD&C Yellow No. 6 Lake; 1 mg—FD&C Blue No. 1 Lake and FD&C Blue No. 2 Lake.

Chemically, clonazepam is 5-(2-chlorophenyl)-1,3-dihydro-7-nitro-2H-1,4-benzodiazepin-2-one. It is a light yellow crystalline powder. It has a molecular weight of 315.72 and the following structural formula:



### CLINICAL PHARMACOLOGY

**Pharmacodynamics:** The precise mechanism by which clonazepam exerts its antiseizure and antipanic effects is unknown, although it is believed to be related to its ability to enhance the activity of gamma aminobutyric acid (GABA), the major inhibitory neurotransmitter in the central nervous system. Convulsions produced in rodents by pentylenetetrazol or, to a lesser extent, electrical stimulation are antagonized, as are convulsions produced by photic stimulation in susceptible baboons. A taming effect in aggressive primates, muscle weakness and hypnosis are also produced. In humans, clonazepam is capable of suppressing the spike and wave discharge in absence seizures (petit mal) and decreasing the frequency, amplitude, duration and spread of discharge in minor motor seizures.

**Pharmacokinetics:** Clonazepam is rapidly and completely absorbed after oral administration. The absolute bioavailability of clonazepam is about 90%. Maximum plasma concentrations of clonazepam are reached within 1 to 4 hours after oral administration. Clonazepam is approximately 85% bound to plasma proteins. Clonazepam is highly metabolized, with less than 2% unchanged clonazepam being excreted in the urine. Biotransformation occurs mainly by reduction of the 7-nitro group

to the 4-amino derivative. This derivative can be acetylated, hydroxylated and glucuronidated. Cytochrome P-450 including CYP3A, may play an important role in clonazepam reduction and oxidation. The elimination half-life of clonazepam is typically 30 to 40 hours. Clonazepam pharmacokinetics are dose-independent throughout the dosing range. There is no evidence that clonazepam induces its own metabolism or that of other drugs in humans.

*Pharmacokinetics in Demographic Subpopulations and in Disease States:* Controlled studies examining the influence of gender and age on clonazepam pharmacokinetics have not been conducted, nor have the effects of renal or liver disease on clonazepam pharmacokinetics been studied. Because clonazepam undergoes hepatic metabolism, it is possible that liver disease will impair clonazepam elimination. Thus, caution should be exercised when administering clonazepam to these patients.

*Clinical Trials: Panic Disorder:* The effectiveness of Klonopin in the treatment of panic disorder was demonstrated in two double-blind, placebo-controlled studies of adult outpatients who had a primary diagnosis of panic disorder (DSM-III-R) with or without agoraphobia. In these studies, Klonopin was shown to be significantly more effective than placebo in treating panic disorder on change from baseline in panic attack frequency, the Clinician's Global Impression Severity of Illness Score and the Clinician's Global Impression Improvement Score.

Study 1 was a 9-week, fixed-dose study involving Klonopin doses of 0.5, 1, 2, 3 or 4 mg/day or placebo. This study was conducted in four phases: a 1-week placebo lead-in, a 3-week upward titration, a 6-week fixed dose and a 7-week discontinuance phase. A significant difference from placebo was observed consistently only for the 1 mg/day group. The difference between the 1 mg dose group and placebo in reduction from baseline in the number of full panic attacks was approximately 1 panic attack per week. At endpoint, 74% of patients receiving clonazepam 1 mg/day were free of full panic attacks, compared to 56% of placebo-treated patients.

Study 2 was a 6-week, flexible-dose study involving Klonopin in a dose range of 0.5 to 4 mg/day or placebo. This study was conducted in three phases: a 1-week placebo lead-in, a 6-week optimal-dose and a 6-week discontinuance phase. The mean clonazepam dose during the optimal dosing period was 2.3 mg/day. The difference between Klonopin and placebo in reduction from baseline in the number of full panic attacks was approximately 1 panic attack per week. At endpoint, 62% of patients receiving clonazepam were free of full panic attacks, compared to 37% of placebo-treated patients.

Subgroup analyses did not indicate that there were any differences in treatment outcomes as a function of race or gender.

## **INDICATIONS AND USAGE**

*Seizure Disorders:* Klonopin is useful alone or as an adjunct in the treatment of the Lennox-Gastaut syndrome (petit mal variant), akinetic and myoclonic seizures. In patients with absence seizures (petit mal) who have failed to respond to succinimides, Klonopin may be useful.

In some studies, up to 30% of patients have shown a loss of anticonvulsant activity, often within 3 months of administration. In some cases, dosage adjustment may reestablish efficacy.

***Panic Disorder:*** Klonopin is indicated for the treatment of panic disorder, with or without agoraphobia, as defined in DSM-IV. Panic disorder is characterized by the occurrence of unexpected panic attacks and associated concern about having additional attacks, worry about the implications or consequences of the attacks, and/or a significant change in behavior related to the attacks.

The efficacy of Klonopin was established in two 6- to 9-week trials in panic disorder patients whose diagnoses corresponded to the DSM-III-R category of panic disorder (see CLINICAL PHARMACOLOGY: *Clinical Trials*).

Panic disorder (DSM-IV) is characterized by recurrent unexpected panic attacks, ie, a discrete period of intense fear or discomfort in which four (or more) of the following symptoms develop abruptly and reach a peak within 10 minutes: (1) palpitations, pounding heart or accelerated heart rate; (2) sweating; (3) trembling or shaking; (4) sensations of shortness of breath or smothering; (5) feeling of choking; (6) chest pain or discomfort; (7) nausea or abdominal distress; (8) feeling dizzy, unsteady, lightheaded or faint; (9) derealization (feelings of unreality) or depersonalization (being detached from oneself); (10) fear of losing control; (11) fear of dying; (12) paresthesias (numbness or tingling sensations); (13) chills or hot flushes.

The effectiveness of Klonopin in long-term use, that is, for more than 9 weeks, has not been systematically studied in controlled clinical trials. The physician who elects to use Klonopin for extended periods should periodically reevaluate the long-term usefulness of the drug for the individual patient (see DOSAGE AND ADMINISTRATION).

## **CONTRAINDICATIONS**

Klonopin should not be used in patients with a history of sensitivity to benzodiazepines, nor in patients with clinical or biochemical evidence of significant liver disease. It may be used in patients with open angle glaucoma who are receiving appropriate therapy but is contraindicated in acute narrow angle glaucoma.

## **WARNINGS**

***Interference With Cognitive and Motor Performance:*** Since Klonopin produces CNS depression, patients receiving this drug should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating machinery or driving a motor vehicle. They should also be warned about the concomitant use of alcohol or other CNS-depressant drugs during Klonopin therapy (see PRECAUTIONS: *Drug Interactions* and *Information for Patients*).

***Suicidal Behavior and Ideation:*** Antiepileptic drugs (AEDs), including Klonopin, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior.

Pooled analyses of 199 placebo-controlled clinical trials (mono- and adjunctive therapy) of 11 different AEDs showed that patients randomized to one of the AEDs had approximately twice the risk (adjusted Relative Risk 1.8, 95% CI:1.2, 2.7) of suicidal thinking or behavior compared to patients randomized to placebo. In these trials, which had a median treatment duration of 12 weeks, the estimated incidence rate of suicidal behavior or ideation among 27,863 AED-treated patients was 0.43% compared to 0.24% among 16,029 placebo-treated patients, representing an increase of approximately one case of suicidal thinking or behavior for every 530 patients treated. There were four suicides in drug-treated patients in the trials and none in placebo-treated patients, but the number is too small to allow any conclusion about drug effect on suicide.

The increased risk of suicidal thoughts or behavior with AEDs was observed as early as one week after starting drug treatment with AEDs and persisted for the duration of treatment assessed. Because most trials included in the analysis did not extend beyond 24 weeks, the risk of suicidal thoughts or behavior beyond 24 weeks could not be assessed.

The risk of suicidal thoughts or behavior was generally consistent among drugs in the data analyzed. The finding of increased risk with AEDs of varying mechanisms of action and across a range of indications suggests that the risk applies to all AEDs used for any indication. The risk did not vary substantially by age (5-100 years) in the clinical trials analyzed.

Table 1 shows absolute and relative risk by indication for all evaluated AEDs.

**Table 1 Risk by Indication for Antiepileptic Drugs in the Pooled Analysis**

<b>Indication</b>	<b>Placebo Patients with Events Per 1000 Patients</b>	<b>Drug Patients with Events Per 1000 Patients</b>	<b>Relative Risk: Incidence of Events in Drug Patients/Incidence in Placebo Patients</b>	<b>Risk Difference: Additional Drug Patients with Events per 1000 Patients</b>
Epilepsy	1.0	3.4	3.5	2.4
Psychiatric	5.7	8.5	1.5	2.9
Other	1.0	1.8	1.9	0.9
Total	2.4	4.3	1.8	1.9

The relative risk for suicidal thoughts or behavior was higher in clinical trials for epilepsy than in clinical trials for psychiatric or other conditions, but the absolute risk differences were similar for the epilepsy and psychiatric indications.

Anyone considering prescribing Klonopin or any other AED must balance the risk of suicidal thoughts or behavior with the risk of untreated illness. Epilepsy and many other illnesses for which AEDs are prescribed are themselves associated with morbidity and mortality and an increased risk of suicidal thoughts and behavior. Should suicidal thoughts and behavior emerge during treatment, the prescriber needs to consider whether the emergence of these symptoms in any given patient may be related to the illness being treated.

Patients, their caregivers, and families should be informed that AEDs increase the risk of suicidal thoughts and behavior and should be advised of the need to be alert for the emergence or worsening of the signs and symptoms of depression, any unusual changes in mood or behavior, or the emergence of suicidal thoughts, behavior, or thoughts about self-harm. Behaviors of concern should be reported immediately to healthcare providers.

***Pregnancy Risks:*** Data from several sources raise concerns about the use of Klonopin during pregnancy.

***Animal Findings:*** In three studies in which Klonopin was administered orally to pregnant rabbits at doses of 0.2, 1, 5 or 10 mg/kg/day (low dose approximately 0.2 times the maximum recommended human dose of 20 mg/day for seizure disorders and equivalent to the maximum dose of 4 mg/day for panic disorder, on a mg/m<sup>2</sup> basis) during the period of organogenesis, a similar pattern of malformations (cleft palate, open eyelid, fused sternebrae and limb defects) was observed in a low, non-dose-related incidence in exposed litters from all dosage groups. Reductions in maternal weight gain occurred at dosages of 5 mg/kg/day or greater and reduction in embryo-fetal growth occurred in one study at a dosage of 10 mg/kg/day. No adverse maternal or embryo-fetal effects were observed in mice and rats following administration during organogenesis of oral doses up to 15 mg/kg/day or 40 mg/kg/day, respectively (4 and 20 times the maximum recommended human dose of 20 mg/day for seizure disorders and 20 and 100 times the maximum dose of 4 mg/day for panic disorder, respectively, on a mg/m<sup>2</sup> basis).

***General Concerns and Considerations About Anticonvulsants:*** Recent reports suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Data are more extensive with respect to diphenylhydantoin and phenobarbital, but these are also the most commonly prescribed anticonvulsants; less systematic or anecdotal reports suggest a possible similar association with the use of all known anticonvulsant drugs.

In children of women treated with drugs for epilepsy, reports suggesting an elevated incidence of birth defects cannot be regarded as adequate to prove a definite cause and effect relationship. There are intrinsic methodologic problems in obtaining adequate data on drug teratogenicity in humans; the possibility also exists that other factors (eg, genetic factors or the epileptic condition itself) may be more important than drug therapy in leading to birth defects. The great majority of mothers on anticonvulsant medication deliver normal infants. It is important to note that anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy; however, it cannot be said with any confidence that even mild seizures do not pose some hazards to the developing embryo or fetus.

***General Concerns About Benzodiazepines:*** An increased risk of congenital malformations associated with the use of benzodiazepine drugs has been suggested in several studies.

There may also be non-teratogenic risks associated with the use of benzodiazepines during pregnancy. There have been reports of neonatal flaccidity, respiratory and feeding difficulties, and hypothermia in children born to mothers who have been receiving benzodiazepines late in pregnancy. In addition, children born to mothers receiving benzodiazepines late in pregnancy may be at some risk of experiencing withdrawal symptoms during the postnatal period.

*Advice Regarding the Use of Klonopin in Women of Childbearing Potential:* In general, the use of Klonopin in women of childbearing potential, and more specifically during known pregnancy, should be considered only when the clinical situation warrants the risk to the fetus.

The specific considerations addressed above regarding the use of anticonvulsants for epilepsy in women of childbearing potential should be weighed in treating or counseling these women.

Because of experience with other members of the benzodiazepine class, Klonopin is assumed to be capable of causing an increased risk of congenital abnormalities when administered to a pregnant woman during the first trimester. Because use of these drugs is rarely a matter of urgency in the treatment of panic disorder, their use during the first trimester should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at the time of institution of therapy should be considered. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. Patients should also be advised that if they become pregnant during therapy or intend to become pregnant, they should communicate with their physician about the desirability of discontinuing the drug.

