

## **SUMMARY OF PRODUCT CHARACTERISTICS**

### **PROVIGIL®**

#### **Caplets**

Each caplet contains: Modafinil 100 mg.

#### **1. INDICATIONS AND USAGE**

PROVIGIL is indicated to improve wakefulness in patients with excessive sleepiness associated with narcolepsy (with or without cataplexy), obstructive sleep apnea (OSA)/hypopnea syndrome (OSAHS) and shift work sleep disorder (SWSD).

#### Limitations of Use

In OSA, PROVIGIL is indicated to treat excessive sleepiness and not as treatment for the underlying obstruction. If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating and during treatment with PROVIGIL for excessive sleepiness.

#### **2. DOSAGE AND ADMINISTRATION**

Treatment should be initiated by or under the supervision of a physician with appropriate knowledge of indicated disorders.

A diagnosis of narcolepsy should be made according to the International Classification of Sleep Disorders (ICSD2) guideline.

Patient monitoring and clinical assessment of the need for treatment should be performed on a periodic basis.

#### Posology

The recommended starting daily dose is 200 mg. The total daily dose may be taken as a single dose in the morning or as two doses, one in the morning and one at noon, according to physician assessment of the patient and the patient's response.

Doses of up to 400mg in one or two divided doses can be used in patients with insufficient response to the initial 200mg modafinil dose.

#### Long-term use

Physicians prescribing modafinil for an extended time should periodically re-evaluate the long-term use for the individual patients as the long-term efficacy of modafinil has not been evaluated (> 9 weeks).

#### Patients with renal impairment

There is inadequate information to determine safety and efficacy of dosing in patients with renal impairment.

Patients with hepatic impairment

The dose of modafinil should be reduced by half in patients with severe hepatic impairment.

#### Elderly

There are limited data available on the use of modafinil in elderly patients. In view of the potential for lower clearance and increased systemic exposure, it is recommended that patients over 65 years of age commence therapy at 100 mg daily.

Paediatric population

Modafinil should not be used in children aged less than 18 years old because of safety and efficacy concerns.

#### Method of administration

For oral use. Caplets should be swallowed whole.

### **3. DOSAGE FORMS AND STRENGTHS**

The caplets are white to off-white, capsule-shaped and debossed with '100' on one side.

### **4. CONTRAINDICATIONS**

PROVIGIL is contraindicated in patients with known hypersensitivity to the active substance (modafinil) or armodafinil or to any of the excipients listed in section [*see Warnings and Precautions (5.1, 5.2, 5.3)*].

### **5. WARNINGS AND PRECAUTIONS**

#### **5.1 Serious Rash, including Stevens-Johnson Syndrome**

Serious rash requiring hospitalization and discontinuation of treatment has been reported in association with the use of modafinil.

In clinical trials of modafinil, the incidence of rash resulting in discontinuation was approximately 0.8% (13 per 1,585) in pediatric patients (age <17 years); these rashes included 1 case of possible Stevens-Johnson Syndrome (SJS) and 1 case of apparent multi-organ hypersensitivity reaction. Several of the cases were associated with fever and other abnormalities (e.g., vomiting, leukopenia). The median time to rash that resulted in discontinuation was 13 days. No such cases were observed among 380 pediatric patients who received placebo. PROVIGIL is not approved for use in pediatric patients for any indication [*see Use in Specific Populations (8.4)*].

Rare cases of serious or life-threatening rash, including SJS, Toxic Epidermal Necrolysis (TEN), and Drug Rash with Eosinophilia and Systemic Symptoms (DRESS) have been reported in adults and children in worldwide postmarketing experience. The reporting rate of TEN and SJS associated with modafinil use, which is generally accepted to be an underestimate due to underreporting, exceeds the background incidence rate. Estimates of the background incidence rate for these serious skin reactions in the general population range between 1 to 2 cases per million-person years.

There are no factors that are known to predict the risk of occurrence or the severity of

rash associated with PROVIGIL. Nearly all cases of serious rash associated with modafinil occurred within 1 to 5 weeks after treatment initiation. However, isolated cases have been reported after prolonged treatment (e.g., 3 months). Accordingly, duration of therapy cannot be relied upon as a means to predict the potential risk heralded by the first appearance of a rash.

Although benign rashes also occur with PROVIGIL, it is not possible to reliably predict which rashes will prove to be serious. Accordingly, PROVIGIL should be discontinued at the first sign of rash, unless the rash is clearly not drug-related. Discontinuation of treatment may not prevent a rash from becoming life-threatening or permanently disabling or disfiguring.

### **5.2 Angioedema and Anaphylaxis Reactions**

Angioedema and hypersensitivity (with rash, dysphagia, and bronchospasm), were observed in patients treated with armodafinil, the R enantiomer of modafinil (which is the racemic mixture). No such cases were observed in modafinil clinical trials. However, angioedema has been reported in postmarketing experience with modafinil. Patients should be advised to discontinue therapy and immediately report to their physician any signs or symptoms suggesting angioedema or anaphylaxis (e.g., swelling of face, eyes, lips, tongue or larynx; difficulty in swallowing or breathing; hoarseness).

### **5.3 Multi-organ Hypersensitivity Reactions**

Multi-organ hypersensitivity reactions, including at least one fatality in postmarketing experience, have occurred in close temporal association (median time to detection 13 days: range 4-33) to the initiation of modafinil.

Although there have been a limited number of reports, multi-organ hypersensitivity reactions may result in hospitalization or be life-threatening. There are no factors that are known to predict the risk of occurrence or the severity of multi-organ hypersensitivity reactions. Signs and symptoms of this disorder were diverse; however, patients typically, although not exclusively, presented with fever and rash associated with other organ system involvement. Other associated manifestations included myocarditis, hepatitis, liver function test abnormalities, hematological abnormalities (e.g., eosinophilia, leukopenia, thrombocytopenia), pruritus, and asthenia. Because multi-organ hypersensitivity is variable in its expression, other organ system symptoms and signs, not noted here, may occur.

If a multi-organ hypersensitivity reaction is suspected, PROVIGIL should be discontinued. Although there are no case reports to indicate cross-sensitivity with other drugs that produce this syndrome, the experience with drugs associated with multi-organ hypersensitivity would indicate this to be a possibility.

