GlaxoSmithKline

Keppra® 100 mg/ml
levetiracetam
oral solution

COMPOSITION Registration No.024651

Each ml contains 100 mg levetiracetam.

PHARMACOTHERAPEUTIC GROUP

Antiepileptics.

Therapeutic indications

Monotherapy in the treatment of partial onset seizures with or without secondary generalization in patients from 16 years of age.

Adjunctive therapy for partial onset seizures with or without secondary generalization in adults and children from 4 years of age with epilepsy.

Adjunctive therapy in the treatment of myoclonic seizures in adults and adolescents from 12 years of age with Juvenile Myoclonic Epilepsy.

Adjunctive therapy in the treatment of primary generalized tonic-clonic seizures in adults and adolescents from 16 years of age with Idiopathic Generalized Epilepsy.

Posology and method of administration

Keppra is classified as a prescription drug.

The oral solution may be diluted in a glass of water and may be taken with or without food. A graduated oral syringe and instructions for use in the package leaflet are provided with Keppra. The daily dose is administered in two equally divided doses.

• Monotherapy

Adults and adolescents from 16 years of age

The recommended starting dose is 250 mg twice daily which should be increased to an initial therapeutic dose of 500 mg twice daily after two weeks. The dose can be further increased by 250 mg twice daily every two weeks depending upon the clinical response. The maximum dose is 1500 mg twice daily.

• Add-on therapy

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

The initial therapeutic dose is 500 mg twice daily. This dose can be started on the first day of treatment.

Depending upon the clinical response and tolerability, the daily dose can be increased up to 1,500 mg twice daily. Dose changes can be made in 500 mg twice daily increments or decrements every two to four weeks.

Elderly (from 65 years old)

Adjustment of the dose is recommended in elderly patients with compromised renal function (see "Patients with renal impairment" below).

Children aged 4 to 11 years and adolescents (12 to 17 years) of less than 50 kg

The initial therapeutic dose is 10 mg/kg twice daily.

Depending upon the clinical response and tolerability, the dose can be increased up to 30 mg/kg twice daily. Dose changes should not exceed increases or decreases of 10 mg/kg twice daily every two weeks. The lowest effective dose should be used.

Dosage in children 50 kg or greater is the same as in adults.

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

Dosage recommendations for children and adolescents:

Weight	Starting dose: 10 mg/kg twice daily	Maximum dose: 30 mg/kg twice daily
15 kg[1]	150 mg twice daily	450 mg twice daily
20 kg[1]	200 mg twice daily	600 mg twice daily
25 kg	250 mg twice daily	750 mg twice daily
From 50 kg[2]	500 mg twice daily	1500 mg twice daily

(1) Children 20 kg or less should preferably start the treatment with Keppra 100 mg/ml Oral Solution.

(2) Dosage in children and adolescents 50 kg or more is the same as in adults.

The graduated oral syringe contains up to 1,000mg levetiracetam (corresponding to 10 ml) with a graduation every 25 mg (corresponding to 0.25ml).

Infants and children less than 4 years

There are insufficient data to recommend the use of levetiracetam in children under 4 years of age due to insufficient data on safety and efficacy.

Patients with renal impairment

The daily dose must be individualised according to renal function. For adult patients, refer to the following table and adjust the dose as indicated. To use this dosing table, an estimate of the patient's creatinine clearance (CL_{cr}) in ml/min is needed. The CL_{cr} in ml/min may be estimated from serum creatinine (mg/dl) determination using the following formula:

$$CL_{cr}\ (ml/min) = \frac{[140\text{-age (years)}] \times \text{weight (kg)}}{72 \times \text{serum creatinine (mg/dl)}} \quad (\times 0.85 \text{ for women})$$

Then CL_{cr} is adjusted for body surface area (BSA) as follows:

$$CL_{cr}\ (ml/min/1.73m^2) = \frac{CL_{cr}\ (ml/min)}{\text{BSA subject } (m^2)} \times 1.73$$