***Withdrawal Symptoms:*** Withdrawal symptoms of the barbiturate type have occurred after the discontinuation of benzodiazepines (see DRUG ABUSE AND DEPENDENCE).

## **PRECAUTIONS**

***General: Worsening of Seizures:*** When used in patients in whom several different types of seizure disorders coexist, Klonopin may increase the incidence or precipitate the onset of generalized tonic-clonic seizures (grand mal). This may require the addition of appropriate anticonvulsants or an increase in their dosages. The concomitant use of valproic acid and Klonopin may produce absence status.

*Laboratory Testing During Long-Term Therapy:* Periodic blood counts and liver function tests are advisable during long-term therapy with Klonopin.

*Risks of Abrupt Withdrawal:* The abrupt withdrawal of Klonopin, particularly in those patients on long-term, high-dose therapy, may precipitate status epilepticus. Therefore, when discontinuing Klonopin, gradual withdrawal is essential. While Klonopin is being gradually withdrawn, the simultaneous substitution of another anticonvulsant may be indicated.

**Caution in Renally Impaired Patients:** Metabolites of Klonopin are excreted by the kidneys; to avoid their excess accumulation, caution should be exercised in the administration of the drug to patients with impaired renal function.

**Hypersalivation:** Klonopin may produce an increase in salivation. This should be considered before giving the drug to patients who have difficulty handling secretions. Because of this and the possibility of respiratory depression, Klonopin should be used with caution in patients with chronic respiratory diseases.

**Information for Patients:** A Klonopin Medication Guide must be given to the patient each time Klonopin is dispensed, as required by law. Patients should be instructed to take Klonopin only as prescribed. Physicians are advised to discuss the following issues with patients for whom they prescribe Klonopin:

**Dose Changes:** To assure the safe and effective use of benzodiazepines, patients should be informed that, since benzodiazepines may produce psychological and physical dependence, it is advisable that they consult with their physician before either increasing the dose or abruptly discontinuing this drug.

**Interference With Cognitive and Motor Performance:** Because benzodiazepines 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 Klonopin therapy does not affect them adversely.

**Suicidal Thinking and Behavior:** Patients, their caregivers, and families should be counseled that AEDs, including Klonopin, may increase the risk of suicidal thoughts and behavior and should be advised of the need to be alert for the emergence or worsening of symptoms of depression, any unusual changes in mood or behavior, or the emergence of suicidal thoughts, behavior, or thoughts about self-harm. Behaviors of concern should be reported immediately to healthcare providers.

**Pregnancy:** Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy with Klonopin (see WARNINGS: *Pregnancy Risks*). Patients should be encouraged to enroll in the North American Antiepileptic Drug (NAAED) Pregnancy Registry if they become pregnant. This registry is collecting information about the safety of antiepileptic drugs during pregnancy. To enroll, patients can call the toll free number 1-888-233-2334 (see PRECAUTIONS: *Pregnancy*).

**Nursing:** Patients should be advised not to breastfeed an infant if they are taking Klonopin.

**Concomitant Medication:** Patients should be advised to inform their physicians if they are taking, or plan to take, any prescription or over-the-counter drugs, since there is a potential for interactions.

**Alcohol:** Patients should be advised to avoid alcohol while taking Klonopin.

**Drug Interactions: Effect of Clonazepam on the Pharmacokinetics of Other Drugs:** Clonazepam does not appear to alter the pharmacokinetics of phenytoin, carbamazepine

or phenobarbital. The effect of clonazepam on the metabolism of other drugs has not been investigated.

***Effect of Other Drugs on the Pharmacokinetics of Clonazepam:*** Literature reports suggest that ranitidine, an agent that decreases stomach acidity, does not greatly alter clonazepam pharmacokinetics.

In a study in which the 2 mg clonazepam orally disintegrating tablet was administered with and without propantheline (an anticholinergic agent with multiple effects on the GI tract) to healthy volunteers, the AUC of clonazepam was 10% lower and the  $C_{max}$  of clonazepam was 20% lower when the orally disintegrating tablet was given with propantheline compared to when it was given alone.

Fluoxetine does not affect the pharmacokinetics of clonazepam. Cytochrome P-450 inducers, such as phenytoin, carbamazepine and phenobarbital, induce clonazepam metabolism, causing an approximately 30% decrease in plasma clonazepam levels. Although clinical studies have not been performed, based on the involvement of the cytochrome P-450 3A family in clonazepam metabolism, inhibitors of this enzyme system, notably oral antifungal agents, should be used cautiously in patients receiving clonazepam.

***Pharmacodynamic Interactions:*** The CNS-depressant action of the benzodiazepine class of drugs may be potentiated by alcohol, narcotics, barbiturates, nonbarbiturate hypnotics, antianxiety agents, the phenothiazines, thioxanthene and butyrophenone classes of antipsychotic agents, monoamine oxidase inhibitors and the tricyclic antidepressants, and by other anticonvulsant drugs.

***Carcinogenesis, Mutagenesis, Impairment of Fertility:*** Carcinogenicity studies have not been conducted with clonazepam.

The data currently available are not sufficient to determine the genotoxic potential of clonazepam.

In a two-generation fertility study in which clonazepam was given orally to rats at 10 and 100 mg/kg/day (low dose approximately 5 times and 24 times the maximum recommended human dose of 20 mg/day for seizure disorder and 4 mg/day for panic disorder, respectively, on a  $mg/m^2$  basis), there was a decrease in the number of pregnancies and in the number of offspring surviving until weaning.

***Pregnancy: Teratogenic Effects:*** Pregnancy Category D (see WARNINGS: *Pregnancy Risks*).

To provide information regarding the effects of in utero exposure to Klonopin, physicians are advised to recommend that pregnant patients taking Klonopin enroll in the NAAED Pregnancy Registry. This can be done by calling the toll free number 1-888-233-2334, and must be done by patients themselves. Information on this registry can also be found at the website <http://www.aedpregnancyregistry.org/>.

***Labor and Delivery:*** The effect of Klonopin on labor and delivery in humans has not been specifically studied; however, perinatal complications have been reported in

children born to mothers who have been receiving benzodiazepines late in pregnancy, including findings suggestive of either excess benzodiazepine exposure or of withdrawal phenomena (see WARNINGS: *Pregnancy Risks*).

***Nursing Mothers:*** Mothers receiving Klonopin should not breastfeed their infants.

***Pediatric Use:*** Because of the possibility that adverse effects on physical or mental development could become apparent only after many years, a benefit-risk consideration of the long-term use of Klonopin is important in pediatric patients being treated for seizure disorder (see INDICATIONS AND USAGE and DOSAGE AND ADMINISTRATION).

Safety and effectiveness in pediatric patients with panic disorder below the age of 18 have not been established.

***Geriatric Use:*** Clinical studies of Klonopin did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

Because clonazepam undergoes hepatic metabolism, it is possible that liver disease will impair clonazepam elimination. Metabolites of Klonopin are excreted by the kidneys; to avoid their excess accumulation, caution should be exercised in the administration of the drug to patients with impaired renal function. Because elderly patients are more likely to have decreased hepatic and/or renal function, care should be taken in dose selection, and it may be useful to assess hepatic and/or renal function at the time of dose selection.

Sedating drugs may cause confusion and over-sedation in the elderly; elderly patients generally should be started on low doses of Klonopin and observed closely.

## **ADVERSE REACTIONS**

The adverse experiences for Klonopin are provided separately for patients with seizure disorders and with panic disorder.

***Seizure Disorders:*** The most frequently occurring side effects of Klonopin are referable to CNS depression. Experience in treatment of seizures has shown that drowsiness has occurred in approximately 50% of patients and ataxia in approximately 30%. In some cases, these may diminish with time; behavior problems have been noted in approximately 25% of patients. Others, listed by system, are:

***Neurologic:*** Abnormal eye movements, aphonia, choreiform movements, coma, diplopia, dysarthria, dysdiadochokinesis, “glassy-eyed” appearance, headache, hemiparesis, hypotonia, nystagmus, respiratory depression, slurred speech, tremor, vertigo

***Psychiatric:*** Confusion, depression, amnesia, hallucinations, hysteria, increased libido, insomnia, psychosis (the behavior effects are more likely to occur in patients with a

history of psychiatric disturbances). The following paradoxical reactions have been observed: excitability, irritability, aggressive behavior, agitation, nervousness, hostility, anxiety, sleep disturbances, nightmares and vivid dreams

*Respiratory:* Chest congestion, rhinorrhea, shortness of breath, hypersecretion in upper respiratory passages

*Cardiovascular:* Palpitations

*Dermatologic:* Hair loss, hirsutism, skin rash, ankle and facial edema

*Gastrointestinal:* Anorexia, coated tongue, constipation, diarrhea, dry mouth, encopresis, gastritis, increased appetite, nausea, sore gums

*Genitourinary:* Dysuria, enuresis, nocturia, urinary retention

*Musculoskeletal:* Muscle weakness, pains

*Miscellaneous:* Dehydration, general deterioration, fever, lymphadenopathy, weight loss or gain

*Hematopoietic:* Anemia, leukopenia, thrombocytopenia, eosinophilia

*Hepatic:* Hepatomegaly, transient elevations of serum transaminases and alkaline phosphatase

***Panic Disorder:*** Adverse events during exposure to Klonopin were obtained by spontaneous report and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and tabulations that follow, CIGY dictionary terminology has been used to classify reported adverse events, except in certain cases in which redundant terms were collapsed into more meaningful terms, as noted below.

The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation.

***Adverse Findings Observed in Short-Term, Placebo-Controlled Trials:***

***Adverse Events Associated With Discontinuation of Treatment:***

Overall, the incidence of discontinuation due to adverse events was 17% in Klonopin compared to 9% for placebo in the combined data of two 6- to 9-week trials. The most common events ( $\geq 1\%$ ) associated with discontinuation and a dropout rate twice or greater for Klonopin than that of placebo included the following:

**Table 2 Most Common Adverse Events (≥1%) Associated with Discontinuation of Treatment**

Adverse Event	Klonopin (N=574)	Placebo (N=294)
Somnolence	7%	1%
Depression	4%	1%
Dizziness	1%	<1%
Nervousness	1%	0%
Ataxia	1%	0%
Intellectual Ability Reduced	1%	0%

Adverse Events Occurring at an Incidence of 1% or More Among Klonopin-Treated Patients:

Table 3 enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred during acute therapy of panic disorder from a pool of two 6- to 9-week trials. Events reported in 1% or more of patients treated with Klonopin (doses ranging from 0.5 to 4 mg/day) and for which the incidence was greater than that in placebo-treated patients are included.

The prescriber should be aware that the figures in Table 3 cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and nondrug factors to the side effect incidence in the population studied.

**Table 3 Treatment-Emergent Adverse Event Incidence in 6- to 9-Week Placebo-Controlled Clinical Trials\***

Clonazepam Maximum Daily Dose						
Adverse Event by Body System	<1mg n=96	1-<2mg n=129	2-<3mg n=113	≥3mg n=235	All Klonopin Groups N=574	Placebo N=294
	%	%	%	%	%	%
Central & Peripheral Nervous System						
Somnolence†	26	35	50	36	37	10
Dizziness	5	5	12	8	8	4
Coordination Abnormal†	1	2	7	9	6	0
Ataxia†	2	1	8	8	5	0
Dysarthria†	0	0	4	3	2	0
Psychiatric						
Depression	7	6	8	8	7	1
Memory Disturbance	2	5	2	5	4	2

<b>Clonazepam Maximum Daily Dose</b>						
<b>Adverse Event by Body System</b>	<b>&lt;1mg n=96 %</b>	<b>1-&lt;2mg n=129 %</b>	<b>2-&lt;3mg n=113 %</b>	<b>≥3mg n=235 %</b>	<b>All Klonopin Groups N=574 %</b>	<b>Placebo N=294 %</b>
Nervousness	1	4	3	4	3	2
Intellectual Ability Reduced	0	2	4	3	2	0
Emotional Lability	0	1	2	2	1	1
Libido Decreased	0	1	3	1	1	0
Confusion	0	2	2	1	1	0
<b>Respiratory System</b>						
Upper Respiratory Tract Infection†	10	10	7	6	8	4
Sinusitis	4	2	8	4	4	3
Rhinitis	3	2	4	2	2	1
Coughing	2	2	4	0	2	0
Pharyngitis	1	1	3	2	2	1
Bronchitis	1	0	2	2	1	1
<b>Gastrointestinal System</b>						
Constipation†	0	1	5	3	2	2
Appetite Decreased	1	1	0	3	1	1
Abdominal Pain†	2	2	2	0	1	1

<b>Clonazepam Maximum Daily Dose</b>						
<b>Adverse Event by Body System</b>	<b>&lt;1mg n=96 %</b>	<b>1-&lt;2mg n=129 %</b>	<b>2-&lt;3mg n=113 %</b>	<b>≥3mg n=235 %</b>	<b>All Klonopin Groups N=574 %</b>	<b>Placebo N=294 %</b>
Body as a Whole						
Fatigue	9	6	7	7	7	4
Allergic Reaction	3	1	4	2	2	1
Musculoskeletal						
Myalgia	2	1	4	0	1	1
Resistance Mechanism Disorders						
Influenza	3	2	5	5	4	3
Urinary System						
Micturition Frequency	1	2	2	1	1	0
Urinary Tract Infection†	0	0	2	2	1	0
Vision Disorders						
Blurred Vision	1	2	3	0	1	1
Reproductive Disorders‡						
Female						
Dysmenorrhea	0	6	5	2	3	2
Colpitis	4	0	2	1	1	1
Male						
Ejaculation Delayed	0	0	2	2	1	0
Impotence	3	0	2	1	1	0

\* Events reported by at least 1% of patients treated with Klonopin and for which the incidence was greater than that for placebo.