### **5.4 Persistent Sleepiness**

Patients with abnormal levels of sleepiness who take PROVIGIL should be advised that their level of wakefulness may not return to normal. Patients with excessive sleepiness, including those taking PROVIGIL, should be frequently reassessed for their degree of sleepiness and, if appropriate, advised to avoid driving or any other potentially dangerous activity. Prescribers should also be aware that patients may not acknowledge sleepiness or drowsiness until directly questioned about drowsiness or sleepiness during specific

activities.

### **5.5 Psychiatric Symptoms**

Psychiatric adverse reactions have been reported in patients treated with modafinil.

In the adult PROVIGIL controlled trials, psychiatric symptoms resulting in treatment discontinuation (at a frequency >0.3%) and reported more often in patients treated with PROVIGIL compared to those treated with placebo were anxiety (1%), nervousness (1%), insomnia (<1%), confusion (<1%), agitation (<1%), and depression (<1%).

Postmarketing adverse reactions associated with the use of modafinil have included mania, delusions, hallucinations, suicidal ideation, and aggression, some resulting in hospitalization. Many, but not all, patients had a prior psychiatric history. One healthy male volunteer developed ideas of reference, paranoid delusions, and auditory hallucinations in association with multiple daily 600 mg doses of PROVIGIL (three times the recommended dose) and sleep deprivation. There was no evidence of psychosis 36 hours after drug discontinuation.

Caution should be exercised when PROVIGIL is given to patients with a history of psychosis, depression, or mania. Consideration should be given to the possible emergence or exacerbation of psychiatric symptoms in patients treated with PROVIGIL. If psychiatric symptoms develop in association with PROVIGIL administration, consider discontinuing PROVIGIL.

### **5.6 Effects on Ability to Drive and Use Machinery**

Although PROVIGIL has not been shown to produce functional impairment, any drug affecting the CNS may alter judgment, thinking or motor skills. Patients should be cautioned about operating an automobile or other hazardous machinery until it is reasonably certain that PROVIGIL therapy will not adversely affect their ability to engage in such activities.

### **5.7 Cardiovascular Events**

In modafinil clinical studies, cardiovascular adverse reactions, including chest pain, palpitations, dyspnea, and transient ischemic T-wave changes on ECG occurred in three subjects in association with mitral valve prolapse or left ventricular hypertrophy. In a Canadian clinical trial, a 35 year old obese narcoleptic male with a prior history of syncopal episodes experienced a 9-second episode of asystole after 27 days of modafinil treatment (300 mg/day in divided doses). PROVIGIL is not recommended in patients with a history of left ventricular hypertrophy or in patients with mitral valve prolapse who have experienced the mitral valve prolapse syndrome when previously receiving CNS stimulants. Findings suggestive of mitral valve prolapse syndrome include but are not limited to ischemic ECG changes, chest pain, or arrhythmia. If new onset of any of these findings occurs, consider cardiac evaluation.

Consider increased monitoring in patients with a recent history of myocardial infarction or unstable angina.

Blood pressure monitoring in short term ( $\leq 3$  months) controlled trials showed no clinically significant changes in mean systolic and diastolic blood pressure in patients receiving PROVIGIL as compared to placebo. However, a retrospective analysis of the use of antihypertensive medication in these studies showed that a greater proportion of

patients on PROVIGIL required new or increased use of antihypertensive medications (2.4%) compared to patients on placebo (0.7%). The differential use was slightly larger when only studies in OSA were included, with 3.4% of patients on PROVIGIL and 1.1% of patients on placebo requiring such alterations in the use of antihypertensive medication. Increased monitoring of heart rate and blood pressure may be appropriate in patients on PROVIGIL. Caution should be exercised when prescribing PROVIGIL to patients with known cardiovascular disease.

### **5.8 Excipients with known effects**

Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium-free'.

## **6. ADVERSE REACTIONS**

The following serious adverse reactions are described elsewhere in the labeling:

- Serious Rash, including Stevens-Johnson Syndrome [*see Warnings and Precautions (5.1)*]
- Angioedema and Anaphylaxis Reactions [*see Warnings and Precautions (5.2)*]
- Multi-organ Hypersensitivity Reactions [*see Warnings and Precautions (5.3)*]
- Persistent Sleepiness [*see Warnings and Precautions (5.4)*]
- Psychiatric Symptoms [*see Warnings and Precautions (5.5)*]
- Effects on Ability to Drive and Use Machinery [*see Warnings and Precautions (5.6)*]
- Cardiovascular Events [*see Warnings and Precautions (5.7)*]

### **6.1 Clinical Trials Experience**

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

PROVIGIL has been evaluated for safety in over 3,500 patients, of whom more than 2,000 patients with excessive sleepiness associated with OSA, SWD, and narcolepsy.

#### Most Common Adverse Reactions

In placebo-controlled clinical trials, the most common adverse reactions ( $\geq 5\%$ ) associated with the use of PROVIGIL more frequently than placebo-treated patients were headache, nausea, nervousness, rhinitis, diarrhea, back pain, anxiety, insomnia, dizziness, and dyspepsia. The adverse reaction profile was similar across these studies.

Table 1 presents the adverse reactions that occurred at a rate of 1% or more and were more frequent in PROVIGIL-treated patients than in placebo-treated patients in the placebo-controlled clinical trials.

**Table 1. Adverse Reactions in Pooled Placebo-Controlled Trials\* in Narcolepsy, OSA, and SWD**

	<b>PROVIGIL (%) (n = 934)</b>	<b>Placebo (%) (n = 567)</b>
Headache	34	23
Nausea	11	3
Nervousness	7	3
Rhinitis	7	6
Back Pain	6	5
Diarrhea	6	5
Anxiety	5	1
Dizziness	5	4
Dyspepsia	5	4
Insomnia	5	1
Anorexia	4	1
Dry Mouth	4	2
Pharyngitis	4	2
Chest Pain	3	1
Hypertension	3	1
Abnormal Liver Function	2	1
Constipation	2	1
Depression	2	1
Palpitation	2	1
Paresthesia	2	0
Somnolence	2	1
Tachycardia	2	1
Vasodilatation	2	0
Abnormal Vision	1	0
Agitation	1	0
Asthma	1	0
Chills	1	0
Confusion	1	0
Dyskinesia	1	0

Edema	1	0
Emotional Lability	1	0
Eosinophilia	1	0
Epistaxis	1	0
Flatulence	1	0
Hyperkinesia	1	0
Hypertonia	1	0
Mouth Ulceration	1	0
Sweating	1	0
Taste Perversion	1	0
Thirst	1	0
Tremor	1	0
Urine Abnormality	1	0
Vertigo	1	0

\* Adverse Reactions that occurred in  $\geq 1\%$  of PROVIGIL-treated patients (either 200, 300, or 400 mg once daily) and greater incidence than placebo.