Dosing adjustment for adult patients with impaired renal function

Group	Creatinine clearance (ml/min/1.73m²)	Dosage and frequency
Normal	> 80	500 to 1,500 mg twice daily
Mild	50 - 79	500 to 1,000 mg twice daily
Moderate	30 - 49	250 to 750 mg twice daily
Severe	< 30	250 to 500 mg twice daily
End-stage renal disease patients	–	500 to 1,000 mg once daily[2]
Undergoing dialysis[1]		

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

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

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

Patients with hepatic impairment

No dose adjustment is needed in patients with mild to moderate hepatic impairment. In patients with severe hepatic impairment, the creatinine clearance may underestimate the renal insufficiency. Therefore a 50% reduction of the daily maintenance dose is recommended when creatinine clearance is < 70 ml/min.

Contraindications

Hypersensitivity to levetiracetam or other pyrrolidone derivatives or any of the excipients.

Special warnings and special precautions for use

In accordance with current clinical practice, if Keppra has to be discontinued it is recommended to withdraw it gradually (e.g. in adults: 500 mg decreases twice daily every two to four weeks; in children: dose decrease should not exceed 10 mg/kg twice daily every two weeks).

Available data in children did not suggest impact on growth and puberty. However, long term effects on learning, intelligence, growth, endocrine function, puberty and childbearing potential in children remain unknown.

An increase in seizure frequency of more than 25% was reported in 14% of levetiracetam treated adult and paediatric patients with partial onset seizures, whereas it was reported in 26% and 21% of placebo treated adult and paediatric patients respectively.

When Keppra was used to treat primary tonic-clinic seizures in adults and adolescents with idiopathic generalized epilepsy, there was no effect on the frequency of absences.

The administration of Keppra to patients with renal impairment may require dose adaptation. In patients with severely impaired hepatic function, assessment of renal function is recommended before dose selection.

Keppra 100mg/ml oral solution includes methyl parahydroxybenzoate (E218) and propyl parahydroxybenzoate (E216) which may cause allergic reactions (possibly delayed).

It also includes maltitol; patients with rare hereditary problems of fructose intolerance should not take this medicine.

Suicide, suicide attempt and suicidal ideation have been reported in patients treated with levetiracetam. Patients should be advised to immediately report any symptoms of depression and/or suicidal ideation to their prescribing physician.

Interaction with other medicinal products and other forms of interaction

Pre-marketing data from clinical studies conducted in adults indicate that Keppra did not influence the serum concentrations of existing antiepileptic medicinal products (phenytoin, carbamazepine, valproic acid, phenobarbital, lamotrigine, gabapentin and primidone) and that these antiepileptic medicinal products did not influence the pharmacokinetics of Keppra.

As in adults, there is no evidence of clinically significant medicinal product interactions in paediatric patients receiving up to 60 mg/kg/day levetiracetam.
A retrospective assessment of pharmacokinetic interactions in children and adolescents with epilepsy (4 to 17 years) confirmed that adjunctive therapy with orally administered levetiracetam did not influence the steady-state serum concentrations of concomitantly administered carbamazepine, valproate, topiramate or lamotrigine. However, data suggested a 22% higher levetiracetam clearance in children taking enzyme-inducing antiepileptic medicinal products. Dosage adjustment is not required.
Probenecid (500 mg four times daily), a renal tubular secretion blocking agent, has been shown to inhibit the renal clearance of the primary metabolite but not of levetiracetam. Nevertheless, the concentration of this metabolite remains low. It is expected that other medicinal products excreted by active tubular secretion could also reduce the renal clearance of the metabolite. The effect of levetiracetam on probenecid was not studied and the effect of levetiracetam on other actively secreted medicinal products, *e.g.* NSAIDs, sulphonamides and methotrexate, is unknown.
Levetiracetam 1,000 mg daily did not influence the pharmacokinetics of oral contraceptives (ethinylestradiol and levonorgestrel); endocrine parameters (luteinizing hormone and progesterone) were not modified. Levetiracetam 2,000 mg daily did not influence the pharmacokinetics of digoxin and warfarin; prothrombin times were not modified. Co-administration with digoxin, oral contraceptives and warfarin did not influence the pharmacokinetics of levetiracetam.
No data on the influence of antacids on the absorption of levetiracetam are available.
The extent of absorption of levetiracetam was not altered by food, but the rate of absorption was slightly reduced.
No data on the interaction of levetiracetam with alcohol are available.