† Indicates that the p-value for the dose-trend test (Cochran-Mantel-Haenszel) for adverse event incidence was ≤0.10.

‡ Denominators for events in gender-specific systems are: n=240 (clonazepam), 102 (placebo) for male, and 334 (clonazepam), 192 (placebo) for female.

Commonly Observed Adverse Events:

**Table 4 Incidence of Most Commonly Observed Adverse Events\* in Acute Therapy in Pool of 6- to 9-Week Trials**

<b>Adverse Event (Genentech Preferred Term)</b>	<b>Clonazepam (N=574)</b>	<b>Placebo (N=294)</b>
Somnolence	37%	10%
Depression	7%	1%
Coordination Abnormal	6%	0%
Ataxia	5%	0%

\* Treatment-emergent events for which the incidence in the clonazepam patients was  $\geq 5\%$  and at least twice that in the placebo patients.

Treatment-Emergent Depressive Symptoms:

In the pool of two short-term placebo-controlled trials, adverse events classified under the preferred term “depression” were reported in 7% of Klonopin-treated patients compared to 1% of placebo-treated patients, without any clear pattern of dose relatedness. In these same trials, adverse events classified under the preferred term “depression” were reported as leading to discontinuation in 4% of Klonopin-treated patients compared to 1% of placebo-treated patients. While these findings are noteworthy, Hamilton Depression Rating Scale (HAM-D) data collected in these trials revealed a larger decline in HAM-D scores in the clonazepam group than the placebo group suggesting that clonazepam-treated patients were not experiencing a worsening or emergence of clinical depression.

Other Adverse Events Observed During the Premarketing Evaluation of Klonopin in Panic Disorder:

Following is a list of modified CIGY terms that reflect treatment-emergent adverse events reported by patients treated with Klonopin at multiple doses during clinical trials. All reported events are included except those already listed in Table 3 or elsewhere in labeling, those events for which a drug cause was remote, those event terms which were so general as to be uninformative, and events reported only once and which did not have a substantial probability of being acutely life-threatening. It is important to emphasize that, although the events occurred during treatment with Klonopin, they were not necessarily caused by it.

Events are further categorized by body system and listed in order of decreasing frequency. These adverse events were reported infrequently, which is defined as occurring in 1/100 to 1/1000 patients.

*Body as a Whole:* weight increase, accident, weight decrease, wound, edema, fever, shivering, abrasions, ankle edema, edema foot, edema periorbital, injury, malaise, pain, cellulitis, inflammation localized

*Cardiovascular Disorders:* chest pain, hypotension postural

*Central and Peripheral Nervous System Disorders:* migraine, paresthesia, drunkenness, feeling of enuresis, paresis, tremor, burning skin, falling, head fullness, hoarseness, hyperactivity, hypoesthesia, tongue thick, twitching

*Gastrointestinal System Disorders:* abdominal discomfort, gastrointestinal inflammation, stomach upset, toothache, flatulence, pyrosis, saliva increased, tooth disorder, bowel movements frequent, pain pelvic, dyspepsia, hemorrhoids

*Hearing and Vestibular Disorders:* vertigo, otitis, earache, motion sickness

*Heart Rate and Rhythm Disorders:* palpitation

*Metabolic and Nutritional Disorders:* thirst, gout

*Musculoskeletal System Disorders:* back pain, fracture traumatic, sprains and strains, pain leg, pain nape, cramps muscle, cramps leg, pain ankle, pain shoulder, tendinitis, arthralgia, hypertonia, lumbago, pain feet, pain jaw, pain knee, swelling knee

*Platelet, Bleeding and Clotting Disorders:* bleeding dermal

*Psychiatric Disorders:* insomnia, organic disinhibition, anxiety, depersonalization, dreaming excessive, libido loss, appetite increased, libido increased, reactions decreased, aggressive reaction, apathy, attention lack, excitement, feeling mad, hunger abnormal, illusion, nightmares, sleep disorder, suicide ideation, yawning

*Reproductive Disorders, Female:* breast pain, menstrual irregularity

*Reproductive Disorders, Male:* ejaculation decreased

*Resistance Mechanism Disorders:* infection mycotic, infection viral, infection streptococcal, herpes simplex infection, infectious mononucleosis, moniliasis

*Respiratory System Disorders:* sneezing excessive, asthmatic attack, dyspnea, nosebleed, pneumonia, pleurisy

*Skin and Appendages Disorders:* acne flare, alopecia, xeroderma, dermatitis contact, flushing, pruritus, pustular reaction, skin burns, skin disorder

*Special Senses Other, Disorders:* taste loss

*Urinary System Disorders:* dysuria, cystitis, polyuria, urinary incontinence, bladder dysfunction, urinary retention, urinary tract bleeding, urine discoloration

*Vascular (Extracardiac) Disorders:* thrombophlebitis leg

*Vision Disorders:* eye irritation, visual disturbance, diplopia, eye twitching, styes, visual field defect, xerophthalmia

## **DRUG ABUSE AND DEPENDENCE**

***Controlled Substance Class:*** Clonazepam is a Schedule IV controlled substance.

***Physical and Psychological Dependence:*** Withdrawal symptoms, similar in character to those noted with barbiturates and alcohol (eg, convulsions, psychosis, hallucinations,

behavioral disorder, tremor, abdominal and muscle cramps) have occurred following abrupt discontinuance of clonazepam. The more severe withdrawal symptoms have usually been limited to those patients who received excessive doses over an extended period of time. Generally milder withdrawal symptoms (eg, dysphoria and insomnia) have been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Consequently, after extended therapy, abrupt discontinuation should generally be avoided and a gradual dosage tapering schedule followed (see DOSAGE AND ADMINISTRATION). Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving clonazepam or other psychotropic agents because of the predisposition of such patients to habituation and dependence.

Following the short-term treatment of patients with panic disorder in Studies 1 and 2 (see CLINICAL PHARMACOLOGY: *Clinical Trials*), patients were gradually withdrawn during a 7-week downward-titration (discontinuance) period. Overall, the discontinuance period was associated with good tolerability and a very modest clinical deterioration, without evidence of a significant rebound phenomenon. However, there are not sufficient data from adequate and well-controlled long-term clonazepam studies in patients with panic disorder to accurately estimate the risks of withdrawal symptoms and dependence that may be associated with such use.

## OVERDOSAGE

**Human Experience:** Symptoms of clonazepam overdose, like those produced by other CNS depressants, include somnolence, confusion, coma and diminished reflexes.

**Overdose Management:** Treatment includes monitoring of respiration, pulse and blood pressure, general supportive measures and immediate gastric lavage. Intravenous fluids should be administered and an adequate airway maintained. Hypotension may be combated by the use of levarterenol or metaraminol. Dialysis is of no known value.

Flumazenil, a specific benzodiazepine-receptor antagonist, is indicated for the complete or partial reversal of the sedative effects of benzodiazepines and may be used in situations when an overdose with a benzodiazepine is known or suspected. Prior to the administration of flumazenil, necessary measures should be instituted to secure airway, ventilation and intravenous access. Flumazenil is intended as an adjunct to, not as a substitute for, proper management of benzodiazepine overdose. Patients treated with flumazenil should be monitored for re sedation, respiratory depression and other residual benzodiazepine effects for an appropriate period after treatment. **The prescriber should be aware of a risk of seizure in association with flumazenil treatment, particularly in long-term benzodiazepine users and in cyclic antidepressant overdose.** The complete flumazenil package insert, including CONTRAINDICATIONS, WARNINGS and PRECAUTIONS, should be consulted prior to use.

**Flumazenil is not indicated in patients with epilepsy who have been treated with benzodiazepines. Antagonism of the benzodiazepine effect in such patients may provoke seizures.**

Serious sequelae are rare unless other drugs or alcohol have been taken concomitantly.

## DOSAGE AND ADMINISTRATION

Clonazepam is available as a tablet. The tablets should be administered with water by swallowing the tablet whole.

***Seizure Disorders: Adults:*** The initial dose for adults with seizure disorders should not exceed 1.5 mg/day divided into three doses. Dosage may be increased in increments of 0.5 to 1 mg every 3 days until seizures are adequately controlled or until side effects preclude any further increase. Maintenance dosage must be individualized for each patient depending upon response. Maximum recommended daily dose is 20 mg.

The use of multiple anticonvulsants may result in an increase of depressant adverse effects. This should be considered before adding Klonopin to an existing anticonvulsant regimen.

***Pediatric Patients:*** Klonopin is administered orally. In order to minimize drowsiness, the initial dose for infants and children (up to 10 years of age or 30 kg of body weight) should be between 0.01 and 0.03 mg/kg/day but not to exceed 0.05 mg/kg/day given in two or three divided doses. Dosage should be increased by no more than 0.25 to 0.5 mg every third day until a daily maintenance dose of 0.1 to 0.2 mg/kg of body weight has been reached, unless seizures are controlled or side effects preclude further increase. Whenever possible, the daily dose should be divided into three equal doses. If doses are not equally divided, the largest dose should be given before retiring.

***Geriatric Patients:*** There is no clinical trial experience with Klonopin in seizure disorder patients 65 years of age and older. In general, elderly patients should be started on low doses of Klonopin and observed closely (see PRECAUTIONS: *Geriatric Use*).

***Panic Disorder: Adults:*** The initial dose for adults with panic disorder is 0.25 mg bid. An increase to the target dose for most patients of 1 mg/day may be made after 3 days. The recommended dose of 1 mg/day is based on the results from a fixed dose study in which the optimal effect was seen at 1 mg/day. Higher doses of 2, 3 and 4 mg/day in that study were less effective than the 1 mg/day dose and were associated with more adverse effects. Nevertheless, it is possible that some individual patients may benefit from doses of up to a maximum dose of 4 mg/day, and in those instances, the dose may be increased in increments of 0.125 to 0.25 mg bid every 3 days until panic disorder is controlled or until side effects make further increases undesired. To reduce the inconvenience of somnolence, administration of one dose at bedtime may be desirable.

Treatment should be discontinued gradually, with a decrease of 0.125 mg bid every 3 days, until the drug is completely withdrawn.

There is no body of evidence available to answer the question of how long the patient treated with clonazepam should remain on it. Therefore, the physician who elects to use Klonopin for extended periods should periodically reevaluate the long-term usefulness of the drug for the individual patient.

***Pediatric Patients:*** There is no clinical trial experience with Klonopin in panic disorder patients under 18 years of age.

*Geriatric Patients:* There is no clinical trial experience with Klonopin in panic disorder patients 65 years of age and older. In general, elderly patients should be started on low doses of Klonopin and observed closely (see PRECAUTIONS: *Geriatric Use*).

## HOW SUPPLIED

Klonopin tablets are available as scored tablets with a K-shaped perforation—0.5 mg, orange (NDC 0004-0068-01); and unscored tablets with a K-shaped perforation—1 mg, blue (NDC 0004-0058-01); 2 mg, white (NDC 0004-0098-01)—bottles of 100.

Imprint on tablets:

0.5 mg — 1/2 KLONOPIN (front)  
ROCHE (scored side)



1 mg — 1 KLONOPIN (front)  
ROCHE (reverse side)



2 mg — 2 KLONOPIN (front)  
ROCHE (reverse side)



Store at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F).

Distributed by:

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1 DNA Way  
South San Francisco, CA 94080-4990

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**Medication Guide**  
**KLONOPIN® (KLON-oh-pin)**  
**(clonazepam)**  
**Tablets**



Read this Medication Guide before you start taking KLONOPIN and each time you get a refill. There may be new information. This information does not take the place of talking to your healthcare provider about your medical condition or treatment.

KLONOPIN can cause serious side effects. Because stopping KLONOPIN suddenly can also cause serious problems, do not stop taking KLONOPIN without talking to your healthcare provider first.

**What is the most important information I should know about KLONOPIN?**

**Do not stop taking KLONOPIN without first talking to your healthcare provider.** Stopping KLONOPIN suddenly can cause serious problems.

**KLONOPIN can cause serious side effects, including:**

**1. KLONOPIN can slow your thinking and motor skills**

- Do not drive, operate heavy machinery, or do other dangerous activities until you know how KLONOPIN affects you.
- Do not drink alcohol or take other drugs that may make you sleepy or dizzy while taking KLONOPIN until you talk to your healthcare provider. When taken with alcohol or drugs that cause sleepiness or dizziness, KLONOPIN may make your sleepiness or dizziness worse.

