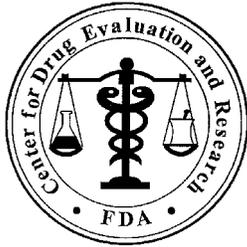


**CENTER FOR DRUG EVALUATION AND  
RESEARCH**

*APPLICATION NUMBER:*

**22-117**

**PROPRIETARY NAME REVIEW(S)**



**Department of Health and Human Services  
Public Health Service  
Food and Drug Administration  
Center for Drug Evaluation and Research  
Office of Surveillance and Epidemiology**

Date: July 30, 2009

To: Thomas Laughren, MD, Director  
Division of Psychiatry Products

Through: Kellie Taylor, PharmD, MPH, Team Leader  
Denise Toyer, PharmD, Deputy Director  
Carol Holquist, RPh, Director  
Division of Medication Error Prevention and Analysis (DMEPA)

From: Felicia Duffy, RN, BSN, MSED, Safety Evaluator  
Division of Medication Error Prevention and Analysis (DMEPA)

Subject: Proprietary Name Review

Drug Name: Saphris (Asenapine) Sublingual Tablets  
5 mg and 10 mg

Application Type/Number: NDA 22-117

Applicant: Organon

OSE RCM #: 2009-1236

**\*\*\* This document contains proprietary and confidential information that should not be released to the public.\*\*\***

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## **EXECUTIVE SUMMARY**

The proposed proprietary name, Saphris, was previously reviewed by DMEPA in OSE review #2008-583, dated June 2, 2008 with conditional acceptability. Acceptability of the proposed name, Saphris, was dependent upon which application received approval first, Saphris or (b) (4) (b) (4) received an approvable letter in October 2006, and, to date, the Applicant has not responded to the deficiencies listed in that letter. Since the previous review, none of the product characteristics of Saphris have changed. We identified seven new names for their similarity to Saphris and the results of the Proprietary Name Risk Assessment found that the proposed name, Saphris, is not vulnerable to name confusion that could lead to medication errors. Thus, the Division of Medication Error Prevention and Analysis does not object to the use of the proprietary name, Saphris, for this product. This is considered a final review; however, if approval is delayed beyond 90 days from the date of this review, the proprietary name should be submitted for re-review.

## **1 METHODS AND MATERIALS**

Appendix A describes the general methods and materials used by the Division of Medication Error Prevention and Analysis (DMEPA) when conducting a re-assessment of a proprietary name 90 days prior to approval of an application. Section 1.1 identifies the specific search criteria associated with the proposed proprietary name, Saphris.

### **1.1 SEARCH CRITERIA**

For this review, DMEPA used the same search criteria used in OSE Review# 2008-583. Please refer to Section 2.1.1 on Page 5 of that review for the search criteria.

## **2 RESULTS**

### **2.1 DATABASE AND INFORMATION SOURCES**

The searches of the databases listed in Section 5 yielded a total of 12 names as having some similarity to the name Saphris. Seven of the 12 names were thought to look like Saphris. Those names include Septra, (b) (4) Sulphrin, Sarafem, Saizen, and Galzin. Two names, Satric and Ser-ap-es, were thought to sound like Saphris. Three names, (b) (4), Suprax, and (b) (4) were thought to both look and sound like Saphris.

Additionally, DMEPA staff did not identify any United States Adopted Names (USAN) stems in the proposed proprietary name, as of July 28, 2009.

### **2.2 EXPERT PANEL DISCUSSION**

The Expert Panel, as described in Appendix A reviewed the pool of names identified by DMEPA staff (See Section 2.1 above) and noted no additional names thought to have orthographic or phonetic similarity to Saphris.

DDMAC had no concerns regarding the proposed name from a promotional perspective, and did not offer any additional comments relating to the proposed name.

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\*\*\* Note: This is proprietary and confidential information that should not be released to the public.\*\*\*

## 2.3 SAFETY EVALUATOR RISK ASSESSMENT

Independent searches by the primary Safety Evaluator did not result in any additional names which were thought to look similar to Saphris and represent a potential source of drug name confusion.

Five names (see Appendix B) were identified in the previous Saphris proprietary name review. None of the Saphris product characteristics have changed since the previous review; therefore, the original evaluation of those five names is maintained. Please see OSE #2008-583 for a detailed analysis of these names.