Pregnancy and lactation

There are no adequate data from the use of Keppra in pregnant women. Studies in animals have shown reproductive toxicity (see „Preclinical safety data"). The potential risk for human is unknown.
Keppra should not be used during pregnancy unless clearly necessary. Discontinuation of antiepileptic treatments may result in exacerbation of the disease which could be harmful to the mother and the foetus.
Levetiracetam is excreted in human breast milk. Therefore, breastfeeding is not recommended.

Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed.
Due to possible different individual sensitivity, some patients might experience somnolence or other central nervous system related symptoms, especially at the beginning of treatment or following a dose increase. Therefore, caution is recommended in those patients when performing skilled tasks, e.g. driving vehicles or operating machinery. Patients are advised not to drive or use machines until it is established that their ability to perform such activities is not affected.

Undesirable effects

Pooled safety data from clinical studies conducted with Keppra oral formulations in adult patients with partial onset seizures showed that 46.4% of the patients in the Keppra group and 42.2% of the patients in the placebo group experienced undesirable effects. Serious undesirable effects were experienced in 2.4% of the patients in the Keppra and 2.0% of the patients in the placebo groups. The most commonly reported undesirable effects were somnolence, asthenia and dizziness. In the pooled safety analysis, there was no clear dose-response relationship but incidence and severity of the central nervous system related undesirable effects decreased over time.
In monotherapy 49.8% of the subjects experienced at least one drug related undesirable effect. The most frequently reported undesirable effects were fatigue and somnolence.
A study conducted in paediatric patients (4 to 16 years) with partial onset seizures showed that 55.4% of the patients in the Keppra group and 40.2% of the patients in the placebo group experienced undesirable effects. Serious undesirable effects were experienced in 0.0% of the patients in the Keppra group and 1.0% of the patients in the placebo group. The most commonly reported undesirable effects were somnolence, hostility, nervousness, emotional lability, agitation, anorexia, asthenia and headache in the paediatric population. Safety results in paediatric patients were consistent with the safety profile of levetiracetam in adults except for behavioural and psychiatric adverse events which were more common in children than in adults (38.6% versus 18.6%). However, the relative risk was similar in children as compared to adults.
A study conducted in adults and adolescents with myoclonic seizures (12 to 65 years) showed that 33.3% of the patients in the Keppra group and 30.0% of the patients in the placebo group experienced undesirable effects that were judged to be related to treatment. The most commonly reported undesirable effects were headache and somnolence. The incidence of undesirable effects in patients with myoclonic seizures was lower than that in adult patients with partial onset seizures (33.3% versus 46.4%).
A study conducted in adults and children (4 to 65 years) with idiopathic generalized epilepsy with primary generalized tonic-clonic seizures showed that 39.2% of the patients in the Keppra group and 29.8% of the patients in the placebo group experienced undesirable effects that were judged to be related to treatment. The most commonly reported undesirable effect was fatigue.
Undesirable effects reported in clinical studies (adults and children) or from post-marketing experience are listed in the following table per System Organ Class and per frequency. For clinical trials, the frequency is defined as follows: very common (≥1/10); common (≥1/100, <1/10); uncommon (≥1/1,000, <1/100); rare (≥1/10,000, <1/1,000); very rare (<1/10,000), including isolated reports.
Data from post-marketing experience are insufficient to support an estimate of their incidence in the population to be treated.

