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RESEARCH**

APPLICATION NUMBER:
204307Orig1s000

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
Office of Medication Error Prevention and Risk Management**

Proprietary Name Review

Date: October 24, 2012

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Drug Name(s) and Strength(s): Vituz (Hydrocodone Bitartrate and Chlorpheniramine
Maleate) Oral Solution
5 mg/4 mg per 5 mL

Application Type/Number: NDA 204307

Applicant/Sponsor: Cypress Pharmaceutical, Inc

OSE RCM #: 2012-1783

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

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1 INTRODUCTION

This review evaluates the proposed proprietary name, Vituz, from a safety and promotional perspective. The sources and methods used to evaluate the proposed name are outlined in the reference section and Appendix A respectively.

1.1 REGULATORY HISTORY

This application is currently under review with the Division of Pulmonary, Allergy, and Rheumatoid Products. The first proposed proprietary name, (b) (4) was found unacceptable in OSE Reviews #2012-1055.

On August 2, 2012, Cypress Pharmaceuticals, Inc. submitted a request to the Agency for an assessment of the proposed proprietary name under NDA 204307.

1.2 PRODUCT INFORMATION

The following product information is provided in the August 2, 2012 proprietary name submission.

- Active Ingredients: Hydrocodone Bitartrate and Chlorpheniramine Maleate
- Indication of Use: Relief of cough associated with common cold and symptoms associated with upper respiratory allergies
- Route of Administration: Oral
- Dosage Form: Solution
- Strength: 5 mg Hydrocodone Bitartrate; 4 mg Chlorpheniramine Maleate per 5 mL
- Dose and Frequency: 5 mL every 4 to 6 hours as needed, not to exceed 4 doses (20 mL) in 24 hours
- How Supplied: Tight, light-resistant container as defined in the USP, with a child resistant closure
- Storage: 20° C to 25° C (68° F to 77° F). [USP Controlled Room Temperature]
- Container and Closure Systems: White HDPE bottles of one pint (480 mL); Dispense in a tight, light-resistant container, as defined in the USP, with a child-resistant closure.

2. RESULTS

The following sections provide the information obtained and considered in the overall evaluation of the proposed proprietary name.

2.1 PROMOTIONAL ASSESSMENT

The Office of Prescription Drug Promotion OPDP determined the proposed name is acceptable from a promotional perspective. DMEPA and the Division of Pulmonary, Allergy, and Rheumatoid Products concurred with the findings of OPDP's promotional assessment of the proposed name.

2.2 SAFETY ASSESSMENT

The following aspects were considered in the safety evaluation of the name.

2.2.1 United States Adopted Names (USAN) SEARCH

The September 21, 2012 search of the United States Adopted Name (USAN) stems did not identify that a USAN stem is present in the proposed proprietary name.

2.2.2 Components of the Proposed Proprietary Name

The Applicant did not submit an intended meaning or derivation of the proposed name, Vituz. This proprietary name is comprised of a single word that does not contain any components (i.e. a modifier, route of administration, dosage form, etc.) that are misleading or can contribute to medication error.

2.2.3 FDA Stimulation Studies

Ninety-six practitioners participated in DMEPA's prescription studies. One participant interpreted the name as, V-tuss. This name was also identified by DMEPA and is evaluated in this review in Appendix E. Twenty-eight participants interpreted the name correctly as "Vituz". The remaining participants provided incorrect responses. See Appendix C for the complete listing of interpretations from the verbal and written prescription studies.

2.2.4 Comments from Other Review Disciplines

In response to the OSE, August 10, 2012 e-mail, the Division of Pulmonary, Allergy, and Rheumatology Products (DPARP) indicated that Vituz means "lively" in Italian and was unsure if the name was appropriate. DPARP's comments were forwarded to OPDP. OPDP reevaluated the name and maintained their position. DPARP concurred with OPDP's final decision regarding the promotional aspect of the name, Vituz. DMEPA also concurred with OPDP.