**2. Like other antiepileptic drugs, KLONOPIN may cause suicidal thoughts or actions in a very small number of people, about 1 in 500.**

**Call a healthcare provider right away if you have any of these symptoms, especially if they are new, worse, or worry you:**

- thoughts about suicide or dying
- attempt to commit suicide
- new or worse depression
- new or worse anxiety
- feeling agitated or restless
- panic attacks
- trouble sleeping (insomnia)
- new or worse irritability
- acting aggressive, being angry, or violent
- acting on dangerous impulses
- an extreme increase in activity and talking (mania)
- other unusual changes in behavior or mood

### **How can I watch for early symptoms of suicidal thoughts and actions?**

- Pay attention to any changes, especially sudden changes, in mood, behaviors, thoughts, or feelings.
- Keep all follow-up visits with your healthcare provider as scheduled.

Call your healthcare provider between visits as needed, especially if you are worried about symptoms.

Suicidal thoughts or actions can be caused by things other than medicines. If you have suicidal thoughts or actions, your healthcare provider may check for other causes.

### **Do not stop KLONOPIN without first talking to a healthcare provider.**

Stopping KLONOPIN suddenly can cause serious problems. Stopping KLONOPIN suddenly can cause seizures that will not stop (status epilepticus).

### **3. KLONOPIN may harm your unborn or developing baby.**

- If you take KLONOPIN during pregnancy, your baby is at risk for serious birth defects. These defects can happen as early as in the first month of pregnancy, even before you know you are pregnant. Birth defects may occur even in children born to women who are not taking any medicines and do not have other risk factors.
- Children born to mothers receiving benzodiazepine medications (including KLONOPIN) late in pregnancy may be at some risk of experiencing breathing problems, feeding problems, hypothermia, and withdrawal symptoms.
- Tell your healthcare provider right away if you become pregnant while taking KLONOPIN. You and your healthcare provider should decide if you will take KLONOPIN while you are pregnant.
- If you become pregnant while taking KLONOPIN, talk to your healthcare provider about registering with the North American Antiepileptic Drug Pregnancy Registry. You can register by calling 1-888-233-2334. The purpose of this registry is to collect information about the safety of antiepileptic drugs during pregnancy.
- KLONOPIN can pass into breast milk. Talk to your healthcare provider about the best way to feed your baby if you take KLONOPIN. You and your healthcare provider should decide if you will take KLONOPIN or breast feed. You should not do both.

### **4. KLONOPIN can cause abuse and dependence.**

- Do not stop taking KLONOPIN all of a sudden. Stopping KLONOPIN suddenly can cause seizures that do not stop, hearing or seeing things that are not there (hallucinations), shaking, and stomach and muscle cramps.

- Talk to your doctor about slowly stopping KLONOPIN to avoid getting sick with withdrawal symptoms.
- Physical dependence is not the same as drug addiction. Your healthcare provider can tell you more about the differences between physical dependence and drug addiction.

**KLONOPIN is a federally controlled substance (C-IV) because it can be abused or lead to dependence. Keep KLONOPIN in a safe place to prevent misuse and abuse. Selling or giving away KLONOPIN may harm others, and is against the law. Tell your doctor if you have ever abused or been dependent on alcohol, prescription medicines or street drugs.**

### **What is KLONOPIN?**

KLONOPIN is a prescription medicine used alone or with other medicines to treat:

- certain types of seizure disorders (epilepsy) in adults and children
- panic disorder with or without fear of open spaces (agoraphobia) in adults

It is not known if KLONOPIN is safe or effective in treating panic disorder in children younger than 18 years old.

### **Who should not take KLONOPIN?**

Do not take KLONOPIN if you:

- are allergic to benzodiazepines
- have significant liver disease
- have an eye disease called acute narrow angle glaucoma

**Ask your healthcare provider if you are not sure if you have any of the problems listed above.**

### **What should I tell my healthcare provider before taking KLONOPIN?**

Before you take KLONOPIN, tell your healthcare provider if you:

- have liver or kidney problems
- have lung problems (respiratory disease)
- have or have had depression, mood problems, or suicidal thoughts or behavior
- have any other medical conditions

**Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. Taking KLONOPIN with certain other medicines can cause side effects or affect**

how well they work. Do not start or stop other medicines without talking to your healthcare provider.

Know the medicines you take. Keep a list of them and show it to your healthcare provider and pharmacist when you get a new medicine.

### **How should I take KLONOPIN?**

- Take KLONOPIN exactly as your healthcare provider tells you. KLONOPIN is available as a tablet.
- Do not stop taking KLONOPIN without first talking to your healthcare provider. Stopping KLONOPIN suddenly can cause serious problems.
- **KLONOPIN tablets** should be taken with water and swallowed whole.
- If you take too much KLONOPIN, call your healthcare provider or local Poison Control Center right away.

### **What should I avoid while taking KLONOPIN?**

- KLONOPIN can slow your thinking and motor skills. Do not drive, operate heavy machinery, or do other dangerous activities until you know how KLONOPIN affects you.
- Do not drink alcohol or take other drugs that may make you sleepy or dizzy while taking KLONOPIN until you talk to your healthcare provider. When taken with alcohol or drugs that cause sleepiness or dizziness, KLONOPIN may make your sleepiness or dizziness worse.

### **What are the possible side effects of KLONOPIN?**

#### **See “What is the most important information I should know about KLONOPIN?”**

KLONOPIN can also make your seizures happen more often or make them worse. Call your healthcare provider right away if your seizures get worse while taking KLONOPIN.

The most common side effects of KLONOPIN include:

- Drowsiness
- Problems with walking and coordination
- Dizziness
- Depression
- Fatigue
- Problems with memory

These are not all the possible side effects of KLONOPIN. For more information, ask your healthcare provider or pharmacist.

Tell your healthcare provider if you have any side effect that bothers you or that does not go away.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

### **How should I store KLONOPIN?**

- Store KLONOPIN between 59°F to 86°F (15°C to 30°C)

**Keep KLONOPIN and all medicines out of the reach of children.**

### **General Information about KLONOPIN**

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use KLONOPIN for a condition for which it was not prescribed. Do not give KLONOPIN to other people, even if they have the same symptoms that you have. It may harm them.

This Medication Guide summarizes the most important information about KLONOPIN. If you would like more information, talk with your healthcare provider. You can ask your pharmacist or healthcare provider for information about KLONOPIN that is written for health professionals.

For more information, go to [www.gene.com/gene/products/information/klonopin](http://www.gene.com/gene/products/information/klonopin) or call 1-888-835-2555.

### **What are the ingredients in KLONOPIN?**

Active ingredient: clonazepam

Inactive ingredients:

- Tablets:
  - 0.5 mg tablets contain lactose, magnesium stearate, microcrystalline cellulose, corn starch, FD&C Yellow No. 6 Lake
  - 1 mg tablets contain lactose, magnesium stearate, microcrystalline cellulose, corn starch, FD&C Blue No. 1 Lake and FD&C Blue No. 2 Lake
  - 2 mg tablets contain lactose, magnesium stearate, microcrystalline cellulose, corn starch

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1 DNA Way

South San Francisco, CA 94080-4990

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[www.gene.com/gene/products/information/klonopin](http://www.gene.com/gene/products/information/klonopin).



1  
2 **KLONOPIN<sup>®</sup> TABLETS**

3 **(clonazepam)**

4 **KLONOPIN<sup>®</sup> WAFERS**

5 **(clonazepam orally disintegrating tablets)**

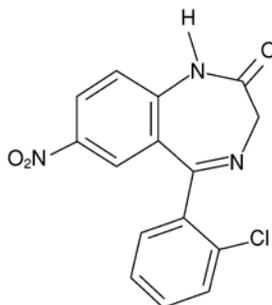
6 **Rx only**

7 **DESCRIPTION**

8 Klonopin, a benzodiazepine, is available as scored tablets with a K-shaped perforation  
9 containing 0.5 mg of clonazepam and unscored tablets with a K-shaped perforation  
10 containing 1 mg or 2 mg of clonazepam. Each tablet also contains lactose, magnesium  
11 stearate, microcrystalline cellulose and corn starch, with the following colorants: 0.5  
12 mg—FD&C Yellow No. 6 Lake; 1 mg—FD&C Blue No. 1 Lake and FD&C Blue No. 2  
13 Lake.

14 Klonopin is also available as an orally disintegrating tablet containing 0.125 mg, 0.25  
15 mg, 0.5 mg, 1 mg or 2 mg clonazepam. Each orally disintegrating tablet also contains  
16 gelatin, mannitol, methylparaben sodium, propylparaben sodium and xanthan gum.

17 Chemically, clonazepam is 5-(2-chlorophenyl)-1,3-dihydro-7-nitro-2H-1,4-  
18 benzodiazepin-2-one. It is a light yellow crystalline powder. It has a molecular weight of  
19 315.72 and the following structural formula:



20  
21 **CLINICAL PHARMACOLOGY**

22 **Pharmacodynamics:** The precise mechanism by which clonazepam exerts its antiseizure  
23 and antipanic effects is unknown, although it is believed to be related to its ability to  
24 enhance the activity of gamma aminobutyric acid (GABA), the major inhibitory  
25 neurotransmitter in the central nervous system. Convulsions produced in rodents by  
26 pentylenetetrazol or, to a lesser extent, electrical stimulation are antagonized, as are  
27 convulsions produced by photic stimulation in susceptible baboons. A taming effect in  
28 aggressive primates, muscle weakness and hypnosis are also produced. In humans,  
29 clonazepam is capable of suppressing the spike and wave discharge in absence seizures  
30 (petit mal) and decreasing the frequency, amplitude, duration and spread of discharge in  
31 minor motor seizures.

32 ***Pharmacokinetics:*** Clonazepam is rapidly and completely absorbed after oral  
33 administration. The absolute bioavailability of clonazepam is about 90%. Maximum  
34 plasma concentrations of clonazepam are reached within 1 to 4 hours after oral  
35 administration. Clonazepam is approximately 85% bound to plasma proteins.  
36 Clonazepam is highly metabolized, with less than 2% unchanged clonazepam being  
37 excreted in the urine. Biotransformation occurs mainly by reduction of the 7-nitro group  
38 to the 4-amino derivative. This derivative can be acetylated, hydroxylated and  
39 glucuronidated. Cytochrome P-450 including CYP3A, may play an important role in  
40 clonazepam reduction and oxidation. The elimination half-life of clonazepam is typically  
41 30 to 40 hours. Clonazepam pharmacokinetics are dose-independent throughout the  
42 dosing range. There is no evidence that clonazepam induces its own metabolism or that  
43 of other drugs in humans.

44 ***Pharmacokinetics in Demographic Subpopulations and in Disease States:*** Controlled  
45 studies examining the influence of gender and age on clonazepam pharmacokinetics have  
46 not been conducted, nor have the effects of renal or liver disease on clonazepam  
47 pharmacokinetics been studied. Because clonazepam undergoes hepatic metabolism, it is  
48 possible that liver disease will impair clonazepam elimination. Thus, caution should be  
49 exercised when administering clonazepam to these patients.

50 ***Clinical Trials: Panic Disorder:*** The effectiveness of Klonopin in the treatment of panic  
51 disorder was demonstrated in two double-blind, placebo-controlled studies of adult  
52 outpatients who had a primary diagnosis of panic disorder (DSM-III-R) with or without  
53 agoraphobia. In these studies, Klonopin was shown to be significantly more effective  
54 than placebo in treating panic disorder on change from baseline in panic attack frequency,  
55 the Clinician's Global Impression Severity of Illness Score and the Clinician's Global  
56 Impression Improvement Score.

57 Study 1 was a 9-week, fixed-dose study involving Klonopin doses of 0.5, 1, 2, 3 or 4  
58 mg/day or placebo. This study was conducted in four phases: a 1-week placebo lead-in, a  
59 3-week upward titration, a 6-week fixed dose and a 7-week discontinuance phase. A  
60 significant difference from placebo was observed consistently only for the 1 mg/day  
61 group. The difference between the 1 mg dose group and placebo in reduction from  
62 baseline in the number of full panic attacks was approximately 1 panic attack per week.  
63 At endpoint, 74% of patients receiving clonazepam 1 mg/day were free of full panic  
64 attacks, compared to 56% of placebo-treated patients.

65 Study 2 was a 6-week, flexible-dose study involving Klonopin in a dose range of 0.5 to 4  
66 mg/day or placebo. This study was conducted in three phases: a 1-week placebo lead-in, a  
67 6-week optimal-dose and a 6-week discontinuance phase. The mean clonazepam dose  
68 during the optimal dosing period was 2.3 mg/day. The difference between Klonopin and  
69 placebo in reduction from baseline in the number of full panic attacks was approximately  
70 1 panic attack per week. At endpoint, 62% of patients receiving clonazepam were free of  
71 full panic attacks, compared to 37% of placebo-treated patients.

72 Subgroup analyses did not indicate that there were any differences in treatment outcomes  
73 as a function of race or gender.