## 3 DISCUSSION

One name, Sarafem, lacked orthographic similarity to the proposed name, Saphris and was not evaluated any further. Thus, we evaluated six newly identified names using failure mode and effect analysis (FMEA) to determine if the proposed name could potentially be confused with any of the six names and lead to medication errors. This analysis determined that the name similarity between Saphris was unlikely to result in medication errors with any of the products for the reasons presented in Appendices D through H.

## 4 CONCLUSIONS AND RECOMMENDATIONS

The Proprietary Name Risk Assessment findings indicate that the proposed name, Saphris, is not vulnerable to name confusion that could lead to medication errors. Thus, the Division of Medication Error Prevention and Analysis (DMEPA) has no objection to the proprietary name, Saphris, for this product at this time. Additionally, DDMAC does not object to the proposed name, Saphris from a promotional perspective.

DMEPA considers this a final review; however, if approval of the NDA is delayed beyond 90 days from the date of this review, the Division of Psychiatry Products should notify DMEPA because the proprietary name must be re-reviewed prior to the new approval date.

If you have further questions or need clarifications, please contact Abolade Adeolu, OSE Project Manager, at 301-796-4264.

## 5 REFERENCES

1. *OSE Review #2008-583, Proprietary Name Review for Saphris (Asenapine) Sublingual Tablets, Duffy, F; June 2, 2008.*
2. *Micromedex Integrated Index (<http://csi.micromedex.com>)*

Micromedex contains a variety of databases covering pharmacology, therapeutics, toxicology and diagnostics.

### 3. *Phonetic and Orthographic Computer Analysis (POCA)*

POCA is a database which was created for the Division of Medication Error Prevention and Analysis, FDA. As part of the name similarity assessment, proposed names are evaluated via a phonetic/orthographic algorithm. The proposed proprietary name is converted into its phonemic representation before it runs through the phonetic algorithm. Likewise, an orthographic algorithm exists which operates in a similar fashion.

**4. Drug Facts and Comparisons, online version, St. Louis, MO (<http://factsandcomparisons.com>)**

Drug Facts and Comparisons is a compendium organized by therapeutic course; it contains monographs on prescription and OTC drugs, with charts comparing similar products.

**5. Division of Medication Errors Prevention and Analysis proprietary name consultation requests**

This is a list of proposed and pending names that is generated by the Division of Medication Error Prevention and Analysis from the Access database/tracking system.

**6. Drugs@FDA (<http://www.accessdata.fda.gov/scripts/cder/drugsatfda/>)**

Drugs@FDA contains most of the drug products approved since 1939. The majority of labels, approval letters, reviews, and other information are available for drug products approved from 1998 to the present. Drugs@FDA contains official information about FDA approved [brand name](#), [generic drugs](#), [therapeutic biological products](#), [prescription](#) and [over-the-counter](#) human drugs and [discontinued drugs](#) and “[Chemical Type 6](#)” approvals.

**7. Electronic online version of the FDA Orange Book (<http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm>)**

The FDA Orange Book provides a compilation of approved drug products with therapeutic equivalence evaluations.

**8. U.S. Patent and Trademark Office (<http://www.uspto.gov>)**

USPTO provides information regarding patent and trademarks.

**9. Clinical Pharmacology Online ([www.clinicalpharmacology-ip.com](http://www.clinicalpharmacology-ip.com))**

Clinical Pharmacology contains full monographs for the most common drugs in clinical use, plus mini monographs covering investigational, less common, combination, nutraceutical and nutritional products. It also provides a keyword search engine.

**10. Data provided by Thomson & Thomson’s SAEGIS™ Online Service, available at ([www.thomson-thomson.com](http://www.thomson-thomson.com))**

The Pharma In-Use Search database contains over 400,000 unique pharmaceutical trademarks and trade names that are used in about 50 countries worldwide. The data is provided under license by IMS HEALTH.

**11. Natural Medicines Comprehensive Databases ([www.naturaldatabase.com](http://www.naturaldatabase.com))**

Natural Medicines contains up-to-date clinical data on the natural medicines, herbal medicines, and dietary supplements used in the western world.