2.2.5 Failure Mode and Effects Analysis of Similar Names

Appendix B lists possible orthographic and phonetic misinterpretations of the letters appearing in the proposed proprietary name, Vituz. Table 1 lists the names with orthographic, phonetic, or spelling similarity to the proposed proprietary name, Vituz identified by the primary reviewer, the Expert Panel Discussion (EPD), and other review disciplines. Tables 1 also includes the names submitted by the Applicant, Cypress Pharmaceuticals, Inc., identified from the databases Drugs @ FDA and Medispan. DMEPA included the names with significant orthographic and phonetic similarities in our evaluation.

Table 1: Collective List of Potentially Similar Names (DMEPA, EPD, Other Disciplines, and External Name Study)

Look Similar					
<i>Name</i>	<i>Source</i>	<i>Name</i>	<i>Source</i>	<i>Name</i>	<i>Source</i>
Velban	FDA	Vitrax	FDA	Viadur	FDA
Reluri	FDA	Vitron-C	FDA	Vexol	FDA
Rutin	FDA	Vitex	FDA	Vita-C	FDA
Ultram	FDA	Vita-21	FDA	Rituxan	FDA
Rebif	FDA	Vita Zinc	FDA	Vistra	FDA
Ultiva	FDA	Valine	FDA	Utac	FDA
Vitrase	Both	VATH	FDA	Utex 10	FDA
Veltin	FDA	Vol-Tab	FDA	Utex 20	FDA
Vitec	FDA	Vioxx	FDA	Vi-Zac	FDA
Ultra R	FDA	Utira	FDA	Vantin	FDA
Vitav	FDA	Vita-Rx	Reviewer		
Sound Similar					
<i>Name</i>	<i>Source</i>				
Veetids	FDA				
Look and Sound Similar					
<i>Name</i>	<i>Source</i>	<i>Name</i>	<i>Source</i>	<i>Name</i>	<i>Source</i>
Vituz	FDA	Vetuss HC	FDA	Vitox	FDA
Videx	FDA	Vidaza	FDA	Vantus	FDA
Vitus	FDA	Victoza	FDA	V-tuss	FDA

Our analysis of the 42 names contained in Table 1 considered the information obtained in the previous sections along with their product characteristics. We determined 42 names will not pose a risk for confusion as described in Appendices D through E.

2.2.6 Communication of DMEPA’s Final Decision to other Disciplines

DMEPA communicated our findings to the Division of Pulmonary, Allergy, and Rheumatology Products (DPARP) via e-mail on October 1, 2012. At that time we also requested additional information or concerns that could inform our review. Per e-mail correspondence from the Division of Pulmonary, Allergy, and Rheumatology Products (DPARP) on October 1, 2012, they stated no additional concerns with the proposed proprietary name, Vituz.

3 CONCLUSIONS

The proposed proprietary name is acceptable from both a promotional and safety perspective.

If you have further questions or need clarifications, please contact Nichelle Rashid, OSE project manager, at 301-796-3904.

3.1 COMMENTS TO THE APPLICANT

We have completed our review of the proposed proprietary name, Vituz, and have concluded that this name is acceptable. However, if any of the proposed product characteristics as stated in your August 2, 2012 submission are altered, the name must be resubmitted for review.

Additionally, the proposed proprietary name must be re-reviewed 90 days prior to approval of the NDA. The conclusions upon re-review are subject to change.

4 REFERENCES

1. *Micromedex Integrated Index* (<http://csi.micromedex.com>)

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

2. *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.

3. *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. This database also lists the orphan drugs.

4. *FDA Document Archiving, Reporting & Regulatory Tracking System [DARRTS]*

DARRTS is a government database used to organize Applicant and Sponsor submissions as well as to store and organize assignments, reviews, and communications from the review divisions.

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/index.cfm>)

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

USPTO provides information regarding patent and trademarks.

8. *Clinical Pharmacology Online* (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.

9. *Data provided by Thomson & Thomson's SAEGIS™ Online Service, available at (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.

10. *Natural Medicines Comprehensive Databases (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.