74 **INDICATIONS AND USAGE**

75 **Seizure Disorders:** Klonopin is useful alone or as an adjunct in the treatment of the  
76 Lennox-Gastaut syndrome (petit mal variant), akinetic and myoclonic seizures. In  
77 patients with absence seizures (petit mal) who have failed to respond to succinimides,  
78 Klonopin may be useful.

79 In some studies, up to 30% of patients have shown a loss of anticonvulsant activity, often  
80 within 3 months of administration. In some cases, dosage adjustment may reestablish  
81 efficacy.

82 **Panic Disorder:** Klonopin is indicated for the treatment of panic disorder, with or  
83 without agoraphobia, as defined in DSM-IV. Panic disorder is characterized by the  
84 occurrence of unexpected panic attacks and associated concern about having additional  
85 attacks, worry about the implications or consequences of the attacks, and/or a significant  
86 change in behavior related to the attacks.

87 The efficacy of Klonopin was established in two 6- to 9-week trials in panic disorder  
88 patients whose diagnoses corresponded to the DSM-III-R category of panic disorder (see  
89 CLINICAL PHARMACOLOGY: *Clinical Trials*).

90 Panic disorder (DSM-IV) is characterized by recurrent unexpected panic attacks, ie, a  
91 discrete period of intense fear or discomfort in which four (or more) of the following  
92 symptoms develop abruptly and reach a peak within 10 minutes: (1) palpitations,  
93 pounding heart or accelerated heart rate; (2) sweating; (3) trembling or shaking; (4)  
94 sensations of shortness of breath or smothering; (5) feeling of choking; (6) chest pain or  
95 discomfort; (7) nausea or abdominal distress; (8) feeling dizzy, unsteady, lightheaded or  
96 faint; (9) derealization (feelings of unreality) or depersonalization (being detached from  
97 oneself); (10) fear of losing control; (11) fear of dying; (12) paresthesias (numbness or  
98 tingling sensations); (13) chills or hot flushes.

99 The effectiveness of Klonopin in long-term use, that is, for more than 9 weeks, has not  
100 been systematically studied in controlled clinical trials. The physician who elects to use  
101 Klonopin for extended periods should periodically reevaluate the long-term usefulness of  
102 the drug for the individual patient (see DOSAGE AND ADMINISTRATION).

103 **CONTRAINDICATIONS**

104 Klonopin should not be used in patients with a history of sensitivity to benzodiazepines,  
105 nor in patients with clinical or biochemical evidence of significant liver disease. It may  
106 be used in patients with open angle glaucoma who are receiving appropriate therapy but  
107 is contraindicated in acute narrow angle glaucoma.

108 **WARNINGS**

109 **Interference With Cognitive and Motor Performance:** Since Klonopin produces CNS  
110 depression, patients receiving this drug should be cautioned against engaging in  
111 hazardous occupations requiring mental alertness, such as operating machinery or driving  
112 a motor vehicle. They should also be warned about the concomitant use of alcohol or

113 other CNS-depressant drugs during Klonopin therapy (see PRECAUTIONS: *Drug*  
114 *Interactions and Information for Patients*).

115 ***Suicidal Behavior and Ideation:*** Antiepileptic drugs (AEDs), including Klonopin,  
116 increase the risk of suicidal thoughts or behavior in patients taking these drugs for any  
117 indication. Patients treated with any AED for any indication should be monitored for the  
118 emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual  
119 changes in mood or behavior.

120 Pooled analyses of 199 placebo-controlled clinical trials (mono- and adjunctive therapy)  
121 of 11 different AEDs showed that patients randomized to one of the AEDs had  
122 approximately twice the risk (adjusted Relative Risk 1.8, 95% CI:1.2, 2.7) of suicidal  
123 thinking or behavior compared to patients randomized to placebo. In these trials, which  
124 had a median treatment duration of 12 weeks, the estimated incidence rate of suicidal  
125 behavior or ideation among 27,863 AED-treated patients was 0.43% compared to 0.24%  
126 among 16,029 placebo-treated patients, representing an increase of approximately one  
127 case of suicidal thinking or behavior for every 530 patients treated. There were four  
128 suicides in drug-treated patients in the trials and none in placebo-treated patients, but the  
129 number is too small to allow any conclusion about drug effect on suicide.

130 The increased risk of suicidal thoughts or behavior with AEDs was observed as early as  
131 one week after starting drug treatment with AEDs and persisted for the duration of  
132 treatment assessed. Because most trials included in the analysis did not extend beyond 24  
133 weeks, the risk of suicidal thoughts or behavior beyond 24 weeks could not be assessed.

134 The risk of suicidal thoughts or behavior was generally consistent among drugs in the  
135 data analyzed. The finding of increased risk with AEDs of varying mechanisms of action  
136 and across a range of indications suggests that the risk applies to all AEDs used for any  
137 indication. The risk did not vary substantially by age (5-100 years) in the clinical trials  
138 analyzed.

139 Table 1 shows absolute and relative risk by indication for all evaluated AEDs.

140 **Table 1 Risk by Indication for Antiepileptic Drugs in the Pooled**  
141 **Analysis**

Indication	Placebo Patients with Events Per 1000 Patients	Drug Patients with Events Per 1000 Patients	Relative Risk: Incidence of Events in Drug Patients/Incidence in Placebo Patients	Risk Difference: Additional Drug Patients with Events per 1000 Patients
Epilepsy	1.0	3.4	3.5	2.4
Psychiatric	5.7	8.5	1.5	2.9
Other	1.0	1.8	1.9	0.9
Total	2.4	4.3	1.8	1.9

142  
143 The relative risk for suicidal thoughts or behavior was higher in clinical trials for epilepsy  
144 than in clinical trials for psychiatric or other conditions, but the absolute risk differences  
145 were similar for the epilepsy and psychiatric indications.

146 Anyone considering prescribing Klonopin or any other AED must balance the risk of  
147 suicidal thoughts or behavior with the risk of untreated illness. Epilepsy and many other  
148 illnesses for which AEDs are prescribed are themselves associated with morbidity and  
149 mortality and an increased risk of suicidal thoughts and behavior. Should suicidal  
150 thoughts and behavior emerge during treatment, the prescriber needs to consider whether  
151 the emergence of these symptoms in any given patient may be related to the illness being  
152 treated.

153 Patients, their caregivers, and families should be informed that AEDs increase the risk of  
154 suicidal thoughts and behavior and should be advised of the need to be alert for the  
155 emergence or worsening of the signs and symptoms of depression, any unusual changes  
156 in mood or behavior, or the emergence of suicidal thoughts, behavior, or thoughts about  
157 self-harm. Behaviors of concern should be reported immediately to healthcare providers.

158 ***Pregnancy Risks:*** Data from several sources raise concerns about the use of Klonopin  
159 during pregnancy.

160 *Animal Findings:* In three studies in which Klonopin was administered orally to pregnant  
161 rabbits at doses of 0.2, 1, 5 or 10 mg/kg/day (low dose approximately 0.2 times the  
162 maximum recommended human dose of 20 mg/day for seizure disorders and equivalent  
163 to the maximum dose of 4 mg/day for panic disorder, on a mg/m<sup>2</sup> basis) during the period  
164 of organogenesis, a similar pattern of malformations (cleft palate, open eyelid, fused  
165 sternebrae and limb defects) was observed in a low, non-dose-related incidence in  
166 exposed litters from all dosage groups. Reductions in maternal weight gain occurred at  
167 dosages of 5 mg/kg/day or greater and reduction in embryo-fetal growth occurred in one  
168 study at a dosage of 10 mg/kg/day. No adverse maternal or embryo-fetal effects were  
169 observed in mice and rats following administration during organogenesis of oral doses up  
170 to 15 mg/kg/day or 40 mg/kg/day, respectively (4 and 20 times the maximum  
171 recommended human dose of 20 mg/day for seizure disorders and 20 and 100 times the  
172 maximum dose of 4 mg/day for panic disorder, respectively, on a mg/m<sup>2</sup> basis).

173 *General Concerns and Considerations About Anticonvulsants:* Recent reports suggest an  
174 association between the use of anticonvulsant drugs by women with epilepsy and an  
175 elevated incidence of birth defects in children born to these women. Data are more  
176 extensive with respect to diphenylhydantoin and phenobarbital, but these are also the  
177 most commonly prescribed anticonvulsants; less systematic or anecdotal reports suggest a  
178 possible similar association with the use of all known anticonvulsant drugs.

179 In children of women treated with drugs for epilepsy, reports suggesting an elevated  
180 incidence of birth defects cannot be regarded as adequate to prove a definite cause and  
181 effect relationship. There are intrinsic methodologic problems in obtaining adequate data  
182 on drug teratogenicity in humans; the possibility also exists that other factors (eg, genetic  
183 factors or the epileptic condition itself) may be more important than drug therapy in  
184 leading to birth defects. The great majority of mothers on anticonvulsant medication  
185 deliver normal infants. It is important to note that anticonvulsant drugs should not be  
186 discontinued in patients in whom the drug is administered to prevent seizures because of  
187 the strong possibility of precipitating status epilepticus with attendant hypoxia and threat

188 to life. In individual cases where the severity and frequency of the seizure disorder are  
189 such that the removal of medication does not pose a serious threat to the patient,  
190 discontinuation of the drug may be considered prior to and during pregnancy; however, it  
191 cannot be said with any confidence that even mild seizures do not pose some hazards to  
192 the developing embryo or fetus.

193 General Concerns About Benzodiazepines: An increased risk of congenital  
194 malformations associated with the use of benzodiazepine drugs has been suggested in  
195 several studies.

196 There may also be non-teratogenic risks associated with the use of benzodiazepines  
197 during pregnancy. There have been reports of neonatal flaccidity, respiratory and feeding  
198 difficulties, and hypothermia in children born to mothers who have been receiving  
199 benzodiazepines late in pregnancy. In addition, children born to mothers receiving  
200 benzodiazepines late in pregnancy may be at some risk of experiencing withdrawal  
201 symptoms during the postnatal period.

202 Advice Regarding the Use of Klonopin in Women of Childbearing Potential: In general,  
203 the use of Klonopin in women of childbearing potential, and more specifically during  
204 known pregnancy, should be considered only when the clinical situation warrants the risk  
205 to the fetus.

206 The specific considerations addressed above regarding the use of anticonvulsants for  
207 epilepsy in women of childbearing potential should be weighed in treating or counseling  
208 these women.

209 Because of experience with other members of the benzodiazepine class, Klonopin is  
210 assumed to be capable of causing an increased risk of congenital abnormalities when  
211 administered to a pregnant woman during the first trimester. Because use of these drugs  
212 is rarely a matter of urgency in the treatment of panic disorder, their use during the first  
213 trimester should almost always be avoided. The possibility that a woman of childbearing  
214 potential may be pregnant at the time of institution of therapy should be considered. If  
215 this drug is used during pregnancy, or if the patient becomes pregnant while taking this  
216 drug, the patient should be apprised of the potential hazard to the fetus. Patients should  
217 also be advised that if they become pregnant during therapy or intend to become  
218 pregnant, they should communicate with their physician about the desirability of  
219 discontinuing the drug.

220 **Withdrawal Symptoms:** Withdrawal symptoms of the barbiturate type have occurred  
221 after the discontinuation of benzodiazepines (see DRUG ABUSE AND DEPENDENCE).

## 222 **PRECAUTIONS**

223 **General: Worsening of Seizures:** When used in patients in whom several different types  
224 of seizure disorders coexist, Klonopin may increase the incidence or precipitate the onset  
225 of generalized tonic-clonic seizures (grand mal). This may require the addition of  
226 appropriate anticonvulsants or an increase in their dosages. The concomitant use of  
227 valproic acid and Klonopin may produce absence status.

228 Laboratory Testing During Long-Term Therapy: Periodic blood counts and liver function  
229 tests are advisable during long-term therapy with Klonopin.

230 Risks of Abrupt Withdrawal: The abrupt withdrawal of Klonopin, particularly in those  
231 patients on long-term, high-dose therapy, may precipitate status epilepticus. Therefore,  
232 when discontinuing Klonopin, gradual withdrawal is essential. While Klonopin is being  
233 gradually withdrawn, the simultaneous substitution of another anticonvulsant may be  
234 indicated.

235 Caution in Renally Impaired Patients: Metabolites of Klonopin are excreted by the  
236 kidneys; to avoid their excess accumulation, caution should be exercised in the  
237 administration of the drug to patients with impaired renal function.

238 Hypersalivation: Klonopin may produce an increase in salivation. This should be  
239 considered before giving the drug to patients who have difficulty handling secretions.  
240 Because of this and the possibility of respiratory depression, Klonopin should be used  
241 with caution in patients with chronic respiratory diseases.

242 Information for Patients: A Klonopin Medication Guide must be given to the patient  
243 each time Klonopin is dispensed, as required by law. Patients should be instructed to take  
244 Klonopin only as prescribed. Physicians are advised to discuss the following issues with  
245 patients for whom they prescribe Klonopin:

246 Dose Changes: To assure the safe and effective use of benzodiazepines, patients should  
247 be informed that, since benzodiazepines may produce psychological and physical  
248 dependence, it is advisable that they consult with their physician before either increasing  
249 the dose or abruptly discontinuing this drug.