**12. Stat!Ref ([www.statref.com](http://www.statref.com))**

Stat!Ref contains full-text information from approximately 30 texts; it includes tables and references. Among the database titles are: Handbook of Adverse Drug Interactions, Rudolphs Pediatrics, Basic Clinical Pharmacology, and Dictionary of Medical Acronyms Abbreviations.

**13. USAN Stems (<http://www.ama-assn.org/ama/pub/about-ama/our-people/coalitions-consortiums/united-states-adopted-names-council/naming-guidelines/approved-stems.shtml>)**

USAN Stems List contains all the recognized USAN stems.

**14. Red Book Pharmacy's Fundamental Reference**

Red Book contains prices and product information for prescription, over-the-counter drugs, medical devices, and accessories.

**15. Lexi-Comp (<http://online.lexi.com/crlsql/servlet/crlonline>)**

Lexi-Comp is a web-based searchable version of the Drug Information Handbook.

**16. Medical Abbreviations Book**

Medical Abbreviations Book contains commonly used medical abbreviations and their definitions.

## **APPENDICES**

### **Appendix A:**

FDA's Proprietary Name Risk Assessment considers the potential for confusion between the proposed proprietary name and the proprietary and established names of drug products existing in the marketplace and those pending IND, NDA, BLA, and ANDA products currently under review by the Center. DMEPA defines a medication error as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.<sup>1</sup>

For the proposed proprietary name, DMEPA staff search a standard set of databases and information sources to identify names with orthographic and phonetic similarity and hold a Center for Drug Evaluation and Research (CDER) Expert Panel discussion to gather professional opinions on the safety of the proposed proprietary name.

The Safety Evaluator assigned to the Proprietary Name Risk Assessment is responsible for considering the collective findings, and provides an overall risk assessment of the proposed proprietary name. DMEPA bases the overall risk assessment on the findings of a Failure Mode and Effects Analysis (FMEA) of the proprietary name, and focuses on the avoidance of medication errors.

FMEA is a systematic tool for evaluating a process and identifying where and how it might fail.<sup>2</sup> DMEPA uses FMEA to analyze whether the drug names identified with orthographic or phonetic similarity to the proposed proprietary name could cause confusion that subsequently leads to medication errors in the clinical setting. DMEPA uses the clinical expertise of its staff to anticipate the conditions of the clinical setting where the product is likely to be used based on the characteristics of the proposed product.

In addition, the product characteristics provide the context for the verbal and written communication of the drug names and can interact with the orthographic and phonetic attributes of the names to increase the risk of confusion when there is overlap or, in some instances, decrease the risk of confusion by helping to differentiate the products through dissimilarity. Accordingly, the DMEPA staff considers the product characteristics associated with the proposed drug throughout the risk assessment because the product characteristics of the proposed may provide a context for communication of the drug name and ultimately determine the use of the product in the *usual* clinical practice setting.

Typical product characteristics considered when identifying drug names that could potentially be confused with the proposed proprietary name include, but are not limited to; established name of the proposed product, proposed indication of use, dosage form, route of administration, strength, unit of measure, dosage units, recommended dose, typical quantity or volume, frequency of administration, product packaging, storage

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<sup>1</sup> National Coordinating Council for Medication Error Reporting and Prevention. <http://www.nccmerp.org/aboutMedErrors.html>. Last accessed 10/11/2007.

<sup>2</sup> Institute for Healthcare Improvement (IHI). Failure Modes and Effects Analysis. Boston. IHI:2004.

conditions, patient population, and prescriber population. Because drug name confusion can occur at any point in the medication use process, DMEPA staff considers the potential for confusion throughout the entire U.S. medication use process, including drug procurement, prescribing and ordering, dispensing, administration, and monitoring the impact of the medication.<sup>3</sup> DMEPA provides the product characteristics considered for this review in section one.