11. *Access Medicine (www.accessmedicine.com)*

Access Medicine® from McGraw-Hill contains full-text information from approximately 60 titles; it includes tables and references. Among the titles are: Harrison's Principles of Internal Medicine, Basic & Clinical Pharmacology, and Goodman and Gilman's The Pharmacologic Basis of Therapeutics.

12. *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.

13. *Red Book (www.thomsonhc.com/home/dispatch)*

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

14. *Lexi-Comp (www.lexi.com)*

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

15. *Medical Abbreviations (www.medilexicon.com)*

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

16. *CVS/Pharmacy (www.CVS.com)*

This database contains commonly used over the counter products not usually identified in other databases.

17. *Walgreens (www.walgreens.com)*

This database contains commonly used over the counter products not usually identified in other databases.

18. Rx List (www.rxlist.com)

RxList is an online medical resource dedicated to offering detailed and current pharmaceutical information on brand and generic drugs.

19. Dogpile (www.dogpile.com)

Dogpile is a [Metasearch](#) engine that searches multiple search engines including Google, Yahoo! and Bing, and returns the most relevant results to the search.

20. Natural Standard (<http://www.naturalstandard.com>)

Natural Standard is a resource that aggregates and synthesizes data on complementary and alternative medicine.

APPENDICES

Appendix A

FDA's Proprietary Name Risk Assessment considers the promotional and safety aspects of a proposed proprietary name. The promotional review of the proposed name is conducted by OPDP. OPDP evaluates proposed proprietary names to determine if they are overly fanciful, so as to misleadingly imply unique effectiveness or composition, as well as to assess whether they contribute to overstatement of product efficacy, minimization of risk, broadening of product indications, or making of unsubstantiated superiority claims. OPDP provides their opinion to DMEPA for consideration in the overall acceptability of the proposed proprietary name.

The safety assessment is conducted by DMEPA. DMEPA staff search a standard set of databases and information sources to identify names that are similar in pronunciation, spelling, and orthographically similar when scripted to the proposed proprietary name. Additionally, we consider inclusion of USAN stems or other characteristics that when incorporated into a proprietary name may cause or contribute to medication errors (i.e., dosing interval, dosage form/route of administration, medical or product name abbreviations, names that include or suggest the composition of the drug product, etc.). 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.¹

Following the preliminary screening of the proposed proprietary name, DMEPA gathers to discuss their professional opinions on the safety of the proposed proprietary name. This meeting is commonly referred to the Center for Drug Evaluation and Research (CDER) Expert Panel discussion. DMEPA also considers other aspects of the name that may be misleading from a safety perspective. DMEPA staff conducts a prescription simulation studies using FDA health care professionals. When provided, DMEPA considers external proprietary name studies conducted by or for the Applicant/Sponsor and incorporates the findings of these studies into the overall risk assessment.

The DMEPA primary reviewer assigned to evaluate the proposed proprietary name 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 misleading nature of the proposed proprietary name with a focus on the avoidance of medication errors.

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. DMEPA considers the product characteristics associated with the proposed product throughout the risk assessment because the product characteristics of the

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

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 conditions, patient population, and prescriber population. DMEPA considers how these product characteristics may or may not be present in communicating a product name throughout the medication use system. Because drug name confusion can occur at any point in the medication use process, DMEPA 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.²

The DMEPA considers the spelling of the name, pronunciation of the name when spoken, and appearance of the name when scripted. DMEPA compares the proposed proprietary name with the proprietary and established name of existing and proposed drug products and names currently under review at the FDA. DMEPA 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. DMEPA examines the phonetic similarity using patterns of speech. If provided, DMEPA will consider the Sponsor's intended pronunciation of the proprietary name. However, DMEPA also considers a variety of pronunciations that could occur in the English language because the Sponsor has little control over how the name will be spoken in clinical practice. The orthographic appearance of the proposed name is evaluated using a number of different handwriting samples. DMEPA applies expertise gained from root-cause analysis of postmarketing 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).