- General disorders and administration site conditions
  Very common: asthenia/fatigue
- Nervous system disorders
  Very common: somnolence
  Common: amnesia, ataxia, convulsion, dizziness, headache, hyperkinesia, tremor, balance disorder, disturbance in attention, memory impairment.
  Post-marketing experience: paraesthesia
- Psychiatric disorders
  Common: agitation, depression, emotional lability/mood swings, hostility/aggression, insomnia, nervousness/irritability, personality disorders, thinking abnormal
  Post-marketing experience: abnormal behaviour, anger, anxiety, confusion, hallucination, psychotic disorder, suicide, suicide attempt and suicidal ideation
- Gastrointestinal disorders
  Common: abdominal pain, diarrhoea, dyspepsia, nausea, vomiting
  Post-marketing experience: pancreatitis
- Hepatobiliary disorders
  Post-marketing experience: hepatic failure, hepatitis, liver function test abnormal
- Metabolism and nutrition disorders
  Common: anorexia, weight increase.
  The risk of anorexia is higher when topiramate is coadministered with levetiracetam.
  Post-marketing experience: weight loss
- Ear and labyrinth disorders
  Common: vertigo
- Eye disorders
  Common: diplopia, vision blurred
- Musculoskeletal and connective tissue disorders
  Common: myalgia
- Injury, poisoning and procedural complications
  Common: accidental injury
- Infections and infestations
  Common: infection, nasopharyngitis
- Respiratory, thoracic and mediastinal disorders
  Common: cough increased
- Skin and subcutaneous tissue disorders
  Common: rash, eczema, pruritus
  Post-marketing experience: alopecia: in several cases, recovery was observed when Keppra was discontinued.
- Blood and lymphatic system disorders
  Common: thrombocytopenia
  Post-marketing experience: leukopenia, neutropenia, pancytopenia (with bone marrow suppression identified in some of the cases)

Overdose

Symptoms

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

Management of overdose

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

Pharmacodynamic properties

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

Mechanism of action

The mechanism of action of levetiracetam still remains to be fully elucidated but appears to be different from the mechanisms of current antiepileptic medicinal products. In vitro and in vivo experiments suggest that levetiracetam does not alter basic cell characteristics and normal neurotransmission.

In vitro studies show that levetiracetam affects intraneuronal Ca2+ levels by partial inhibition of N-type Ca2+ currents and by reducing the release of Ca2+ from intraneuronal stores. In addition it partially reverses the reductions in GABA- and glycine-gated currents induced by zinc and ß-carbolines. Furthermore, levetiracetam has been shown in *in vitro* studies to bind to a specific site in rodent brain tissue. This binding site is the synaptic vesicle protein 2A, believed to be involved in vesicle fusion and neurotransmitter exocytosis. Levetiracetam and related analogs show a rank order of affinity for binding to the synaptic vesicle protein 2A which correlates with the potency of their anti-seizure protection in the mouse audiogenic model of epilepsy. This finding suggests that the interaction between levetiracetam and the synaptic vesicle protein 2A seems to contribute to the antiepileptic mechanism of action of the medicinal product.

Pharmacodynamic effects

Levetiracetam induces seizure protection in a broad range of animal models of partial and primary generalized seizures without having a pro-convulsant effect. The primary metabolite is inactive.

In man, an activity in both partial and generalized epilepsy conditions (epileptiform discharge / photoparoxysmal response) has confirmed the broad spectrum pharmacological profile of levetiracetam.

Clinical experience

Adjunctive therapy in the treatment of partial onset seizures with or without secondary generalization in adults and children from 4 years of age with epilepsy:

In adults, levetiracetam efficacy has been demonstrated in 3 double-blind, placebo-controlled studies at 1000 mg, 2000 mg, or 3000 mg/day, given in 2 divided doses, with a treatment duration of up to 18 weeks. In a pooled analysis, the percentage of patients who achieved 50% or greater reduction from baseline in the partial onset seizure frequency per week at stable dose (12/14 weeks) was of 27.7%, 31.6% and 41.3% for patients on 1000, 2000 or 3000 mg levetiracetam respectively and of 12.6% for patients on placebo.