The Division of Medication Error Prevention and Analysis considers the spelling of the name, pronunciation of the name when spoken, and appearance of the name when scripted. DMEPA also compares the spelling of the proposed proprietary name with the proprietary and established name of existing and proposed drug products because similarly spelled names may have greater likelihood to sound similar to one another when spoken or look similar to one another when scripted. DMEPA staff also examines the orthographic appearance of the proposed name using a number of different handwriting samples. Handwritten communication of drug names has a long-standing association with drug name confusion. Handwriting can cause similarly and even dissimilarly spelled drug name pairs to appear very similar to one another. The similar appearance of drug names when scripted has led to medication errors. The DMEPA staff applies expertise gained from root-cause analysis of such medication errors to identify sources of ambiguity within the name that could be introduced when scripting (e.g., “T” may look like “F,” lower case ‘a’ looks like a lower case ‘u,’ etc). Additionally, other orthographic attributes that determine the overall appearance of the drug name when scripted (see Table 1 below for details). In addition, the DMEPA staff compares the pronunciation of the proposed proprietary name with the pronunciation of other drug names because verbal communication of medication names is common in clinical settings. If provided, DMEPA will consider the Applicant’s intended pronunciation of the proprietary name. However, DMEPA also considers a variety of pronunciations that could occur in the English language because the Applicant has little control over how the name will be spoken in clinical practice.

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<sup>3</sup> Institute of Medicine. Preventing Medication Errors. The National Academies Press: Washington DC. 2006.

**Table 1.** Criteria used to identify drug names that look- or sound-similar to a proposed proprietary name.

Type of similarity	Considerations when searching the databases		
	<i>Potential causes of drug name similarity</i>	<i>Attributes examined to identify similar drug names</i>	<i>Potential Effects</i>
Look-alike	Similar spelling	Identical prefix Identical infix Identical suffix Length of the name Overlapping product characteristics	<ul style="list-style-type: none"> <li>Names may appear similar in print or electronic media and lead to drug name confusion in printed or electronic communication</li> <li>Names may look similar when scripted and lead to drug name confusion in written communication</li> </ul>
	Orthographic similarity	Similar spelling Length of the name Upstrokes Down strokes Cross-strokes Dotted letters Ambiguity introduced by scripting letters Overlapping product characteristics	<ul style="list-style-type: none"> <li>Names may look similar when scripted, and lead to drug name confusion in written communication</li> </ul>
Sound-alike	Phonetic similarity	Identical prefix Identical infix Identical suffix Number of syllables Stresses Placement of vowel sounds Placement of consonant sounds Overlapping product characteristics	<ul style="list-style-type: none"> <li>Names may sound similar when pronounced and lead to drug name confusion in verbal communication</li> </ul>

Lastly, the DMEPA staff also considers the potential for the proposed proprietary name to inadvertently function as a source of error for reasons other than name confusion. Post-marketing experience has demonstrated that proprietary names (or components of the proprietary name) can be a source of error in a variety of ways. Consequently, DMEPA considers and evaluates these broader safety implications of the name throughout this assessment and DMEPA provides additional comments related to the safety of the proposed proprietary name or product based on professional experience with medication errors.

### 1. Database and Information Sources

DMEPA staff conducts searches of the internet, several standard published drug product reference texts, and FDA databases to identify existing and proposed drug names that may sound-alike or look-alike to the proposed proprietary name using the criteria outlined in Section 2.1. Section 6 provides a standard description of the databases used in the searches. To complement the process, the DMEPA staff use a computerized method of identifying phonetic and orthographic similarity between medication names. The program, Phonetic and Orthographic Computer Analysis (POCA), uses complex algorithms to select a list of names from a database that have some similarity (phonetic, orthographic, or both) to the trademark being evaluated. Lastly, the DMEPA staff review the USAN stem list to determine if any USAN stems are present within the

proprietary name. The individual findings of multiple safety evaluators are pooled and presented to the CDER Expert Panel.

## **2. CDER Expert Panel Discussion**

DMEPA conducts an Expert Panel Discussion to gather CDER professional opinions on the safety of the proposed product and the proposed proprietary name. The Expert Panel is composed of Division of Medication Errors Prevention (DMEPA) staff and representatives from the Division of Drug Marketing, Advertising, and Communications (DDMAC). The Expert Panel also discusses potential concerns regarding drug marketing and promotion related to the proposed names.

The primary Safety Evaluator presents the pooled results of the DMEPA staff to the Expert Panel for consideration. Based on the clinical and professional experiences of the Expert Panel members, the Panel may recommend the addition of names, additional searches by the primary Safety Evaluator to supplement the pooled results, or general advice to consider when reviewing the proposed proprietary name.