#### Dose-Dependent Adverse Reactions

In the placebo-controlled clinical trials which compared doses of 200, 300, and 400 mg/day of PROVIGIL and placebo, the following adverse reactions were dose related: headache and anxiety.

#### Adverse Reactions Resulting in Discontinuation of Treatment

In placebo-controlled clinical trials, 74 of the 934 patients (8%) who received PROVIGIL discontinued due to an adverse reaction compared to 3% of patients that received placebo. The most frequent reasons for discontinuation that occurred at a higher rate for PROVIGIL than placebo patients were headache (2%), nausea, anxiety, dizziness, insomnia, chest pain, and nervousness (each <1%).

#### Laboratory Abnormalities

Clinical chemistry, hematology, and urinalysis parameters were monitored in the studies. Mean plasma levels of gamma glutamyltransferase (GGT) and alkaline phosphatase (AP) were found to be higher following administration of PROVIGIL, but not placebo. Few patients, however, had GGT or AP elevations outside of the normal range. Shifts to higher, but not clinically significantly abnormal, GGT and AP values appeared to increase with time in the population treated with PROVIGIL in the placebo-controlled clinical trials. No differences were apparent in alanine aminotransferase (ALT), aspartate aminotransferase (AST), total protein, albumin, or total bilirubin.

## **6.2 Postmarketing Experience**

The following adverse reactions have been identified during post approval use of

PROVIGIL. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Hematologic: agranulocytosis

Psychiatric disorders: psychomotor hyperactivity

### **Reporting of suspected adverse reactions**

Reporting suspected adverse reactions after authorization of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form

<https://sideeffects.health.gov.il/>

## **7. DRUG INTERACTIONS**

### **Effects of PROVIGIL on CYP3A4/5 Substrates**

The clearance of drugs that are substrates for CYP3A4/5 (e.g., steroidal contraceptives, cyclosporine, midazolam, and triazolam) may be increased by PROVIGIL via induction of metabolic enzymes, which results in lower systemic exposure. Dosage adjustment of these drugs should be considered when these drugs are used concomitantly with PROVIGIL [see *Clinical Pharmacology (12.3)*].

The effectiveness of steroidal contraceptives may be reduced when used with PROVIGIL and for two months after discontinuation of therapy. Alternative or concomitant methods of contraception are recommended for patients taking steroidal contraceptives (e.g., ethinyl estradiol) when treated concomitantly with PROVIGIL and for two months after discontinuation of PROVIGIL treatment.

Blood levels of cyclosporine may be reduced when used with PROVIGIL. Monitoring of circulating cyclosporine concentrations and appropriate dosage adjustment for cyclosporine should be considered when used concomitantly with PROVIGIL.

### **Effects of PROVIGIL on CYP2C19 Substrates**

Elimination of drugs that are substrates for CYP2C19 (e.g., phenytoin, diazepam, propranolol, omeprazole, and clomipramine) may be prolonged by PROVIGIL via inhibition of metabolic enzymes, with resultant higher systemic exposure. In individuals deficient in the CYP2D6 enzyme, the levels of CYP2D6 substrates which have ancillary routes of elimination through CYP2C19, such as tricyclic antidepressants and selective serotonin reuptake inhibitors, may be increased by co-administration of PROVIGIL. Dose adjustments of these drugs and other drugs that are substrates for CYP2C19 may be necessary when used concomitantly with PROVIGIL [see *Clinical Pharmacology (12.3)*].

### **Warfarin**

More frequent monitoring of prothrombin times/INR should be considered whenever PROVIGIL is coadministered with warfarin [see *Clinical Pharmacology (12.3)*].



## Monoamine Oxidase (MAO) Inhibitors

Caution should be used when concomitantly administering MAO inhibitors and PROVIGIL.

## **8. USE IN SPECIFIC POPULATIONS**

### **8.1 Pregnancy**

Based on limited human experience from a pregnancy registry and spontaneous reporting modafinil is suspected to cause congenital malformations when administered during pregnancy.

PROVIGIL should not be used during pregnancy.

Intrauterine growth restriction and spontaneous abortion have been reported in association with modafinil (a mixture of R- and S-modafinil) and armodafinil (the R-enantiomer of modafinil). Although the pharmacology of modafinil is not identical to that of the sympathomimetic amines, it does share some pharmacologic properties with this class. Certain of these drugs have been associated with intrauterine growth restriction and spontaneous abortions. Whether the cases reported with modafinil are drug-related is unknown. In studies of modafinil and armodafinil conducted in rats (modafinil, armodafinil) and rabbits (modafinil), developmental toxicity was observed at clinically relevant plasma exposures. PROVIGIL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Studies in animals have shown reproductive toxicity. Modafinil (50, 100, or 200 mg/kg/day) administered orally to pregnant rats throughout organogenesis caused, in the absence of maternal toxicity, an increase in resorptions and an increased incidence of visceral and skeletal variations in the offspring at the highest dose tested. The higher no-effect dose for embryofetal developmental toxicity in rats (100 mg/kg/day) was associated with a plasma modafinil AUC less than that in humans at the recommended human dose (RHD) of PROVIGIL (200 mg/day).

However, in a subsequent study of up to 480 mg/kg/day of modafinil, no adverse effects on embryofetal development were observed. Oral administration of armodafinil (60, 200, or 600 mg/kg/day) to pregnant rats throughout organogenesis resulted in increased incidences of fetal visceral and skeletal variations and decreased fetal body weight at the highest dose tested. The highest no-effect dose for embryofetal developmental toxicity in rats (200 mg/kg/day) was associated with a plasma armodafinil AUC less than that in humans at the RHD of PROVIGIL.

Modafinil administered orally to pregnant rabbits throughout organogenesis at doses of up to 100 mg/kg/day had no effect on embryofetal development; however, the doses used were too low to adequately assess the effects of modafinil on embryofetal development. In a subsequent developmental toxicity study evaluating doses of 45, 90, and 180 mg/kg/day in pregnant rabbits, the incidences of fetal structural alterations and embryofetal death were increased at the highest dose. The highest no-effect dose for developmental toxicity (100 mg/kg/day) was associated with a plasma modafinil AUC similar to that in humans at the RHD of PROVIGIL.