² 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"> Names may appear similar in print or electronic media and lead to drug name confusion in printed or electronic communication Names may look similar when scripted and lead to drug name confusion in written communication
	Orthographic similarity	Similar spelling Length of the name/Similar shape Upstrokes Down strokes Cross-strokes Dotted letters Ambiguity introduced by scripting letters Overlapping product characteristics	<ul style="list-style-type: none"> Names may look similar when scripted, and lead to drug name confusion in written communication
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"> Names may sound similar when pronounced and lead to drug name confusion in verbal communication

Lastly, DMEPA 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 the medication error staff 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 searches 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. A standard description of the databases used in the searches is provided in the reference section of this review. To complement the process, the DMEPA uses 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, DMEPA reviews 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. DMEPA also evaluates if there are characteristics included in the composition that may render the name unacceptable from a safety perspective (abbreviation, dosing interval, etc.).

2. Expert Panel Discussion

DMEPA gathers CDER professional opinions on the safety of the proposed product and discussed the proposed proprietary name (Expert Panel Discussion). The Expert Panel is composed of Division of Medication Errors Prevention (DMEPA) staff and representatives from the Office of Prescription Drug Promotion (OPDP). We also consider input from other review disciplines (OND, ONDQA/OBP). 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 database and information searches to the Expert Panel for consideration. Based on the clinical and professional experiences of the Expert Panel members, the Panel may recommend additional 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. FDA Prescription Simulation Studies

Three separate studies are conducted within the Centers of the FDA for the proposed proprietary name to determine the degree of confusion of the proposed proprietary name with marketed U.S. drug names (proprietary and established) due to similarity in visual appearance with handwritten prescriptions or verbal pronunciation of the drug name. The studies employ healthcare professionals (pharmacists, physicians, and nurses), and attempts to simulate the prescription ordering process. The primary Safety Evaluator uses the results to identify orthographic or phonetic vulnerability of the proposed name to be misinterpreted by healthcare practitioners.

In order to evaluate the potential for misinterpretation of the proposed proprietary name in handwriting and verbal communication of the name, inpatient medication orders and/or outpatient prescriptions are written, each consisting of a combination of marketed and unapproved drug products, including the proposed name. These orders are optically

scanned and one prescription is delivered to a random sample of participating health professionals via e-mail. In addition, a verbal prescription is recorded on voice mail. The voice mail messages are then sent to a random sample of the participating health professionals for their interpretations and review. After receiving either the written or verbal prescription orders, the participants record their interpretations of the orders which are recorded electronically.

4. Comments from Other Review Disciplines

DMEPA requests the Office of New Drugs (OND) and/or Office of Generic Drugs (OGD), ONDQA or OBP for their comments or concerns with the proposed proprietary name, ask for any clinical issues that may impact the DMEPA review during the initial phase of the name review. Additionally, when applicable, at the same time DMEPA requests concurrence/non-concurrence with OPDP's decision on the name. The primary Safety Evaluator addresses any comments or concerns in the safety evaluator's assessment.

The OND/OGD Regulatory Division is contacted a second time following our analysis of the proposed proprietary name. At this point, DMEPA conveys their decision to accept or reject the name. The OND or OGD Regulatory Division is requested to provide any further information that might inform DMEPA's final decision on the proposed name.

Additionally, other review disciplines opinions such as ONDQA or OBP may be considered depending on the proposed proprietary name.

5. 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, considers all aspects of the name that may be misleading or confusing, conducts a Failure Mode and Effects Analysis, and provides an overall decision on acceptability dependent on their 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.³ 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

³ Institute for Healthcare Improvement (IHI). Failure Mode and Effects Analysis. Boston. IHI:2004.

characteristics listed in Section 1.2 of this review. 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? And are there any components of the name that may function as a source of error beyond sound/look-alike?”

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 or because of some other component of the name. 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:

“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.