In pediatric patients (4 to 16 years of age), levetiracetam efficacy was established in a double-blind, placebo-controlled study, which included 198 patients and had a treatment duration of 14 weeks. In this study, the patients received levetiracetam as a fixed dose of 60 mg/kg/day (with twice a day dosing),

44.6% of the levetiracetam treated patients and 19.6% of the patients on placebo had a 50% or greater reduction from baseline in the partial onset seizure frequency per week. With continued long-term treatment, 11.4% of the patients were seizure-free for at least 6 months and 7.2% were seizure-free for at least 1 year.

Monotherapy in the treatment of partial onset seizures with or without secondary generalization in patients from 16 years of age with newly diagnosed epilepsy:

Efficacy of levetiracetam as monotherapy was established in a double-blind, parallel group, non-inferiority comparison to carbamazepine controlled release (CR) in 576 patients 16 years of age or older with newly or recently diagnosed epilepsy. The patients had to present with unprovoked partial seizures or with generalized tonic-clonic seizures only. The patients were randomized to carbamazepine CR 400-1200 mg/day or levetiracetam 1000-3000 mg/day, the duration of the treatment was up to 121 weeks depending on the response.

Six-month seizure freedom was achieved in 73.0% of levetiracetam-treated patients and 72.8% of cabamazepine-CR treated patients; the adjusted absolute difference between treatments was 0.2% (95% CI: -7.8 8.2). More than half of the subjects remained seizure free for 12 months (56.6% and 58.5% of subjects on levetiracetam and on carbamazepine CR respectively).

In a study reflecting clinical practice, the concomitant antiepileptic medication could be withdrawn in a limited number of patients who responded to levetiracetam adjunctive therapy (36 adult patients out of 69).

Adjunctive therapy in the treatment of myoclonic seizures in adults and adolescents from 12 years of age with Juvenile Myoclonic Epilepsy:

Levetiracetam efficacy was established in a double-blind, placebo-controlled study of 16 weeks duration, in patients 12 years of age and older suffering from idiopathic generalized epilepsy with myoclonic seizures in different syndromes. The majority of patients presented with juvenile myoclonic epilepsy.

In this study, levetiracetam, dose was 3000 mg/day given in 2 divided doses.

58.3% of the levetiracetam treated patients and 23.3% of the patients on placebo had at least a 50% reduction in myoclonic seizure days per week. With continued long-term treatment, 28.6% of the patients were free of myoclonic seizures for at least 6 months and 21.0% were free of myoclonic seizures for at least 1 year.

Adjunctive therapy in the treatment of primary generalized tonic-clonic seizures in adults and adolescents from 16 years of age with idiopathic generalized epilepsy:

Levetiracetam efficacy was established in a 24-week double-blind, placebo-controlled study, which included adults, adolescents and a limited number of children suffering from idiopathic generalized epilepsy with primary generalized tonic-clonic (PGTC) seizures in different syndromes (juvenile myoclonic epilepsy, juvenile absence epilepsy, childhood absence epilepsy, or epilepsy with Grand Mal seizures on awakening). In this study, levetiracetam dose was 3000 mg/day for adults and adolescents or 60 mg/kg/day for children, given in 2 divided doses.

72.2% of the levetiracetam treated patients and 45.2% of the patients on placebo had a 50% or greater decrease in the frequency of PGTC seizures per week. With continued long-term treatment, 47.4% of the patients were free of tonic-clonic seizures for at least 6 months and 31.5% were free of tonic-clonic seizures for at least 1 year.

Pharmacokinetic properties

Levetiracetam is a highly soluble and permeable compound. The pharmacokinetic profile is linear with low intra- and inter-subject variability. There is no modification of the clearance after repeated administration. There is no evidence for any relevant gender, race or circadian variability. The pharmacokinetic profile is comparable in healthy volunteers and in patients with epilepsy.

Due to its complete and linear absorption, plasma levels can be predicted from the oral dose of levetiracetam expressed as mg/kg bodyweight. Therefore there is no need for plasma level monitoring of levetiracetam.

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

Adults and adolescents

Absorption

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

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

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

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

Distribution

No tissue distribution data are available in humans.