Modafinil administration to rats throughout gestation and lactation at oral doses of up to 200 mg/kg/day resulted in decreased viability in the offspring at doses greater than 20 mg/kg/day, a dose resulting in a plasma modafinil AUC less than that in humans at the RHD of PROVIGIL. No effects on postnatal developmental and neurobehavioral parameters were observed in surviving offspring.

Women of childbearing potential have to use effective contraception. As modafinil may reduce the effectiveness of oral contraception alternative additional methods of contraception are required [*see Drug Interactions (7)*].

### **8.3 Nursing Mothers**

It is not known whether modafinil or its metabolites are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when PROVIGIL is administered to a nursing woman.

### **8.4 Pediatric Use**

Safety and effectiveness in pediatric patients have not been established. PROVIGIL is not approved in this population for any indication.

Serious skin rashes, including erythema multiforme major (EMM) and Stevens-Johnson Syndrome (SJS) have been associated with modafinil use in pediatric patients [*see Warnings and Precautions (5.1)*].

In a controlled 6-week study, 165 pediatric patients (aged 5-17 years) with narcolepsy were treated with modafinil (n=123), or placebo (n=42). There were no statistically significant differences favoring modafinil over placebo in prolonging sleep latency as measured by MSLT, or in perceptions of sleepiness as determined by the clinical global impression-clinician scale (CGI-C).

In the controlled and open-label clinical studies, treatment emergent adverse reactions of the psychiatric and nervous system included Tourette's syndrome, insomnia, hostility, increased cataplexy, increased hypnagogic hallucinations, and suicidal ideation. Transient leukopenia, which resolved without medical intervention, was also observed. In the controlled clinical study, 3 of 38 girls, ages 12 or older, treated with modafinil experienced dysmenorrhea compared to 0 of 10 girls who received placebo.

There were three 7 to 9 week, double-blind, placebo-controlled, parallel group studies in children and adolescents (aged 6-17 years) with Attention-Deficit Hyperactivity Disorder (ADHD). Two of the studies were flexible-dose studies (up to 425 mg/day), and the third was a fixed-dose study (340 mg/day for patients <30 kg and 425 mg/day for patients >30 kg). Although these studies showed statistically significant differences favoring modafinil over placebo in reducing ADHD symptoms as measured by the ADHD-RS (school version), there were 3 cases of serious rash including one case of possible SJS among 933 patients exposed to modafinil in this program. Modafinil is not approved for use in treating ADHD.

### **8.5 Geriatric Use**

In clinical trials, experience in a limited number of modafinil-treated patients who were greater than 65 years of age showed an incidence of adverse reactions similar to other age groups. In elderly patients, elimination of modafinil and its metabolites may be reduced as a consequence of aging. Therefore, consideration should be given to the use of lower

doses and close monitoring in this population [*see Dosage and Administration (2.4) and Clinical Pharmacology (12.3)*].

## **8.6 Hepatic Impairment**

In patients with severe hepatic impairment, the dose of PROVIGIL should be reduced to one-half of that recommended for patients with normal hepatic function [*see Dosage and Administration (2.3) and Clinical Pharmacology (12.3)*].

## **9. DRUG ABUSE AND DEPENDENCE**

### **9.1 Abuse**

In humans, modafinil produces psychoactive and euphoric effects, alterations in mood, perception, thinking, and feelings typical of other CNS stimulants. In in vitro binding studies, modafinil binds to the dopamine reuptake site and causes an increase in extracellular dopamine, but no increase in dopamine release. Modafinil is reinforcing, as evidenced by its self-administration in monkeys previously trained to self-administer cocaine. In some studies, modafinil was also partially discriminated as stimulant-like. Physicians should follow patients closely, especially those with a history of drug and/or stimulant (e.g., methylphenidate, amphetamine, or cocaine) abuse. Patients should be observed for signs of misuse or abuse (e.g., incrementation of doses or drug-seeking behavior).

The abuse potential of modafinil (200, 400, and 800 mg) was assessed relative to methylphenidate (45 and 90 mg) in an inpatient study in individuals experienced with drugs of abuse. Results from this clinical study demonstrated that modafinil produced psychoactive and euphoric effects and feelings consistent with other scheduled CNS stimulants (methylphenidate).

### **9.2 Dependence**

In one placebo-controlled clinical trial, the effects of modafinil withdrawal were monitored following 9 weeks of modafinil use. There were no reported withdrawal symptoms with modafinil during 14 days of observation, although sleepiness returned in narcoleptic patients.

## **10. OVERDOSAGE**

In clinical trials, a total of 151 protocol-specified doses ranging from 1000 to 1600 mg/day (5 to 8 times the recommended daily dose of PROVIGIL) have been administered to 32 subjects, including 13 subjects who received doses of 1000 or 1200 mg/day for 7 to 21 consecutive days. In addition, several intentional acute overdoses occurred; the two largest being 4500 mg and 4000 mg taken by two subjects participating in foreign depression studies. None of these study subjects experienced any unexpected or life-threatening effects. Adverse reactions that were reported at these doses included excitation or agitation, insomnia, and slight or moderate elevations in hemodynamic parameters. Other observed high-dose effects in clinical studies have included anxiety, irritability, aggressiveness, confusion, nervousness, tremor, palpitations, sleep disturbances, nausea, diarrhea, and decreased prothrombin time.

From postmarketing experience, there have been reports of fatal overdoses involving modafinil alone or in combination with other drugs. Symptoms most often accompanying PROVIGIL overdose, alone or in combination with other drugs have included insomnia; central nervous system symptoms such as restlessness, disorientation, confusion, agitation, anxiety, excitation, and hallucination; digestive changes such as nausea and diarrhea; and cardiovascular changes such as tachycardia, bradycardia, hypertension, and chest pain.

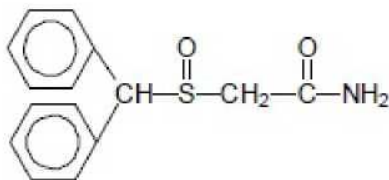
Cases of accidental ingestion/overdose have been reported in children as young as 11 months of age. The highest reported accidental ingestion on a mg/kg basis occurred in a three-year-old boy who ingested 800-1000 mg (50-63 mg/kg) of PROVIGIL. The child remained stable. The symptoms associated with overdose in children were similar to those observed in adults.

No specific antidote exists for the toxic effects of a PROVIGIL overdose. Such overdoses should be managed with primarily supportive care, including cardiovascular monitoring.