Moreover, 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 Overall Risk Assessment:

- a. OPDP finds the proposed proprietary name misleading from a promotional perspective, and the Review Division concurs with OPDP’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 but involve a naming characteristic that when incorporated into a proprietary name, may be confusing, misleading, cause or contribute to medication errors.

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 generally recommends that the Sponsor select an alternative proprietary name and submit the alternate name to the Agency for 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 Sponsor 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/Sponsor. However, the safety concerns set forth in criteria a through e above are supported either by FDA regulation or by external healthcare authorities, including the Institute of Medicine (IOM), World Health Organization (WHO), the Joint Commission, and the Institute for Safe Medication Practices (ISMP). These organizations have examined medication errors resulting from look- or sound-alike drug names, confusing, or misleading 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 preventable source of medication error that, in many instances, the Agency and/or Sponsor 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. Sponsors have undertaken higher-leverage strategies, such as drug name changes, in the

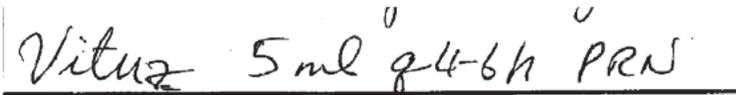
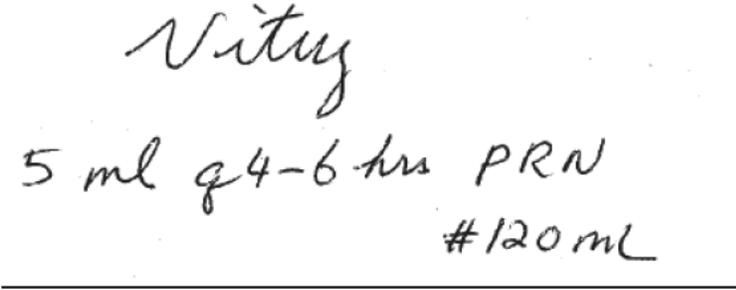
past but at great financial cost to the Sponsor and at the expense of the public welfare, not to mention the Agency's credibility as the authority responsible for approving the error-prone proprietary name. Moreover, even after Sponsors' have changed a product's proprietary name in the post-approval 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: Letters with Possible Orthographic or Phonetic Misinterpretation

Letters in Name, Vituz	Scripted May Appear as	Spoken May Be Interpreted as
Capital 'V'	'U', 'N',	'L', 'D', 'Z'
lower case 'v'	'r', 'u'	'L', 'D', 'Z'
lower case 'i'	Any vowel	Any vowel
lower case 't'	'r', 'f', 'x', 'A', 'l'	'd'
lower case 'u'	'n', 'y', 'v', 'w', any vowel	Any vowel
lower case 'z'	'c', 'e', 'g', 'n', 'm', 'q', 'r', 't', 'v', 'y', 'ii'	'c', 's', 'x'
letter string 'uz'		'ooz'

Appendix C: Prescription Simulation Samples and Results

Figure 1. Vituz Conducted on 8/10/2012)

Handwritten Requisition Medication Order	Verbal Prescription
<p><u>Medication Order:</u></p> 	<p>Vituz 5 mL q4-6 hours prn #120 mL</p>
<p><u>Outpatient Prescription:</u></p> 	

FDA Prescription Simulation Responses (Aggregate 1 Rx Studies Report)

184 People Received Study
96 People Responded

Study Name: Vituz

	Total	31	35	31
INTERPRETATION	INPATIENT	VOICE	OUTPATIENT	TOTAL
?	0	2	1	3
DETUSE	0	1	0	1
LETUSE	0	1	0	1
LETUSE LETUSE	0	1	0	1
NETU	0	1	0	1
NITRAZ	0	0	1	1
NITRY	0	0	1	1
NITUZ	0	0	1	1
VENTAVIS	0	1	0	1
VETOOZE	0	1	0	1
VETUSE	0	2	0	2
VETUZ	0	1	0	1
VIRTUZ 5 ML Q 4-6 HRS PRN #120 ML	0	0	1	1
VISTA	1	0	0	1
VITERG	0	0	1	1
VITIY	0	0	2	2
VITOOZ	0	1	0	1