## **3. Safety Evaluator Risk Assessment of the Proposed Proprietary Name**

The primary Safety Evaluator applies his/her individual expertise gained from evaluating medication errors reported to FDA, conducts a Failure Mode and Effects Analysis, and provides an overall risk assessment of name confusion. Failure Mode and Effects Analysis (FMEA) is a systematic tool for evaluating a process and identifying where and how it might fail.<sup>4</sup> When applying FMEA to assess the risk of a proposed proprietary name, DMEPA seeks to evaluate the potential for a proposed proprietary name to be confused with another drug name because of name confusion and, thereby, cause errors to occur in the medication use system. FMEA capitalizes on the predictable and preventable nature of medication errors associated with drug name confusion. FMEA allows the Agency to identify the potential for medication errors due to orthographically or phonetically similar drug names prior to approval, where actions to overcome these issues are easier and more effective than remedies available in the post-approval phase.

In order to perform an FMEA of the proposed name, the primary Safety Evaluator must analyze the use of the product at all points in the medication use system. Because the proposed product is has not been marketed, the primary Safety Evaluator anticipates the use of the product in the usual practice settings by considering the clinical and product characteristics listed in Section one. The Safety Evaluator then analyzes the proposed proprietary name in the context of the usual practice setting and works to identify potential failure modes and the effects associated with the failure modes.

In the initial stage of the Risk Assessment, the Safety Evaluator compares the proposed proprietary name to all of the names gathered from the above searches, Expert Panel Discussion, and prescription studies, external studies, and identifies potential failure modes by asking:

***“Is the proposed proprietary name convincingly similar to another drug name, which may cause practitioners to become confused at any point in the usual practice setting?”***

An affirmative answer indicates a failure mode and represents a potential for the proposed proprietary name to be confused with another proprietary or established drug name because of look- or sound-alike similarity. If the answer to the question is no, the Safety Evaluator is not convinced that the names possess similarity that would cause confusion at any point in the medication use system, thus the name is eliminated from further review.

In the second stage of the Risk Assessment, the primary Safety Evaluator evaluates all potential failure modes to determine the likely *effect* of the drug name confusion, by asking:

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<sup>4</sup> Institute for Healthcare Improvement (IHI). Failure Mode and Effects Analysis. Boston. IHI:2004.

***“Could the confusion of the drug names conceivably result in medication errors in the usual practice setting?”***

The answer to this question is a central component of the Safety Evaluator’s overall risk assessment of the proprietary name. If the Safety Evaluator determines through FMEA that the name similarity would not ultimately be a source of medication errors in the usual practice setting, the primary Safety Evaluator eliminates the name from further analysis. However, if the Safety Evaluator determines through FMEA that the name similarity could ultimately cause medication errors in the usual practice setting, the Safety Evaluator will then recommend the use of an alternate proprietary name.

DMEPA will object to the use of proposed proprietary name when the primary Safety Evaluator identifies one or more of the following conditions in the Risk Assessment:

- a. DDMAC finds the proposed proprietary name misleading from a promotional perspective, and the Review Division concurs with DDMAC’s findings. The Federal Food, Drug, and Cosmetic Act provides that labeling or advertising can misbrand a product if misleading representations are made or suggested by statement, word, design, device, or any combination thereof, whether through a PROPRIETARY name or otherwise [21 U.S.C 321(n); See also 21 U.S.C. 352(a) & (n)].
- b. DMEPA identifies that the proposed proprietary name is misleading because of similarity in spelling or pronunciation to another proprietary or established name of a different drug or ingredient [CFR 201.10.(C)(5)].
- c. FMEA identifies the potential for confusion between the proposed proprietary name and other proprietary or established drug name(s), and demonstrates that medication errors are likely to result from the drug name confusion under the conditions of usual clinical practice.
- d. The proposed proprietary name contains an USAN (United States Adopted Names) stem.
- e. DMEPA identifies a potential source of medication error within the proposed proprietary name. For example, the proprietary name may be misleading or, inadvertently, introduce ambiguity and confusion that leads to errors. Such errors may not necessarily involve confusion between the proposed drug and another drug product.