## 11. DESCRIPTION

PROVIGIL (modafinil) is a wakefulness-promoting agent for oral administration. Modafinil is a racemic compound. The chemical name for modafinil is 2-[(diphenylmethyl)sulfinyl]acetamide. The molecular formula is  $C_{15}H_{15}NO_2S$  and the molecular weight is 273.35.

The chemical structure is:



Modafinil is a white to off-white, crystalline powder that is practically insoluble in water and cyclohexane. It is sparingly to slightly soluble in methanol and acetone.

PROVIGIL caplets contain 100 mg of modafinil and the following inactive ingredients: lactose monohydrate, pregelatinized starch, microcrystalline cellulose, povidone, croscarmellose sodium, magnesium stearate.

## 12. CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

The mechanism(s) through which modafinil promotes wakefulness is unknown. Modafinil has wake-promoting actions similar to sympathomimetic agents including amphetamine and methylphenidate, although the pharmacologic profile is not identical to that of the sympathomimetic amines.

Modafinil-induced wakefulness can be attenuated by the  $\alpha$ 1-adrenergic receptor

antagonist, prazosin; however, modafinil is inactive in other in vitro assay systems known to be responsive to  $\alpha$ -adrenergic agonists such as the rat vas deferens preparation.

Modafinil is not a direct- or indirect-acting dopamine receptor agonist. However, in vitro, modafinil binds to the dopamine transporter and inhibits dopamine reuptake. This activity has been associated in vivo with increased extracellular dopamine levels in some brain regions of animals. In genetically engineered mice lacking the dopamine transporter (DAT), modafinil lacked wake-promoting activity, suggesting that this activity was DAT-dependent. However, the wake-promoting effects of modafinil, unlike those of amphetamine, were not antagonized by the dopamine receptor antagonist haloperidol in rats. In addition, alpha-methyl-p-tyrosine, a dopamine synthesis inhibitor, blocks the action of amphetamine, but does not block locomotor activity induced by modafinil.

In the cat, equal wakefulness-promoting doses of methylphenidate and amphetamine increased neuronal activation throughout the brain. Modafinil at an equivalent wakefulness-promoting dose selectively and prominently increased neuronal activation in more discrete regions of the brain. The relationship of this finding in cats to the effects of modafinil in humans is unknown.

In addition to its wake-promoting effects and ability to increase locomotor activity in animals, modafinil produces psychoactive and euphoric effects, alterations in mood, perception, thinking, and feelings typical of other CNS stimulants in humans. Modafinil has reinforcing properties, as evidenced by its self-administration in monkeys previously trained to self-administer cocaine; modafinil was also partially discriminated as stimulant-like.

The optical enantiomers of modafinil have similar pharmacological actions in animals. Two major metabolites of modafinil, modafinil acid and modafinil sulfone, do not appear to contribute to the CNS-activating properties of modafinil.

### **12.3 Pharmacokinetics**

Modafinil is a 1:1 racemic compound, whose enantiomers have different pharmacokinetics (e.g., the half-life of R-modafinil is approximately three times that of S-modafinil in adult humans). The enantiomers do not interconvert. At steady state, total exposure to R-modafinil is approximately three times that for S-modafinil. The trough concentration ( $C_{\min,ss}$ ) of circulating modafinil after once daily dosing consists of 90% of R-modafinil and 10% of S-modafinil. The effective elimination half-life of modafinil after multiple doses is about 15 hours. The enantiomers of modafinil exhibit linear kinetics upon multiple dosing of 200-600 mg/day once daily in healthy volunteers. Apparent steady states of total modafinil and R-modafinil are reached after 2-4 days of dosing.

#### Absorption

PROVIGIL is readily absorbed after oral administration, with peak plasma concentrations occurring at 2-4 hours. The bioavailability of PROVIGIL tablets is approximately equal to that of an aqueous suspension. The absolute oral bioavailability was not determined due to the aqueous insolubility (<1 mg/mL) of modafinil, which precluded intravenous administration. Food has no effect on overall PROVIGIL bioavailability; however, time to reach peak concentration ( $t_{\max}$ ) may be delayed by approximately one hour if taken

with food.

### Distribution

PROVIGIL has an apparent volume of distribution of approximately 0.9 L/kg. In human plasma, in vitro, modafinil is moderately bound to plasma protein (approximately 60%), mainly to albumin. The potential for interactions of PROVIGIL with highly protein-bound drugs is considered to be minimal.

### Metabolism and Elimination

The major route of elimination is metabolism (approximately 90%), primarily by the liver, with subsequent renal elimination of the metabolites. Urine alkalization has no effect on the elimination of modafinil.

Metabolism occurs through hydrolytic deamidation, S-oxidation, aromatic ring hydroxylation, and glucuronide conjugation. Less than 10% of an administered dose is excreted as the parent compound. In a clinical study using radiolabeled modafinil, a total of 81% of the administered radioactivity was recovered in 11 days post-dose, predominantly in the urine (80% vs. 1.0% in the feces). The largest fraction of the drug in urine was modafinil acid, but at least six other metabolites were present in lower concentrations. Only two metabolites reach appreciable concentrations in plasma, i.e., modafinil acid and modafinil sulfone. In preclinical models, modafinil acid, modafinil sulfone, 2- [(diphenylmethyl) sulfonyl] acetic acid and 4-hydroxy modafinil, were inactive or did not appear to mediate the arousal effects of modafinil.

In adults, decreases in trough levels of modafinil have sometimes been observed after multiple weeks of dosing, suggesting auto-induction, but the magnitude of the decreases and the inconsistency of their occurrence suggest that their clinical significance is minimal. Significant accumulation of modafinil sulfone has been observed after multiple doses due to its long elimination half-life of 40 hours. Auto-induction of metabolizing enzymes, most importantly cytochrome P-450 CYP3A4, has also been observed in vitro after incubation of primary cultures of human hepatocytes with modafinil and in vivo after extended administration of modafinil at 400 mg/day.

### Specific Populations

#### *Age*

A slight decrease (approximately 20%) in the oral clearance (CL/F) of modafinil was observed in a single dose study at 200 mg in 12 subjects with a mean age of 63 years (range 53 - 72 years), but the change was considered not likely to be clinically significant. In a multiple dose study (300 mg/day) in 12 patients with a mean age of 82 years (range 67 - 87 years), the mean levels of modafinil in plasma were approximately two times those historically obtained in matched younger subjects. Due to potential effects from the multiple concomitant medications with which most of the patients were being treated, the apparent difference in modafinil pharmacokinetics may not be attributable solely to the effects of aging. However, the results suggest that the clearance of modafinil may be reduced in the elderly [*see Dosage and Administration (2.4) and Use in Specific Populations (8.5)*].