250 Interference With Cognitive and Motor Performance: Because benzodiazepines have the  
251 potential to impair judgment, thinking or motor skills, patients should be cautioned about  
252 operating hazardous machinery, including automobiles, until they are reasonably certain  
253 that Klonopin therapy does not affect them adversely.

254 Suicidal Thinking and Behavior: Patients, their caregivers, and families should be  
255 counseled that AEDs, including Klonopin, may increase the risk of suicidal thoughts and  
256 behavior and should be advised of the need to be alert for the emergence or worsening of  
257 symptoms of depression, any unusual changes in mood or behavior, or the emergence of  
258 suicidal thoughts, behavior, or thoughts about self-harm. Behaviors of concern should be  
259 reported immediately to healthcare providers.

260 Pregnancy: Patients should be advised to notify their physician if they become pregnant  
261 or intend to become pregnant during therapy with Klonopin (see WARNINGS:  
262 *Pregnancy Risks*). Patients should be encouraged to enroll in the North American  
263 Antiepileptic Drug (NAAED) Pregnancy Registry if they become pregnant. This registry  
264 is collecting information about the safety of antiepileptic drugs during pregnancy. To  
265 enroll, patients can call the toll free number 1-888-233-2334 (see PRECAUTIONS:  
266 *Pregnancy*).

267 Nursing: Patients should be advised not to breastfeed an infant if they are taking  
268 Klonopin.

269 Concomitant Medication: Patients should be advised to inform their physicians if they are  
270 taking, or plan to take, any prescription or over-the-counter drugs, since there is a  
271 potential for interactions.

272 Alcohol: Patients should be advised to avoid alcohol while taking Klonopin.

273 **Drug Interactions: Effect of Clonazepam on the Pharmacokinetics of Other Drugs:**  
274 Clonazepam does not appear to alter the pharmacokinetics of phenytoin, carbamazepine  
275 or phenobarbital. The effect of clonazepam on the metabolism of other drugs has not  
276 been investigated.

277 **Effect of Other Drugs on the Pharmacokinetics of Clonazepam:** Literature reports suggest  
278 that ranitidine, an agent that decreases stomach acidity, does not greatly alter clonazepam  
279 pharmacokinetics.

280 In a study in which the 2 mg clonazepam orally disintegrating tablet was administered  
281 with and without propantheline (an anticholinergic agent with multiple effects on the GI  
282 tract) to healthy volunteers, the AUC of clonazepam was 10% lower and the C<sub>max</sub> of  
283 clonazepam was 20% lower when the orally disintegrating tablet was given with  
284 propantheline compared to when it was given alone.

285 Fluoxetine does not affect the pharmacokinetics of clonazepam. Cytochrome P-450  
286 inducers, such as phenytoin, carbamazepine and phenobarbital, induce clonazepam  
287 metabolism, causing an approximately 30% decrease in plasma clonazepam levels.  
288 Although clinical studies have not been performed, based on the involvement of the  
289 cytochrome P-450 3A family in clonazepam metabolism, inhibitors of this enzyme  
290 system, notably oral antifungal agents, should be used cautiously in patients receiving  
291 clonazepam.

292 **Pharmacodynamic Interactions:** The CNS-depressant action of the benzodiazepine class  
293 of drugs may be potentiated by alcohol, narcotics, barbiturates, nonbarbiturate hypnotics,  
294 antianxiety agents, the phenothiazines, thioxanthene and butyrophenone classes of  
295 antipsychotic agents, monoamine oxidase inhibitors and the tricyclic antidepressants, and  
296 by other anticonvulsant drugs.

297 **Carcinogenesis, Mutagenesis, Impairment of Fertility:** Carcinogenicity studies have not  
298 been conducted with clonazepam.

299 The data currently available are not sufficient to determine the genotoxic potential of  
300 clonazepam.

301 In a two-generation fertility study in which clonazepam was given orally to rats at 10 and  
302 100 mg/kg/day (low dose approximately 5 times and 24 times the maximum  
303 recommended human dose of 20 mg/day for seizure disorder and 4 mg/day for panic  
304 disorder, respectively, on a mg/m<sup>2</sup> basis), there was a decrease in the number of  
305 pregnancies and in the number of offspring surviving until weaning.

306 ***Pregnancy: Teratogenic Effects:*** Pregnancy Category D (see WARNINGS: *Pregnancy*  
307 *Risks*).

308 To provide information regarding the effects of in utero exposure to Klonopin, physicians  
309 are advised to recommend that pregnant patients taking Klonopin enroll in the NAAED  
310 Pregnancy Registry. This can be done by calling the toll free number 1-888-233-2334,  
311 and must be done by patients themselves. Information on this registry can also be found  
312 at the website <http://www.aedpregnancyregistry.org/>.

313 ***Labor and Delivery:*** The effect of Klonopin on labor and delivery in humans has not  
314 been specifically studied; however, perinatal complications have been reported in  
315 children born to mothers who have been receiving benzodiazepines late in pregnancy,  
316 including findings suggestive of either excess benzodiazepine exposure or of withdrawal  
317 phenomena (see WARNINGS: *Pregnancy Risks*).

318 ***Nursing Mothers:*** Mothers receiving Klonopin should not breastfeed their infants.

319 ***Pediatric Use:*** Because of the possibility that adverse effects on physical or mental  
320 development could become apparent only after many years, a benefit-risk consideration  
321 of the long-term use of Klonopin is important in pediatric patients being treated for  
322 seizure disorder (see INDICATIONS AND USAGE and DOSAGE AND  
323 ADMINISTRATION).

324 Safety and effectiveness in pediatric patients with panic disorder below the age of 18  
325 have not been established.

326 ***Geriatric Use:*** Clinical studies of Klonopin did not include sufficient numbers of subjects  
327 aged 65 and over to determine whether they respond differently from younger subjects.  
328 Other reported clinical experience has not identified differences in responses between the  
329 elderly and younger patients. In general, dose selection for an elderly patient should be  
330 cautious, usually starting at the low end of the dosing range, reflecting the greater  
331 frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or  
332 other drug therapy.

333 Because clonazepam undergoes hepatic metabolism, it is possible that liver disease will  
334 impair clonazepam elimination. Metabolites of Klonopin are excreted by the kidneys; to  
335 avoid their excess accumulation, caution should be exercised in the administration of the  
336 drug to patients with impaired renal function. Because elderly patients are more likely to  
337 have decreased hepatic and/or renal function, care should be taken in dose selection, and  
338 it may be useful to assess hepatic and/or renal function at the time of dose selection.

339 Sedating drugs may cause confusion and over-sedation in the elderly; elderly patients  
340 generally should be started on low doses of Klonopin and observed closely.

#### 341 **ADVERSE REACTIONS**

342 The adverse experiences for Klonopin are provided separately for patients with seizure  
343 disorders and with panic disorder.

344 **Seizure Disorders:** The most frequently occurring side effects of Klonopin are referable  
345 to CNS depression. Experience in treatment of seizures has shown that drowsiness has  
346 occurred in approximately 50% of patients and ataxia in approximately 30%. In some  
347 cases, these may diminish with time; behavior problems have been noted in  
348 approximately 25% of patients. Others, listed by system, are:

349 *Neurologic:* Abnormal eye movements, aphonia, choreiform movements, coma, diplopia,  
350 dysarthria, dysdiadochokinesis, “glassy-eyed” appearance, headache, hemiparesis,  
351 hypotonia, nystagmus, respiratory depression, slurred speech, tremor, vertigo

352 *Psychiatric:* Confusion, depression, amnesia, hallucinations, hysteria, increased libido,  
353 insomnia, psychosis (the behavior effects are more likely to occur in patients with a  
354 history of psychiatric disturbances). The following paradoxical reactions have been  
355 observed: excitability, irritability, aggressive behavior, agitation, nervousness, hostility,  
356 anxiety, sleep disturbances, nightmares and vivid dreams

357 *Respiratory:* Chest congestion, rhinorrhea, shortness of breath, hypersecretion in upper  
358 respiratory passages

359 *Cardiovascular:* Palpitations

360 *Dermatologic:* Hair loss, hirsutism, skin rash, ankle and facial edema

361 *Gastrointestinal:* Anorexia, coated tongue, constipation, diarrhea, dry mouth, encopresis,  
362 gastritis, increased appetite, nausea, sore gums

363 *Genitourinary:* Dysuria, enuresis, nocturia, urinary retention

364 *Musculoskeletal:* Muscle weakness, pains

365 *Miscellaneous:* Dehydration, general deterioration, fever, lymphadenopathy, weight loss  
366 or gain

367 *Hematopoietic:* Anemia, leukopenia, thrombocytopenia, eosinophilia

368 *Hepatic:* Hepatomegaly, transient elevations of serum transaminases and alkaline  
369 phosphatase

370 **Panic Disorder:** Adverse events during exposure to Klonopin were obtained by  
371 spontaneous report and recorded by clinical investigators using terminology of their own  
372 choosing. Consequently, it is not possible to provide a meaningful estimate of the  
373 proportion of individuals experiencing adverse events without first grouping similar types  
374 of events into a smaller number of standardized event categories. In the tables and  
375 tabulations that follow, CIGY dictionary terminology has been used to classify reported  
376 adverse events, except in certain cases in which redundant terms were collapsed into  
377 more meaningful terms, as noted below.

378 The stated frequencies of adverse events represent the proportion of individuals who  
379 experienced, at least once, a treatment-emergent adverse event of the type listed. An

380 event was considered treatment-emergent if it occurred for the first time or worsened  
381 while receiving therapy following baseline evaluation.

382

383

384 ***Adverse Findings Observed in Short-Term, Placebo-Controlled Trials:***

385 ***Adverse Events Associated With Discontinuation of Treatment:***

386 Overall, the incidence of discontinuation due to adverse events was 17% in Klonopin  
387 compared to 9% for placebo in the combined data of two 6- to 9-week trials. The most  
388 common events ( $\geq 1\%$ ) associated with discontinuation and a dropout rate twice or greater  
389 for Klonopin than that of placebo included the following:

390 **Table 2 Most Common Adverse Events ( $\geq 1\%$ ) Associated with**  
391 **Discontinuation of Treatment**

Adverse Event	Klonopin (N=574)	Placebo (N=294)
Somnolence	7%	1%
Depression	4%	1%
Dizziness	1%	<1%
Nervousness	1%	0%
Ataxia	1%	0%
Intellectual Ability Reduced	1%	0%

392 ***Adverse Events Occurring at an Incidence of 1% or More Among Klonopin-Treated***  
393 ***Patients:***

394 Table 3 enumerates the incidence, rounded to the nearest percent, of treatment-emergent  
395 adverse events that occurred during acute therapy of panic disorder from a pool of two 6-  
396 to 9-week trials. Events reported in 1% or more of patients treated with Klonopin (doses  
397 ranging from 0.5 to 4 mg/day) and for which the incidence was greater than that in  
398 placebo-treated patients are included.

399 The prescriber should be aware that the figures in Table 3 cannot be used to predict the  
400 incidence of side effects in the course of usual medical practice where patient  
401 characteristics and other factors differ from those that prevailed in the clinical trials.  
402 Similarly, the cited frequencies cannot be compared with figures obtained from other  
403 clinical investigations involving different treatments, uses and investigators. The cited  
404 figures, however, do provide the prescribing physician with some basis for estimating the  
405 relative contribution of drug and nondrug factors to the side effect incidence in the  
406 population studied.

407 **Table 3 Treatment-Emergent Adverse Event Incidence in 6- to 9-**  
408 **Week Placebo-Controlled Clinical Trials\***

Clonazepam Maximum Daily Dose
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<b>Adverse Event by Body System</b>	<b>&lt;1mg n=96 %</b>	<b>1-&lt;2mg n=129 %</b>	<b>2-&lt;3mg n=113 %</b>	<b>≥3mg n=235 %</b>	<b>All Klonopin Groups N=574 %</b>	<b>Placebo N=294 %</b>
<b>Central &amp; Peripheral Nervous System</b>						
Somnolence†	26	35	50	36	37	10
Dizziness	5	5	12	8	8	4
Coordination Abnormal†	1	2	7	9	6	0
Ataxia†	2	1	8	8	5	0
Dysarthria†	0	0	4	3	2	0
<b>Psychiatric</b>						
Depression	7	6	8	8	7	1
Memory Disturbance	2	5	2	5	4	2
Nervousness	1	4	3	4	3	2
Intellectual Ability Reduced	0	2	4	3	2	0
Emotional Lability	0	1	2	2	1	1
Libido Decreased	0	1	3	1	1	0
Confusion	0	2	2	1	1	0
<b>Respiratory System</b>						
Upper Respiratory Tract Infection†	10	10	7	6	8	4
Sinusitis	4	2	8	4	4	3
Rhinitis	3	2	4	2	2	1
Coughing	2	2	4	0	2	0
Pharyngitis	1	1	3	2	2	1
Bronchitis	1	0	2	2	1	1
<b>Gastrointestinal System</b>						
Constipation†	0	1	5	3	2	2
Appetite Decreased	1	1	0	3	1	1
Abdominal Pain†	2	2	2	0	1	1

Clonazepam Maximum Daily Dose						
Adverse Event by Body System	<1mg n=96 %	1-<2mg n=129 %	2-<3mg n=113 %	≥3mg n=235 %	All Klonopin Groups N=574 %	Placebo N=294 %
Body as a Whole						
Fatigue	9	6	7	7	7	4
Allergic Reaction	3	1	4	2	2	1
Musculoskeletal						
Myalgia	2	1	4	0	1	1
Resistance Mechanism Disorders						
Influenza	3	2	5	5	4	3
Urinary System						
Micturition Frequency	1	2	2	1	1	0
Urinary Tract Infection†	0	0	2	2	1	0
Vision Disorders						
Blurred Vision	1	2	3	0	1	1
Reproductive Disorders‡						
Female						
Dysmenorrhea	0	6	5	2	3	2
Colpitis	4	0	2	1	1	1
Male						
Ejaculation Delayed	0	0	2	2	1	0
Impotence	3	0	2	1	1	0

409 \* Events reported by at least 1% of patients treated with Klonopin and for which the  
410 incidence was greater than that for placebo.