If DMEPA objects to a proposed proprietary name on the basis that drug name confusion could lead to medication errors, the primary Safety Evaluator uses the FMEA process to identify strategies to reduce the risk of medication errors. DMEPA is likely to recommend that the Applicant select an alternative proprietary name and submit the alternate name to the Agency for DMEPA to review. However, in rare instances FMEA may identify plausible strategies that could reduce the risk of medication error of the currently proposed name. In that instance, DMEPA may be able to provide the Applicant with recommendations that reduce or eliminate the potential for error and, thereby, would render the proposed name acceptable.

In the event that DMEPA objects to the use of the proposed proprietary name, based upon the potential for confusion with another proposed (but not yet approved) proprietary name, DMEPA will provide a contingency objection based on the date of approval. Whichever product, the Agency approves first has the right to use the proprietary name, while DMEPA will recommend that the second product to reach approval seek an alternative name.

The threshold set for objection to the proposed proprietary name may seem low to the Applicant. However, the safety concerns set forth in criteria a through e are supported either by FDA regulation or by external healthcare authorities, including the Institute of Medicine (IOM), World Health Organization (WHO), Joint Commission on Accreditation of Hospitals (JCOAH), and the Institute for Safe Medication Practices (ISMP). These organizations have examined medication errors resulting from look- or sound-alike drug names and called for regulatory authorities to address the issue prior to approval. Additionally, DMEPA contends that the threshold set for the Proprietary Name Risk Assessment is reasonable because proprietary drug name confusion is a

predictable and a preventable source of medication error that, in many instances, the Agency and/or Applicant can identify and rectify prior to approval to avoid patient harm.

Furthermore, post-marketing experience has demonstrated that medication errors resulting from drug name confusion are notoriously difficult to rectify post-approval. Educational and other post-approval efforts are low-leverage strategies that have had limited effectiveness at alleviating medication errors involving drug name confusion. Applicants have undertaken higher-leverage strategies, such as drug name changes, in the past but at great financial cost to the Applicant and at the expense of the public welfare, not to mention the Agency's credibility as the authority responsible for approving the error-prone proprietary name. Moreover, even after Applicants' have changed a product's proprietary name in the post-approval phase, it is difficult to eradicate the original proprietary name from practitioners' vocabulary, and as a result, the Agency has continued to receive reports of drug name confusion long after a name change in some instances. Therefore, DMEPA believes that post-approval efforts at reducing name confusion errors should be reserved for those cases in which the potential for name confusion could not be predicted prior to approval.

**Appendix B:** Names previously reviewed in OSE review #2008-583 and determined not to pose a safety risk

Name	Name
Septra	Suprax
Sulphrin	(b) (4)
Satric	

**Appendix C:** Name lacking convincingly look-alike and/or sound-alike similarities with Saphris

Proprietary Name
Sarafem

**Appendix D:** Proprietary names trademarked in foreign countries

Proprietary Name	Similarity to Saphris	Country
(b) (4)	Look	Philippines
(b) (4)	Look	Malaysia

**Appendix E:** Discontinued product with no generic equivalent

Proprietary Name	Similarity to Saphris	Status	Source
Ser-ap-es (Hydralazine HCl; Hydrochlorothiazide; Reserpine) tablets	Sound	Discontinued, no generics available	Drugs@FDA

\*\*\* Note: This is proprietary and confidential information that should not be released to the public.\*\*\*

**Appendix F:** Products with limited or no additional information found in DMEPA references 1-16

Proprietary Name	Similarity to Saphris	Status	Source
(b) (4)	Look/Sound	Abandoned	Saegis

**Appendix G:** Products with a numerical overlap or similar numerical overlap in strength, but with different product characteristics

Product name with potential for confusion	Similarity to Saphris	Strength	Usual Dose
Saphris (Asenapine) Tablets		5 mg and 10 mg	Schizophrenia: 5 mg to 10 mg sublingually twice daily Bipolar Disorder: 5 mg to 10 mg sublingually twice daily.
Saizen (Somatropin) Injection	Look	5 mg/vial and 8.8 mg/vial	0.005 mg/kg to 0.01 mg/kg administered subcutaneously once daily.