### *Gender*

The pharmacokinetics of modafinil are not affected by gender.

### *Race*

The influence of race on the pharmacokinetics of modafinil has not been studied.

### *Renal Impairment*

In a single dose 200 mg modafinil study, severe chronic renal failure (creatinine clearance  $\leq 20$  mL/min) did not significantly influence the pharmacokinetics of modafinil, but exposure to modafinil acid (an inactive metabolite) was increased 9-fold.

### *Hepatic Impairment*

The pharmacokinetics and metabolism of modafinil were examined in patients with cirrhosis of the liver (6 men and 3 women). Three patients had stage B or B+ cirrhosis and 6 patients had stage C or C+ cirrhosis (per the Child-Pugh score criteria). Clinically 8 of 9 patients were icteric and all had ascites. In these patients, the oral clearance of modafinil was decreased by about 60% and the steady state concentration was doubled compared to normal patients [*see Dosage and Administration (2.3) and Use in Specific Populations (8.6)*].

### Drug Interactions

In vitro data demonstrated that modafinil weakly induces CYP1A2, CYP2B6, and possibly CYP3A activities in a concentration-related manner and that CYP2C19 activity is reversibly inhibited by modafinil. In vitro data also demonstrated that modafinil produced an apparent concentration-related suppression of expression of CYP2C9 activity. Other CYP activities did not appear to be affected by modafinil.

#### *Potential Interactions with Drugs That Inhibit, Induce, or Are Metabolized by Cytochrome P450 Isoenzymes and Other Hepatic Enzymes*

The existence of multiple pathways for modafinil metabolism, as well as the fact that a non-CYP-related pathway is the most rapid in metabolizing modafinil, suggest that there is a low probability of substantive effects on the overall pharmacokinetic profile of PROVIGIL due to CYP inhibition by concomitant medications. However, due to the partial involvement of CYP3A enzymes in the metabolic elimination of modafinil, coadministration of potent inducers of CYP3A4/5 (e.g., carbamazepine, phenobarbital, rifampin) or inhibitors of CYP3A4/5 (e.g., ketoconazole, erythromycin) could alter the plasma concentrations of modafinil.

#### *The Potential of PROVIGIL to Alter the Metabolism of Other Drugs by Enzyme Induction or Inhibition • Drugs Metabolized by CYP3A4/5*

- In vitro data demonstrated that modafinil is a weak inducer of CYP3A activity in a concentration-related manner. Therefore, the blood levels and effectiveness of drugs that are substrates for CYP3A enzymes (e.g., steroidal contraceptives, cyclosporine, midazolam, and triazolam) may be reduced after initiation of concomitant treatment with PROVIGIL [*see Drug Interactions (7)*].
- Ethinyl Estradiol - Administration of modafinil to female volunteers once daily at 200 mg/day for 7 days followed by 400 mg/day for 21 days resulted in a mean

- 11% decrease in mean  $C_{max}$  and 18% decrease in mean  $AUC_{0-24}$  of ethinyl estradiol (EE2; 0.035 mg; administered orally with norgestimate). There was no apparent change in the elimination rate of ethinyl estradiol.
- Triazolam - In the drug interaction study between PROVIGIL and ethinyl estradiol (EE2), on the same days as those for the plasma sampling for EE2 pharmacokinetics, a single dose of triazolam (0.125 mg) was also administered. Mean  $C_{max}$  and  $AUC_{0-\infty}$  of triazolam were decreased by 42% and 59%, respectively, and its elimination half-life was decreased by approximately an hour after the modafinil treatment.
  - Cyclosporine - One case of an interaction between modafinil and cyclosporine, a substrate of CYP3A4, has been reported in a 41 year old woman who had undergone an organ transplant.
  - After one month of administration of 200 mg/day of modafinil, cyclosporine blood levels were decreased by 50%. The interaction was postulated to be due to the increased metabolism of cyclosporine, since no other factor expected to affect the disposition of the drug had changed.
  - Midazolam - In a clinical study, concomitant administration of armodafinil 250 mg resulted in a reduction in systemic exposure to midazolam by 32% after a single oral dose (5 mg) and 17% after a single intravenous dose (2 mg).
  - Quetiapine - In a separate clinical study, concomitant administration of armodafinil 250 mg with quetiapine (300 mg to 600 mg daily doses) resulted in a reduction in the mean systemic exposure of quetiapine by approximately 29%.
  - Drugs Metabolized by CYP1A2
    - In vitro data demonstrated that modafinil is a weak inducer of CYP1A2 in a concentration-related manner. However, in a clinical study with armodafinil using caffeine as a probe substrate, no significant effect on CYP1A2 activity was observed.
  - Drugs Metabolized by CYP2B6
    - In vitro data demonstrated that modafinil is a weak inducer of CYP2B6 activity in a concentration- related manner.
  - Drugs Metabolized by CYP2C9
    - In vitro data demonstrated that modafinil produced an apparent concentration-related suppression of expression of CYP2C9 activity suggesting that there is a potential for a metabolic interaction between modafinil and the substrates of this enzyme (e.g., S-warfarin and phenytoin) [*see Drug Interactions (7)*].
    - Warfarin: Concomitant administration of modafinil with warfarin did not produce significant changes in the pharmacokinetic profiles of R- and S-warfarin. However, since only a single dose of warfarin was tested in this study, an interaction cannot be ruled out [*see Drug Interactions (7)*].
  - Drugs Metabolized by CYP2C19
    - In vitro data demonstrated that modafinil is a reversible inhibitor of CYP2C19 activity. CYP2C19 is also reversibly inhibited, with similar potency, by a circulating metabolite, modafinil sulfone. Although the maximum plasma concentrations of modafinil sulfone are much lower than those of parent modafinil, the combined effect of both compounds could produce sustained partial inhibition of the enzyme. Therefore, exposure to some drugs that are