411 † Indicates that the p-value for the dose-trend test (Cochran-Mantel-Haenszel) for  
412 adverse event incidence was ≤0.10.

413 ‡ Denominators for events in gender-specific systems are: n=240 (clonazepam), 102  
414 (placebo) for male, and 334 (clonazepam), 192 (placebo) for female.

415 Commonly Observed Adverse Events:

416 **Table 4 Incidence of Most Commonly Observed Adverse Events\* in**  
417 **Acute Therapy in Pool of 6- to 9-Week Trials**

<b>Adverse Event (Genentech Preferred Term)</b>	<b>Clonazepam (N=574)</b>	<b>Placebo (N=294)</b>
Somnolence	37%	10%
Depression	7%	1%
Coordination Abnormal	6%	0%
Ataxia	5%	0%

418 \* Treatment-emergent events for which the incidence in the clonazepam patients was  
419  $\geq 5\%$  and at least twice that in the placebo patients.

420 Treatment-Emergent Depressive Symptoms:

421 In the pool of two short-term placebo-controlled trials, adverse events classified under the  
422 preferred term “depression” were reported in 7% of Klonopin-treated patients compared  
423 to 1% of placebo-treated patients, without any clear pattern of dose relatedness. In these  
424 same trials, adverse events classified under the preferred term “depression” were reported  
425 as leading to discontinuation in 4% of Klonopin-treated patients compared to 1% of  
426 placebo-treated patients. While these findings are noteworthy, Hamilton Depression  
427 Rating Scale (HAM-D) data collected in these trials revealed a larger decline in HAM-D  
428 scores in the clonazepam group than the placebo group suggesting that clonazepam-  
429 treated patients were not experiencing a worsening or emergence of clinical depression.

430 Other Adverse Events Observed During the Premarketing Evaluation of Klonopin in  
431 Panic Disorder:

432 Following is a list of modified CIGY terms that reflect treatment-emergent adverse  
433 events reported by patients treated with Klonopin at multiple doses during clinical trials.  
434 All reported events are included except those already listed in Table 3 or elsewhere in  
435 labeling, those events for which a drug cause was remote, those event terms which were  
436 so general as to be uninformative, and events reported only once and which did not have  
437 a substantial probability of being acutely life-threatening. It is important to emphasize  
438 that, although the events occurred during treatment with Klonopin, they were not  
439 necessarily caused by it.

440 Events are further categorized by body system and listed in order of decreasing  
441 frequency. These adverse events were reported infrequently, which is defined as  
442 occurring in 1/100 to 1/1000 patients.

443 *Body as a Whole:* weight increase, accident, weight decrease, wound, edema, fever,  
444 shivering, abrasions, ankle edema, edema foot, edema periorbital, injury, malaise, pain,  
445 cellulitis, inflammation localized

446 *Cardiovascular Disorders:* chest pain, hypotension postural

- 447 *Central and Peripheral Nervous System Disorders:* migraine, paresthesia, drunkenness,  
448 feeling of enuresis, paresis, tremor, burning skin, falling, head fullness, hoarseness,  
449 hyperactivity, hypoesthesia, tongue thick, twitching
- 450 *Gastrointestinal System Disorders:* abdominal discomfort, gastrointestinal inflammation,  
451 stomach upset, toothache, flatulence, pyrosis, saliva increased, tooth disorder, bowel  
452 movements frequent, pain pelvic, dyspepsia, hemorrhoids
- 453 *Hearing and Vestibular Disorders:* vertigo, otitis, earache, motion sickness
- 454 *Heart Rate and Rhythm Disorders:* palpitation
- 455 *Metabolic and Nutritional Disorders:* thirst, gout
- 456 *Musculoskeletal System Disorders:* back pain, fracture traumatic, sprains and strains, pain  
457 leg, pain nape, cramps muscle, cramps leg, pain ankle, pain shoulder, tendinitis,  
458 arthralgia, hypertonia, lumbago, pain feet, pain jaw, pain knee, swelling knee
- 459 *Platelet, Bleeding and Clotting Disorders:* bleeding dermal
- 460 *Psychiatric Disorders:* insomnia, organic disinhibition, anxiety, depersonalization,  
461 dreaming excessive, libido loss, appetite increased, libido increased, reactions decreased,  
462 aggressive reaction, apathy, attention lack, excitement, feeling mad, hunger abnormal,  
463 illusion, nightmares, sleep disorder, suicide ideation, yawning
- 464 *Reproductive Disorders, Female:* breast pain, menstrual irregularity
- 465 *Reproductive Disorders, Male:* ejaculation decreased
- 466 *Resistance Mechanism Disorders:* infection mycotic, infection viral, infection  
467 streptococcal, herpes simplex infection, infectious mononucleosis, moniliasis
- 468 *Respiratory System Disorders:* sneezing excessive, asthmatic attack, dyspnea, nosebleed,  
469 pneumonia, pleurisy
- 470 *Skin and Appendages Disorders:* acne flare, alopecia, xeroderma, dermatitis contact,  
471 flushing, pruritus, pustular reaction, skin burns, skin disorder
- 472 *Special Senses Other, Disorders:* taste loss
- 473 *Urinary System Disorders:* dysuria, cystitis, polyuria, urinary incontinence, bladder  
474 dysfunction, urinary retention, urinary tract bleeding, urine discoloration
- 475 *Vascular (Extracardiac) Disorders:* thrombophlebitis leg
- 476 *Vision Disorders:* eye irritation, visual disturbance, diplopia, eye twitching, styes, visual  
477 field defect, xerophthalmia
- 478 **DRUG ABUSE AND DEPENDENCE**
- 479 *Controlled Substance Class:* Clonazepam is a Schedule IV controlled substance.

480 ***Physical and Psychological Dependence:*** Withdrawal symptoms, similar in character to  
481 those noted with barbiturates and alcohol (eg, convulsions, psychosis, hallucinations,  
482 behavioral disorder, tremor, abdominal and muscle cramps) have occurred following  
483 abrupt discontinuance of clonazepam. The more severe withdrawal symptoms have  
484 usually been limited to those patients who received excessive doses over an extended  
485 period of time. Generally milder withdrawal symptoms (eg, dysphoria and insomnia)  
486 have been reported following abrupt discontinuance of benzodiazepines taken  
487 continuously at therapeutic levels for several months. Consequently, after extended  
488 therapy, abrupt discontinuation should generally be avoided and a gradual dosage  
489 tapering schedule followed (see DOSAGE AND ADMINISTRATION). Addiction-prone  
490 individuals (such as drug addicts or alcoholics) should be under careful surveillance when  
491 receiving clonazepam or other psychotropic agents because of the predisposition of such  
492 patients to habituation and dependence.

493 Following the short-term treatment of patients with panic disorder in Studies 1 and 2 (see  
494 CLINICAL PHARMACOLOGY: *Clinical Trials*), patients were gradually withdrawn  
495 during a 7-week downward-titration (discontinuance) period. Overall, the discontinuance  
496 period was associated with good tolerability and a very modest clinical deterioration,  
497 without evidence of a significant rebound phenomenon. However, there are not sufficient  
498 data from adequate and well-controlled long-term clonazepam studies in patients with  
499 panic disorder to accurately estimate the risks of withdrawal symptoms and dependence  
500 that may be associated with such use.

## 501 **OVERDOSAGE**

502 ***Human Experience:*** Symptoms of clonazepam overdose, like those produced by other  
503 CNS depressants, include somnolence, confusion, coma and diminished reflexes.

504 ***Overdose Management:*** Treatment includes monitoring of respiration, pulse and blood  
505 pressure, general supportive measures and immediate gastric lavage. Intravenous fluids  
506 should be administered and an adequate airway maintained. Hypotension may be  
507 combated by the use of levarterenol or metaraminol. Dialysis is of no known value.

508 Flumazenil, a specific benzodiazepine-receptor antagonist, is indicated for the complete  
509 or partial reversal of the sedative effects of benzodiazepines and may be used in  
510 situations when an overdose with a benzodiazepine is known or suspected. Prior to the  
511 administration of flumazenil, necessary measures should be instituted to secure airway,  
512 ventilation and intravenous access. Flumazenil is intended as an adjunct to, not as a  
513 substitute for, proper management of benzodiazepine overdose. Patients treated with  
514 flumazenil should be monitored for re sedation, respiratory depression and other residual  
515 benzodiazepine effects for an appropriate period after treatment. **The prescriber should  
516 be aware of a risk of seizure in association with flumazenil treatment, particularly in  
517 long-term benzodiazepine users and in cyclic antidepressant overdose.** The complete  
518 flumazenil package insert, including CONTRAINDICATIONS, WARNINGS and  
519 PRECAUTIONS, should be consulted prior to use.

520 **Flumazenil is not indicated in patients with epilepsy who have been treated with**  
521 **benzodiazepines. Antagonism of the benzodiazepine effect in such patients may**  
522 **provoke seizures.**

523 Serious sequelae are rare unless other drugs or alcohol have been taken concomitantly.

## 524 **DOSAGE AND ADMINISTRATION**

525 Clonazepam is available as a tablet or an orally disintegrating tablet (wafer). The tablets  
526 should be administered with water by swallowing the tablet whole. The orally  
527 disintegrating tablet should be administered as follows: After opening the pouch, peel  
528 back the foil on the blister. Do not push tablet through foil. Immediately upon opening  
529 the blister, using dry hands, remove the tablet and place it in the mouth. Tablet  
530 disintegration occurs rapidly in saliva so it can be easily swallowed with or without  
531 water.

532

533 ***Seizure Disorders: Adults:*** The initial dose for adults with seizure disorders should not  
534 exceed 1.5 mg/day divided into three doses. Dosage may be increased in increments of  
535 0.5 to 1 mg every 3 days until seizures are adequately controlled or until side effects  
536 preclude any further increase. Maintenance dosage must be individualized for each  
537 patient depending upon response. Maximum recommended daily dose is 20 mg.

538 The use of multiple anticonvulsants may result in an increase of depressant adverse  
539 effects. This should be considered before adding Klonopin to an existing anticonvulsant  
540 regimen.

541 ***Pediatric Patients:*** Klonopin is administered orally. In order to minimize drowsiness, the  
542 initial dose for infants and children (up to 10 years of age or 30 kg of body weight)  
543 should be between 0.01 and 0.03 mg/kg/day but not to exceed 0.05 mg/kg/day given in  
544 two or three divided doses. Dosage should be increased by no more than 0.25 to 0.5 mg  
545 every third day until a daily maintenance dose of 0.1 to 0.2 mg/kg of body weight has  
546 been reached, unless seizures are controlled or side effects preclude further increase.  
547 Whenever possible, the daily dose should be divided into three equal doses. If doses are  
548 not equally divided, the largest dose should be given before retiring.

549 ***Geriatric Patients:*** There is no clinical trial experience with Klonopin in seizure disorder  
550 patients 65 years of age and older. In general, elderly patients should be started on low  
551 doses of Klonopin and observed closely (see PRECAUTIONS: *Geriatric Use*).

552 ***Panic Disorder: Adults:*** The initial dose for adults with panic disorder is 0.25 mg bid. An  
553 increase to the target dose for most patients of 1 mg/day may be made after 3 days. The  
554 recommended dose of 1 mg/day is based on the results from a fixed dose study in which  
555 the optimal effect was seen at 1 mg/day. Higher doses of 2, 3 and 4 mg/day in that study  
556 were less effective than the 1 mg/day dose and were associated with more adverse  
557 effects. Nevertheless, it is possible that some individual patients may benefit from doses  
558 of up to a maximum dose of 4 mg/day, and in those instances, the dose may be increased  
559 in increments of 0.125 to 0.25 mg bid every 3 days until panic disorder is controlled or

560 until side effects make further increases undesired. To reduce the inconvenience of  
561 somnolence, administration of one dose at bedtime may be desirable.