VITRIG?	0	0	1	1
VITRIQ	0	0	2	2
VITRUS	0	1	0	1
VITRY	0	0	9	9
VITTRY	0	0	1	1
VITU	1	0	0	1
VITUA	1	0	0	1
VITUES	0	2	0	2
VITUESE	0	1	0	1
VITUG	0	0	3	3
VITUQ	0	0	1	1
VITUS	3	1	0	4
VITUSE	0	8	0	8
VITUX	3	0	0	3
VITUY	0	0	1	1
VITUZ	20	4	4	28
VITUZ???	1	0	0	1
VITUZE	0	3	0	3
V-TUSS	1	0	0	1
VUTUSE	0	1	0	1
ZETAZ	0	1	0	1
ZETUS	0	1	0	1

Appendix D: Proprietary names not likely to be confused or not used in usual practice settings for the reasons described.

Proprietary Name		Active Ingredient	Similarity to Vituz	Failure preventions
1	Velban	Vinblastine	Look alike	The pair has sufficient orthographic differences.
2	Ultram	Tramadol	Look alike	The pair has sufficient orthographic differences.
3	Ultiva	Remifentanyl	Look alike	The pair has sufficient orthographic differences.
4	Veltin	Clindamycin; Tretinoin	Look alike	The pair has sufficient orthographic differences.
5	VATH	Vinblastine; Adriamycin; Thiotepa; Halotestin	Look alike	The pair has sufficient orthographic differences.
6	Vol-Tab Rx	Prenatal Vitamin w/ Minerals	Look alike	The pair has sufficient orthographic differences.
7	Vioxx	Rofecoxib	Look alike	The pair has sufficient orthographic differences. This product was also discontinued due to safety issues.
8	Vexol	Rimexolone	Look alike	The pair has sufficient orthographic differences.
9	Rituxan	Rituximab	Look alike	The pair has sufficient orthographic differences.
10	Utex 10	Urea	Look alike	The pair has sufficient orthographic differences.
11	Utex 20	Urea	Look alike	The pair has sufficient orthographic differences.
12	Ultra R	Barium Sulfate	Look alike	The pair has sufficient orthographic differences.
13	Utira	Hyoscyamine; Methenamine; Methylene Blue;Phenyl Salicylate;Sodium Biphos	Look alike	The pair has sufficient orthographic differences.
14	Vantin	Cefpodoxime	Look alike	The pair has sufficient orthographic differences.

Proprietary Name		Active Ingredient	Similarity to Vituz	Failure preventions
15	Vetuss HC	Phenylephrine; Hydrocodone; Pyrilamine; Pheniramine; Phenylpropanolamine	Look and Sound alike	The drug has been discontinued since 12/31/2000 and contains hydrocodone. This product must be submitted to the Agency for review if remarketed.
16	Vantas	Histrelin	Look and Sound alike	The pair has sufficient orthographic and phonetic differences.
17	Victoza	Liraglutide	Look and Sound alike	The pair has sufficient orthographic and phonetic differences.
18	Veetids	Penicillin V	Look and Sound alike	The pair has sufficient orthographic and phonetic differences.
19	Vituz	Hydrocodone bitartrate and Chlorpheniramine maleate	Look and Sound alike	The name is the subject of this review.
20	Vita Zinc	Multivitamin with minerals	Look alike	The pair has sufficient orthographic differences.
21	Vita #12	Cyanocobalamin	Look Like	The pair has sufficient orthographic differences.
22	N/A	Valine	Look alike	This is an orphan drug that has two commercial IND within the Agency. One is inactive and the other has been withdrawn.
23	VitaV		Look alike	This product is not a drug product. This is a dietary food supplement (nutritional drink) that is not currently marketed.
24	Grape Seed extract	vitus vinifera	Look alike	This is an herbal component in grape seed extract.
25	Vita-C Crystals	Ascorbic Acid	Look alike	The pair has sufficient orthographic differences.