- substrates for CYP2C19 (e.g., phenytoin, diazepam, propranolol, omeprazole, and clomipramine) may be increased when used concomitantly with PROVIGIL [*see Drug Interactions (7)*].
- In a clinical study, concomitant administration of armodafinil 400 mg resulted in a 40% increase in exposure to omeprazole after a single oral dose (40 mg), as a result of moderate inhibition of CYP2C19 activity.
  - Interactions with CNS Active Drugs
    - Concomitant administration of modafinil with methylphenidate or dextroamphetamine produced no significant alterations on the pharmacokinetic profile of modafinil or either stimulant, even though the absorption of modafinil was delayed for approximately one hour.
    - Concomitant modafinil or clomipramine did not alter the pharmacokinetic profile of either drug; however, one incident of increased levels of clomipramine and its active metabolite desmethylclomipramine was reported in a patient with narcolepsy during treatment with modafinil.
    - CYP2C19 also provides an ancillary pathway for the metabolism of certain tricyclic antidepressants (e.g., clomipramine and desipramine) and selective serotonin reuptake inhibitors that are primarily metabolized by CYP2D6. In tricyclic-treated patients deficient in CYP2D6 (i.e., those who are poor metabolizers of debrisoquine; 7-10% of the Caucasian population; similar or lower in other populations), the amount of metabolism by CYP2C19 may be substantially increased. PROVIGIL may cause elevation of the levels of the tricyclics in this subset of patients [*see Drug Interactions (7)*].
    - Concomitant administration of armodafinil with quetiapine reduced the systemic exposure of quetiapine.
  - Interaction with P-Glycoprotein
    - An in vitro study demonstrated that armodafinil is a substrate of P-glycoprotein. The impact of inhibition of P-glycoprotein is not known.

## 13. NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

#### Carcinogenesis

Carcinogenicity studies were conducted in which modafinil (a mixture of R- and S-modafinil) was administered in the diet to mice for 78 weeks and to rats for 104 weeks at doses of 6, 30, and 60 mg/kg/day. The highest doses studied were associated with plasma modafinil exposures (AUC) less than that in humans at the recommended human dose (RHD) of PROVIGIL (200 mg/day). There was no evidence of tumorigenesis associated with modafinil administration in these studies. However, the mouse study was inadequate because the high dose was not a maximum tolerated dose (MTD). In a mouse carcinogenicity study in which armodafinil (the R-enantiomer of modafinil) was administered at oral doses of up to 300 mg/kg/day in males and 100 mg/kg/day in females for approximately 2 years, no tumorigenic effects were observed. The highest doses studied, which were considered MTDs, were associated with plasma armodafinil exposures less than (females) or 2 times (males) that in humans at the RHD of PROVIGIL.

### Mutagenesis

Modafinil was negative in a series of in vitro (i.e., bacterial reverse mutation, mouse lymphoma tk, chromosomal aberration in human lymphocytes, cell transformation in BALB/3T3 mouse embryo cells) or in vivo (mouse bone marrow micronucleus) assays.

### Impairment of Fertility

Oral administration of modafinil (doses of up to 480 mg/kg/day) to male and female rats prior to and throughout mating, and continuing in females through day 7 of gestation produced an increase in the time to mate at the highest dose; no effects were observed on other fertility or reproductive parameters. The no-effect dose of 240 mg/kg/day was associated with a plasma modafinil AUC less than that in humans at the RHD of PROVIGIL.

## **14. CLINICAL STUDIES**

### **14.1 Narcolepsy**

The effectiveness of PROVIGIL in improving wakefulness in adult patients with excessive sleepiness associated with narcolepsy was established in two US 9-week, multi-center, placebo-controlled, parallel-group, double-blind studies of outpatients who met the criteria for narcolepsy. A total of 558 patients were randomized to receive PROVIGIL 200 or 400 mg/day, or placebo. The criteria for narcolepsy include either: 1) recurrent daytime naps or lapses into sleep that occur almost daily for at least three months, plus sudden bilateral loss of postural muscle tone in association with intense emotion (cataplexy); or 2) a complaint of excessive sleepiness or sudden muscle weakness with associated features: sleep paralysis, hypnagogic hallucinations, automatic behaviors, disrupted major sleep episode; and polysomnography demonstrating one of the following: sleep latency less than 10 minutes or rapid eye movement (REM) sleep latency less than 20 minutes. For entry into these studies, all patients were required to have objectively documented excessive daytime sleepiness, via a Multiple Sleep Latency Test (MSLT) with two or more sleep onset REM periods and the absence of any other clinically significant active medical or psychiatric disorder. The MSLT, an objective polysomnographic assessment of the patient's ability to fall asleep in an unstimulating environment, measured latency (in minutes) to sleep onset averaged over 4 test sessions at 2-hour intervals. For each test session, the subject was told to lie quietly and attempt to sleep. Each test session was terminated after 20 minutes if no sleep occurred or 15 minutes after sleep onset.

In both studies, the primary measures of effectiveness were: 1) sleep latency, as assessed by the Maintenance of Wakefulness Test (MWT); and 2) the change in the patient's overall disease status, as measured by the Clinical Global Impression of Change (CGI-C). For a successful trial, both measures had to show statistically significant improvement.

The MWT measures latency (in minutes) to sleep onset averaged over 4 test sessions at 2 hour intervals following nocturnal polysomnography. For each test session, the subject was asked to attempt to remain awake without using extraordinary measures. Each test session was terminated after 20 minutes if no sleep occurred or 10 minutes after sleep

onset. The CGI-C is a 7-point scale, centered at *No Change*, and ranging from *Very Much Worse* to *Very Much Improved*. Patients were rated by evaluators who had no access to any data about the patients other than a measure of their baseline severity. Evaluators were not given any specific guidance about the criteria they were to apply when rating patients.

Both studies demonstrated improvement in objective and subjective measures of excessive daytime sleepiness for both the 200 mg and 400 mg doses compared to placebo. Patients treated with PROVIGIL showed a statistically significantly enhanced ability to remain awake on the MWT at each dose compared to placebo at final visit (Table 2). A statistically significantly greater number of patients treated with PROVIGIL at each dose showed improvement in overall clinical condition as rated by the CGI-C scale at final visit (Table 3).

Nighttime sleep measured with polysomnography was not affected by the use of PROVIGIL.