562 Treatment should be discontinued gradually, with a decrease of 0.125 mg bid every  
563 3 days, until the drug is completely withdrawn.

564 There is no body of evidence available to answer the question of how long the patient  
565 treated with clonazepam should remain on it. Therefore, the physician who elects to use  
566 Klonopin for extended periods should periodically reevaluate the long-term usefulness of  
567 the drug for the individual patient.

568 Pediatric Patients: There is no clinical trial experience with Klonopin in panic disorder  
569 patients under 18 years of age.

570 Geriatric Patients: There is no clinical trial experience with Klonopin in panic disorder  
571 patients 65 years of age and older. In general, elderly patients should be started on low  
572 doses of Klonopin and observed closely (see PRECAUTIONS: *Geriatric Use*).

### 573 HOW SUPPLIED

574 Klonopin tablets are available as scored tablets with a K-shaped perforation—0.5 mg,  
575 orange (NDC 0004-0068-01); and unscored tablets with a K-shaped perforation—1 mg,  
576 blue (NDC 0004-0058-01); 2 mg, white (NDC 0004-0098-01)—bottles of 100.

577 Imprint on tablets:

578 0.5 mg — 1/2 KLONOPIN (front)  
579 ROCHE (scored side)



580 1 mg — 1 KLONOPIN (front)  
581 ROCHE (reverse side)



582 2 mg — 2 KLONOPIN (front)  
583 ROCHE (reverse side)



584 Klonopin Wafers (clonazepam orally disintegrating tablets) are white, round and  
585 debossed with the tablet strength expressed as a fraction or whole number (1/8, 1/4, 1/2,  
586 1, or 2). The tablets are available in blister packages of 60 (10 pouches/carton) as  
587 follows:

588 0.125 mg debossed 1/8, (NDC 0004-0279-22)

589 0.25 mg debossed 1/4, (NDC 0004-0280-22)

590 0.5 mg debossed 1/2, (NDC 0004-0281-22)

591 1 mg debossed 1, (NDC 0004-0282-22)

592 2 mg debossed 2, (NDC 0004-0283-22)

593 Store at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F).

594

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A Member of the Roche Group

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596

597 Revised: Month Year

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1 **Medication Guide**

2 **KLONOPIN® (KLON-oh-pin)**

3 **(clonazepam)**

4 **Tablets and Wafers**



6 Read this Medication Guide before you start taking KLONOPIN and each time  
7 you get a refill. There may be new information. This information does not take the  
8 place of talking to your healthcare provider about your medical condition or  
9 treatment.

10 KLONOPIN can cause serious side effects. Because stopping KLONOPIN  
11 suddenly can also cause serious problems, do not stop taking KLONOPIN without  
12 talking to your healthcare provider first.

13 **What is the most important information I should know about KLONOPIN?**

14 **Do not stop taking KLONOPIN without first talking to your healthcare**  
15 **provider.** Stopping KLONOPIN suddenly can cause serious problems.

16 **KLONOPIN can cause serious side effects, including:**

17 **1. KLONOPIN can slow your thinking and motor skills**

- 18 • Do not drive, operate heavy machinery, or do other dangerous activities  
19 until you know how KLONOPIN affects you.
- 20 • Do not drink alcohol or take other drugs that may make you sleepy or  
21 dizzy while taking KLONOPIN until you talk to your healthcare  
22 provider. When taken with alcohol or drugs that cause sleepiness or  
23 dizziness, KLONOPIN may make your sleepiness or dizziness worse.

24 **2. Like other antiepileptic drugs, KLONOPIN may cause suicidal thoughts**  
25 **or actions in a very small number of people, about 1 in 500.**

26 **Call a healthcare provider right away if you have any of these**  
27 **symptoms, especially if they are new, worse, or worry you:**

- 28 ■ thoughts about suicide or dying  
29 ■ attempt to commit suicide  
30 ■ new or worse depression  
31 ■ new or worse anxiety  
32 ■ feeling agitated or restless  
33 ■ panic attacks  
34 ■ trouble sleeping (insomnia)  
35 ■ new or worse irritability  
36 ■ acting aggressive, being angry, or violent  
37 ■ acting on dangerous impulses  
38 ■ an extreme increase in activity and talking (mania)

- 39       ▪     other unusual changes in behavior or mood

40       **How can I watch for early symptoms of suicidal thoughts and actions?**

- 41       •     Pay attention to any changes, especially sudden changes, in mood,  
42       behaviors, thoughts, or feelings.

- 43       •     Keep all follow-up visits with your healthcare provider as scheduled.

44       Call your healthcare provider between visits as needed, especially if you are  
45       worried about symptoms.

46  
47       Suicidal thoughts or actions can be caused by things other than medicines. If  
48       you have suicidal thoughts or actions, your healthcare provider may check  
49       for other causes.

50       **Do not stop KLONOPIN without first talking to a healthcare provider.**

51       Stopping KLONOPIN suddenly can cause serious problems. Stopping  
52       KLONOPIN suddenly can cause seizures that will not stop (status  
53       epilepticus).

54       **3. KLONOPIN may harm your unborn or developing baby.**

- 55       •     If you take KLONOPIN during pregnancy, your baby is at risk for serious  
56       birth defects. These defects can happen as early as in the first month of  
57       pregnancy, even before you know you are pregnant. Birth defects may  
58       occur even in children born to women who are not taking any medicines  
59       and do not have other risk factors.

- 60       •     Children born to mothers receiving benzodiazepine medications (including  
61       KLONOPIN) late in pregnancy may be at some risk of experiencing  
62       breathing problems, feeding problems, hypothermia, and withdrawal  
63       symptoms.

- 64       •     Tell your healthcare provider right away if you become pregnant while  
65       taking KLONOPIN. You and your healthcare provider should decide if  
66       you will take KLONOPIN while you are pregnant.

- 67       •     If you become pregnant while taking KLONOPIN, talk to your healthcare  
68       provider about registering with the North American Antiepileptic Drug  
69       Pregnancy Registry. You can register by calling 1-888-233-2334. The  
70       purpose of this registry is to collect information about the safety of  
71       antiepileptic drugs during pregnancy.

- 72       •     KLONOPIN can pass into breast milk. Talk to your healthcare provider  
73       about the best way to feed your baby if you take KLONOPIN. You and  
74       your healthcare provider should decide if you will take KLONOPIN or  
75       breast feed. You should not do both.

76       **4. KLONOPIN can cause abuse and dependence.**

- 77 • Do not stop taking KLONOPIN all of a sudden. Stopping KLONOPIN  
78 suddenly can cause seizures that do not stop, hearing or seeing things that  
79 are not there (hallucinations), shaking, and stomach and muscle cramps.
- 80 ○ Talk to your doctor about slowly stopping KLONOPIN to avoid  
81 getting sick with withdrawal symptoms.
- 82 ○ Physical dependence is not the same as drug addiction. Your  
83 healthcare provider can tell you more about the differences  
84 between physical dependence and drug addiction.

85 **KLONOPIN is a federally controlled substance (C-IV) because it can be**  
86 **abused or lead to dependence. Keep KLONOPIN in a safe place to prevent**  
87 **misuse and abuse. Selling or giving away KLONOPIN may harm others, and**  
88 **is against the law. Tell your doctor if you have ever abused or been**  
89 **dependent on alcohol, prescription medicines or street drugs.**

### 90 **What is KLONOPIN?**

91 KLONOPIN is a prescription medicine used alone or with other medicines to  
92 treat:

- 93 • certain types of seizure disorders (epilepsy) in adults and children  
94 • panic disorder with or without fear of open spaces (agoraphobia) in adults

95 It is not known if KLONOPIN is safe or effective in treating panic disorder in  
96 children younger than 18 years old.

### 97 **Who should not take KLONOPIN?**

98 Do not take KLONOPIN if you:

- 99 • are allergic to benzodiazepines  
100 • have significant liver disease  
101 • have an eye disease called acute narrow angle glaucoma

102 **Ask your healthcare provider if you are not sure if you have any of the**  
103 **problems listed above.**

### 104 **What should I tell my healthcare provider before taking KLONOPIN?**

105 Before you take KLONOPIN, tell your healthcare provider if you:

- 106 • have liver or kidney problems  
107 • have lung problems (respiratory disease)  
108 • have or have had depression, mood problems, or suicidal thoughts or  
109 behavior  
110 • have any other medical conditions  
111

112 **Tell your healthcare provider about all the medicines you take**, including  
113 prescription and non-prescription medicines, vitamins, and herbal supplements.  
114 Taking KLONOPIN with certain other medicines can cause side effects or affect  
115 how well they work. Do not start or stop other medicines without talking to your  
116 healthcare provider.

117 Know the medicines you take. Keep a list of them and show it to your healthcare  
118 provider and pharmacist when you get a new medicine.

### 119 **How should I take KLONOPIN?**

- 120 • Take KLONOPIN exactly as your healthcare provider tells you.  
121 KLONOPIN is available as a tablet or as an orally disintegrating tablet  
122 (wafer).
- 123 • Do not stop taking KLONOPIN without first talking to your healthcare  
124 provider. Stopping KLONOPIN suddenly can cause serious problems.
- 125 • **KLONOPIN tablets** should be taken with water and swallowed whole.
- 126 • **KLONOPIN wafers** can be taken with or without water.
  - 127 ○ Do not open the pouch until you are ready to take KLONOPIN.
  - 128 ○ After opening the pouch, peel back the foil on the blister pack.
  - 129 ○ Do not push the wafer through the foil.
  - 130 ○ After opening the blister pack, with dry hands, take the wafer and  
131 place it in your mouth.
  - 132 ○ The wafer will melt quickly.
- 133 • If you take too much KLONOPIN, call your healthcare provider or local  
134 Poison Control Center right away.

### 135 **What should I avoid while taking KLONOPIN?**

- 136 • KLONOPIN can slow your thinking and motor skills. Do not drive,  
137 operate heavy machinery, or do other dangerous activities until you know  
138 how KLONOPIN affects you.
- 139 • Do not drink alcohol or take other drugs that may make you sleepy or  
140 dizzy while taking KLONOPIN until you talk to your healthcare  
141 provider. When taken with alcohol or drugs that cause sleepiness or  
142 dizziness, KLONOPIN may make your sleepiness or dizziness worse.

### 143 **What are the possible side effects of KLONOPIN?**

144 **See “What is the most important information I should know about**  
145 **KLONOPIN?”**

146 KLONOPIN can also make your seizures happen more often or make them worse.  
147 Call your healthcare provider right away if your seizures get worse while taking  
148 KLONOPIN.

149 The most common side effects of KLONOPIN include:

- 150 • Drowsiness
- 151 • Problems with walking and coordination
- 152 • Dizziness
- 153 • Depression
- 154 • Fatigue
- 155 • Problems with memory

156 These are not all the possible side effects of KLONOPIN. For more information,  
157 ask your healthcare provider or pharmacist.

158 Tell your healthcare provider if you have any side effect that bothers you or that  
159 does not go away.

160 Call your doctor for medical advice about side effects. You may report side  
161 effects to FDA at 1-800-FDA-1088.

### 162 **How should I store KLONOPIN?**

- 163 • Store KLONOPIN between 59°F to 86°F (15°C to 30°C)

164 **Keep KLONOPIN and all medicines out of the reach of children.**

### 165 **General Information about KLONOPIN**

166 Medicines are sometimes prescribed for purposes other than those listed in a  
167 Medication Guide. Do not use KLONOPIN for a condition for which it was not  
168 prescribed. Do not give KLONOPIN to other people, even if they have the same  
169 symptoms that you have. It may harm them.

170 This Medication Guide summarizes the most important information about  
171 KLONOPIN. If you would like more information, talk with your healthcare  
172 provider. You can ask your pharmacist or healthcare provider for information  
173 about KLONOPIN that is written for health professionals.

174 For more information, go to [www.gene.com/gene/products/information/klonopin](http://www.gene.com/gene/products/information/klonopin)  
175 or call 1-888-835-2555.

### 176 **What are the ingredients in KLONOPIN?**

177 Active ingredient: clonazepam

178 Inactive ingredients:

- 179 • Tablets:
  - 180 ○ 0.5 mg tablets contain lactose, magnesium stearate,  
181 microcrystalline cellulose, corn starch, FD&C Yellow No. 6 Lake
  - 182 ○ 1 mg tablets contain lactose, magnesium stearate, microcrystalline  
183 cellulose, corn starch, FD&C Blue No. 1 Lake and FD&C Blue  
184 No. 2 Lake
  - 185 ○ 2 mg tablets contain lactose, magnesium stearate, microcrystalline  
186 cellulose, corn starch

187       • Wafers: gelatin, mannitol, methylparaben sodium, propylparaben sodium  
188           and xanthan gum  
189

190 Issued: Month Year

191 This Medication Guide has been approved by the U.S. Food and Drug  
192 Administration.

193

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196 For additional copies of this Medication Guide, please call 1-877-436-3683 or visit

197 [www.gene.com/gene/products/information/klonopin](http://www.gene.com/gene/products/information/klonopin).