**Appendix H:** Products with a similar numerical overlap in strength and dose but with some differentiating product characteristics

Product name with potential for confusion	Similarity to Product Name	Strength	Usual Dose	Other Differentiating Product Characteristics
Saphris (asenapine) sublingual tablets		5 mg, 10 mg	Schizophrenia: 5 mg to 10 mg sublingually twice daily Bipolar Disorder: 5 mg to 10 mg sublingually twice daily.	
Galzin (Zinc acetate) capsules	Look	25 mg, 50 mg	50 mg by mouth three times daily.	<b>Indication:</b> Wilson's disease vs. Schizophrenia or bipolar disorder <b>Frequency of administration:</b> Three times daily vs. twice daily <b>Dose:</b> 50 mg vs. 5 mg or 10 mg  Galzin must be taken on an empty stomach at least one hour before meals or two to three hours after meals.

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/s/  
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FELICIA DUFFY  
07/30/2009

KELLIE A TAYLOR  
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**Department of Health and Human Services  
Public Health Service  
Food and Drug Administration  
Center for Drug Evaluation and Research  
Office of Surveillance and Epidemiology**

Date: February 6, 2009

To: Thomas Laughren, MD, Director  
Division of Psychiatry Products

Through: Kellie Taylor, PharmD, MPH, Team Leader  
Denise Toyer, PharmD, Deputy Director  
Carol Holquist, RPh, Director  
Division of Medication Error Prevention and Analysis

From: Felicia Duffy, RN, BSN, MSED, Safety Evaluator  
Division of Medication Error Prevention and Analysis

Subject: Label and Labeling Review for Saphris

Drug Name: Saphris (Asenapine) Sublingual Tablets

Application Type/Number: NDA 22-117

Applicant/sponsor: Organon

OSE RCM #: 2008-1232

## 1 INTRODUCTION

This memorandum is in response to a July 31, 2008, request from the Division of Psychiatry Products for a review of the revised container labels, carton and insert labeling for Saphris (Asenapine) Sublingual Tablets.

We found that the established name (Asenapine) may be prone to potential orthographic confusion with olanzapine which is currently marketed. Because established names are not regulated by FDA, we recommended the Applicant discuss this issue with USAN/INN. The Applicant's response dated July 28, 2008, indicated that the World Health Organization (WHO) selected the name "asenapine" by its members of the Expert Advisory Panel on the International Pharmacopeia and Pharmaceutical Preparations. Thus, the Applicant does not believe that a change in the established name is warranted.

## 2 MATERIAL REVIEWED

Revised container labels, and carton and insert labeling submitted on April 14, 2008 (see Appendices A through G for revised container labels and carton labeling) and OSE review #2008-583 labels, labeling, and comments.

## 3 DISCUSSION

The Applicant has addressed most of our label and labeling revisions. Specifically, our recommendations for the blister labels were to differentiate the 5 mg and 10 mg blister labels in order to avoid confusion, provide some type of indication that the user should peel the label to remove the tablet, and to remove (b)(4) from the labels. With respect to the revised blister labels, the Applicant improved the readability and differentiation of the blisters by using a dark (black) contrasting font against the background and by encircling the 5 mg strength. The strength on the 10 mg blister is still difficult to locate as it is not prominent. Increasing the prominence will help the user to more easily and readily locate the strength.

The Applicant intends to implement our recommendations after the depletion of the blister labels that were printed to support product launch. However, DMEPA does not agree with the Applicant's proposal. The revisions to the blister labels should be implemented at product launch because the current appearance of the product launch blister labels increases the potential for confusion between the 5 mg and 10 mg blisters. The light color of the orange font is difficult to read, thus it is difficult to differentiate the 5 mg blister from the 10 mg blister. In addition to the light colored font, the strengths are not differentiated, which may also contribute to medication errors. The symbols (b)(4) may cause confusion. It may be confusing to the patient if the inadvertently take the (b)(4) or vice versa.

## 4 CONCLUSIONS AND RECOMMENDATIONS

Upon review of the revised labels and labeling, we have the following recommendations:

1. Increase the prominence of the strength on the 10 mg blister label by bolding the strength (10 mg).
2. Implement the revised blister labels noted in this review (see Appendix F) at product launch rather than after the depletion of the blisters that were printed to support product launch.

We would appreciate feedback on the final outcome of this review. We would be willing to meet with the Division for further discussion, if needed. Please copy DMEPA on any communication to the Applicant with regard to this review. If you have further questions or need clarifications, please contact Abolade Adeolu, OSE Project Manager, at 301-796-4264.

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