Appendix E: Risk of medication errors due to product confusion minimized by dissimilarity of the names and/ or use in clinical practice for the reasons described.

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>	
<p>1</p>	<p>Reluri (Guaifenesin;Phenylephrine)</p> <p><u>Sustained Release Tablets</u> 1200 mg; 30 mg</p> <p><u>Usual Dose</u> 1 tablet PO every 12 hours. Do not exceed 2 tablets/24 hours.</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u></p> <p>Both names contain two upstrokes ('R', 'l') in the same position.</p> <p>The letter string 'rel' when scripted appears similar to the letter string 'vit'.</p> <p>Both names contain the letter 'u' in the same position.</p> <p>The letter string 'ri' when scripted appears similar to the letter string 'z'.</p> <p><u>Strength</u></p> <p>Both products are available as a single strength which does not require a strength to be written on the prescription.</p>	<p><u>Differences</u></p> <p><u>Usual Dose</u> 1-2 tablets vs. 5 mL or one tsp</p> <p><u>Frequency of Administration</u> Every 12 hours vs. every 4-6 hours as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>2</p> <p>Rutin (Vitamin P1)</p> <p><u>Capsule</u> 500 mg</p> <p><u>Usual Dose</u> 500 mg twice daily</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names contain two upstrokes ('R', 't' vs. 'V', 't') in the same position.</p> <p>The letter string 'rut' when scripted appears similar to the letter string 'vit'.</p> <p>The letter string 'in' when scripted appears similar to the letter string 'uz'.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription.</p>	<p><u>Differences</u></p> <p><u>Usual Dose</u> 1 tablet or 500 mg vs. 5 mL or one tsp</p> <p><u>Frequency of Administration</u> Twice daily vs. every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>	
<p>4</p>	<p>Rebif (Interferon Beta 1a)</p> <p><u>Solution for Injection</u> 22 mcg/0.5 mL and 44 mcg/0.5 mL</p> <p><u>Usual Dose</u> 22 or 44 mcg subcutaneously three times weekly</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> The letter string ‘reb’ when scripted appears similar to the letter string ‘vit’.</p> <p>The letter string ‘if’ when scripted appears similar to the letter string ‘uz’.</p> <p><u>Usual Dose</u> 0.5 mL vs. 5 mL</p>	<p><u>Differences</u></p> <p><u>Strength</u> Vituz is available as a single strength which does not require a strength to be written on the prescription vs. Rebif are available in multiple strengths (i.e. 22 mcg and 44 mcg) which would require a strength on a prescription.</p> <p><u>Frequency of Administration</u> Three times daily vs. every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>	
<p>5</p>	<p>Vitrase (Hyaluronidase)</p> <p><u>Solution for Injection</u> 200 USP units/mL</p> <p><u>Usual Dose</u> 50-200 units subcutaneously once.</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names begin with the letter string ‘Vit’</p> <p>The letter string ‘ra’ when scripted appears similar to the letter string ‘uz’.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription</p>	<p><u>Differences</u></p> <p><u>Orthographics</u> The ending letter string ‘se’ in the name Vitrase provides difference between the name Vituz by elongating the name.</p> <p><u>Usual Dose</u> 50-200 units vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> Once vs. Every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>7</p> <p>Vitec (Vitamin E)</p> <p><u>Lotion</u> 113 grams</p> <p><u>Usual Dose</u> Apply a thin layer over affected area as needed or Use as directed</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names begin with the letter string ‘Vit’</p> <p>The letter string ‘ec’ when scripted appears similar to the letter string ‘uz’.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription</p>	<p><u>Differences</u></p> <p><u>Usual Dose</u> Apply a thin layer vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> As needed vs. Every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>	