## **14.2 Obstructive Sleep Apnea (OSA)**

The effectiveness of PROVIGIL in improving wakefulness in patients with excessive sleepiness associated with OSA was established in two multi-center, placebo-controlled clinical studies of patients who met the criteria for OSA. The criteria include either: 1) excessive sleepiness or insomnia, plus frequent episodes of impaired breathing during sleep, and associated features such as loud snoring, morning headaches and dry mouth upon awakening; or 2) excessive sleepiness or insomnia and polysomnography demonstrating one of the following: more than five obstructive apneas, each greater than 10 seconds in duration, per hour of sleep and one or more of the following: frequent arousals from sleep associated with the apneas, bradycardia, and arterial oxygen desaturation in association with the apneas. In addition, for entry into these studies, all patients were required to have excessive sleepiness as demonstrated by a score >10 on the Epworth Sleepiness Scale (ESS), despite treatment with continuous positive airway pressure (CPAP). Evidence that CPAP was effective in reducing episodes of apnea/hypopnea was required along with documentation of CPAP use.

In the first study, a 12-week trial, a total of 327 patients with OSA were randomized to receive PROVIGIL 200 mg/day, PROVIGIL 400 mg/day, or matching placebo. The majority of patients (80%) were fully compliant with CPAP, defined as CPAP use greater than 4 hours/night on > 70% of nights. The remainder were partially CPAP compliant, defined as CPAP use < 4 hours/night on >30% of nights. CPAP use continued throughout the study. The primary measures of effectiveness were 1) sleep latency, as assessed by the Maintenance of Wakefulness Test (MWT) and 2) the change in the patient's overall disease status, as measured by the Clinical Global Impression of Change (CGI-C) at the final visit [see *Clinical Studies (14.1)* for a description of these measures].

Patients treated with PROVIGIL showed a statistically significant improvement in the ability to remain awake compared to placebo-treated patients as measured by the MWT at final visit (Table 2). A statistically significant greater number of patients treated with PROVIGIL showed improvement in overall clinical condition as rated by the CGI-C scale at final visit (Table 3). The 200 mg and 400 mg doses of PROVIGIL produced statistically significant effects of similar magnitude on the MWT, and also on the CGI-C. In the second study, a 4-week trial, 157 patients with OSA were randomized to receive

PROVIGIL 400 mg/day or placebo. Documentation of regular CPAP use (at least 4 hours/night on 70% of nights) was required for all patients. The primary measure of effectiveness was the change from baseline on the ESS at final visit. The baseline ESS scores for the PROVIGIL and placebo groups were 14.2 and 14.4, respectively. At week 4, the ESS was reduced by 4.6 in the PROVIGIL group and by 2.0 in the placebo group, a difference that was statistically significant.

Nighttime sleep measured with polysomnography was not affected by the use of PROVIGIL.

### **14.3 Shift Work Disorder (SWD)**

The effectiveness of PROVIGIL in improving wakefulness in patients with excessive sleepiness associated with SWD was demonstrated in a 12-week placebo-controlled clinical trial. A total of 209 patients with chronic SWD were randomized to receive PROVIGIL 200 mg/day or placebo. All patients met the criteria for chronic SWD. The criteria include: 1) either, a) a primary complaint of excessive sleepiness or insomnia which is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase, or b) polysomnography and the MSLT demonstrate loss of a normal sleep-wake pattern (i.e., disturbed chronobiological rhythmicity); and 2) no other medical or mental disorder accounts for the symptoms, and 3) the symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., time zone change [jet lag] syndrome).

It should be noted that not all patients with a complaint of sleepiness who are also engaged in shift work meet the criteria for the diagnosis of SWD. In the clinical trial, only patients who were symptomatic for at least 3 months were enrolled.

Enrolled patients were also required to work a minimum of 5 night shifts per month, have excessive sleepiness at the time of their night shifts (MSLT score < 6 minutes), and have daytime insomnia documented by a daytime polysomnogram.

The primary measures of effectiveness were 1) sleep latency, as assessed by the MSLT performed during a simulated night shift at the final visit and 2) the change in the patient's overall disease status, as measured by the CGI-C at the final visit [see *Clinical Studies (14.1)* for a description of these measures.].

Patients treated with PROVIGIL showed a statistically significant prolongation in the time to sleep onset compared to placebo-treated patients, as measured by the nighttime MSLT at final visit (Table 2). A statistically significant greater number of patients treated with PROVIGIL showed improvement in overall clinical condition as rated by the CGI-C scale at final visit (Table 3).

Daytime sleep measured with polysomnography was not affected by the use of PROVIGIL.

**Table 2. Average Baseline Sleep Latency and Change from Baseline at Final Visit (MWT and MSLT in minutes)**

\* Significantly different than placebo for all trials (p<0.01 for all trials but SWD, which was p<0.05)

Disorder	Measure	PROVIGIL 200 mg *		PROVIGIL 400 mg *		Placebo	
		Baseline	Change from Baseline	Baseline	Change from Baseline	Baseline	Change from Baseline
Narcolepsy I	MWT	5.8	2.3	6.6	2.3	5.8	-0.7
Narcolepsy II	MWT	6.1	2.2	5.9	2.0	6.0	-0.7
OSA	MWT	13.1	1.6	13.6	1.5	13.8	-1.1
SWD	MSLT	2.1	1.7	-	-	2.0	0.3

**Table 3. Clinical Global Impression of Change (CGI-C) (Percent of Patients Who Improved at Final Visit)**

Disorder	PROVIGIL 200 mg *	PROVIGIL 400 mg *	Placebo
Narcolepsy I	64%	72%	37%
Narcolepsy II	58%	60%	38%
OSA	61%	68%	37%
SWD	74%	-----	36%

\* Significantly different than placebo for all trials (p<0.01)

## 16. HOW SUPPLIED/STORAGE AND HANDLING

### PHARMACEUTICAL PARTICULARS

**List of excipients:** lactose monohydrate, pregelatinized starch, microcrystalline cellulose, povidone, croscarmellose sodium, magnesium stearate.

#### 16.1 How Supplied

PROVIGIL® (modafinil) caplets are available as:

White to off-white, capsule-shaped, and debossed with '100' on one side.

Each package contains 10, 30, 60, or 90 caplets packed in blisters. Not all package sizes may be marketed.

## **16.2 Storage**

Store below 25°C.

The expiry date of the product is indicated on the packaging materials.

## **17. LICENCE HOLDER AND MANUFACTURER**

### **Licence Holder**

Teva Israel Ltd.,

124 Dvora HaNevi'a St. Tel Aviv

### **Manufacturer**

Teva Pharma B.V., Utrecht, The Netherlands.

## **18. REGISTRATION NUMBER**

124.37.30383

**The leaflet has been revised in January 2023 in accordance with the Ministry of Health guidelines.**