Neither levetiracetam nor its primary metabolite are significantly bound to plasma proteins (< 10 %).

The volume of distribution of levetiracetam is approximately 0.5 to 0.7 l/kg, a value close to the total body water volume.

Biotransformation

Levetiracetam is not extensively metabolised in humans. The major metabolic pathway (24 % of the dose) is an enzymatic hydrolysis of the acetamide group. Production of the primary metabolite, ucb L057, is not supported by liver cytochrome P_{450} isoforms. Hydrolysis of the acetamide group was measurable in a large number of tissues including blood cells. The metabolite ucb L057 is pharmacologically inactive.

Two minor metabolites were also identified. One was obtained by hydroxylation of the pyrrolidone ring (1.6 % of the dose) and the other one by opening of the pyrrolidone ring (0.9 % of the dose).

Other unidentified components accounted only for 0.6 % of the dose.

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

In vitro, levetiracetam and its primary metabolite have been shown not to inhibit the major human liver cytochrome P_{450} isoforms (CYP3A4, 2A6, 2C9, 2C19, 2D6, 2E1 and 1A2), glucuronyl transferase (UGT1A1 and UGT1A6) and epoxide hydroxylase activities. In addition, levetiracetam does not affect the in vitro glucuronidation of valproic acid.

In human hepatocytes in culture, levetiracetam had little or no effect on ethinylestradiol conjugation or CYP1A1/2. Levetiracetam caused mild induction of CYP2B6 and CYP3A4 at high concentrations (680 µg/mL), however at concentrations approximating to the C_{max} following a repeated 1500mg twice daily dose, the effects were not considered to be biologically relevant. Therefore, the interaction of Keppra with other substances, or *vice versa*, is unlikely.

Elimination

The plasma half-life in adults was 7±1 hours and did not vary either with dose, route of administration or repeated administration. The mean total body clearance was 0.96 ml/min/kg.

The major route of excretion was via urine, accounting for a mean 95 % of the dose (approximately 93 % of the dose was excreted within 48 hours). Excretion via faeces accounted for only 0.3 % of the dose.

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

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

Elderly

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

Children (4 to 12 years)

Following single oral dose administration (20 mg/kg) to epileptic children (6 to 12 years), the half-life of levetiracetam was 6.0 hours.

The apparent body weight adjusted clearance was approximately 30% higher than in epileptic adults.

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

Infants and children (1 month to 4 years)

Following single dose administration (20 mg/kg) of a 100 mg/ml oral solution to epileptic children (1 month to 4 years), levetiracetam was rapidly absorbed and peak plasma concentrations were observed approximately 1 hour after dosing. The pharmacokinetic results indicated that half-life was shorter (5.3 h) than adults (7.2 h) and apparent clearance was faster (1.5 ml/min/kg) than for adults (0.96 ml/min/kg).

Renal impairment

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

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

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

Hepatic impairment

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

Preclinical safety data

Preclinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, genotoxicity and carcinogenicity.

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

In reproductive toxicity studies in the rat, levetiracetam induced developmental toxicity (increase in skeletal variations/minor anomalies, retarded growth, increased pup mortality) at exposure levels similar to or greater than the human exposure. In the rabbit foetal effects (embryonic death, increased skeletal anomalies, and increased malformations) were observed in the presence of maternal toxicity.

The systemic exposure at the observed no effect level in the rabbit was about 4 to 5 times the human exposure.

Neonatal and juvenile animal studies in rats and dogs demonstrated that there were no adverse effects seen in any of the standard development or maturation endpoints at doses up to 1800 mg/kg/day corresponding to 30 times the maximum recommended human dose.

Special precautions for storage

Store in the original container below 25°C. Keep out of the reach and sight of children.

Shelf life

Finished product: 2 years.

After first opening: 2 months

Presentations

Glass bottle containing less than 4,000ml.

Manufacturer:

NextPharma SAS
Address: 17,
Route de Meulan,
78520 Limay,
France

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