<p>8</p>	<p>Vitraz (Sodium Hyaluronate;Hyaluronic Acid)</p> <p><u>Ophthalmic Solution for Irrigation</u> 3%</p> <p><u>Usual Dose</u> Slowly inject sufficient amount into anterior chamber. Inject either before or after delivery of lens.</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names begin with the letter string ‘Vit’</p> <p>The letter string ‘ax’ when scripted appears similar to the letter string ‘uz’.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription</p>	<p><u>Differences</u></p> <p><u>Usual Dose</u> Slowly inject sufficient amount vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> Once vs. Every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>9 Vitron-C (Ascorbic Acid;Ferrous fumerate)</p> <p><u>Tablet</u> 125 mg;200 mg</p> <p><u>Usual Dose</u> Take one tablet once daily</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names begin with the letter string ‘Vit’</p> <p>The letter string ‘on’ when scripted appears similar to the letter string ‘uz’.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription</p>	<p><u>Differences</u></p> <p><u>Orthographics</u> The suffix ‘uz’ appear different from the suffix ‘ron’ due to the additional letter ‘r’ in it. If the modifier ‘C’ is written with Vitron, this name appears longer than Vituz when scripted</p> <p><u>Usual Dose</u> 1 tablet vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> Once Daily vs. Every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>10 Vitex-discontinued otc product (Chaseberry)-herbal supplement</p> <p><u>Capsules</u></p> <p><u>Usual Dose</u> Take 1 capsule 1-2 times daily.</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names begin with the letter string ‘Vit’</p> <p>The letter string ‘ex’ when scripted appears similar to the letter string ‘uz’.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription</p>	<p><u>Differences</u></p> <p><u>Usual Dose</u> 1 tablet vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> Once-Twice Daily vs. Every 4-6 hours as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>	
<p>11</p>	<p>Viadur (Leuprolide Acetate)</p> <p><u>Implant</u> 65 mg</p> <p><u>Usual Dose</u> 1 implant device SC every 12 months.</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names contain two upstrokes ('V', 'd') in a similar position.</p> <p>Both names begin with the letter string 'Vi'.</p> <p>The letter string 'dur' when scripted appears similar to the letter string 'tuz'.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription.</p>	<p><u>Differences</u></p> <p><u>Orthographics</u> The letter 'a' in the name Viadur provides differentiation between the name Vituz by elongating the name.</p> <p><u>Usual Dose</u> 1 implant device vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> Every 12 months vs. Every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>12 Vitox-otc product that can be only found on company’s website and in USPTO (Multivitamin w/ minerals)</p> <p><u>Capsule</u></p> <p><u>Usual Dose</u> Take two capsules with eight ounces of liquid with your morning and evening meals</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names begin with the letter string ‘Vit’</p> <p>The letter string ‘ox’ when scripted appears similar to the letter string ‘uz’.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription</p>	<p><u>Differences</u></p> <p><u>Usual Dose</u> 2 capsules vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> Twice- three times daily vs. Every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>13 Videx and Videx EC (Didanosine)</p> <p><u>Delayed Release Capsule</u> 125 mg, 200 mg, 250 mg, 400 mg</p> <p><u>Powder for Oral Solution</u> 2 grams , 4 grams</p> <p><u>Usual Dose</u> 125 mg twice daily or 200 mg-400 mg once daily</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names contain upstrokes ('V', 'd') in the same position.</p> <p>The letter string 'ex' when scripted appears similar to the letter string 'uz'.</p>	<p><u>Differences</u></p> <p><u>Strength</u> Vituz is available as a single strength which does not require a strength to be written on the prescription vs. Videx and Videx EC are available in multiple strengths (i.e. 125 mg, 200 mg, 250 mg, 400 mg, 2 grams, 4 grams) which would require a strength on a prescription.</p> <p><u>Frequency of Administration</u> Once daily –twice daily vs. every 4-6 hours or as needed</p> <p><u>Usual Dose</u> 125 mg, 200 mg, 250 or vs. 5 mL or 1 tsp</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>14 Vita-rx- discontinued Rx product w/generic equivalents available (hydrocortisone; neomycin sulfate; polymycin b sulfate)</p> <p><u>Otic Solution</u> 1%;0.35%;10000 units/mL</p> <p><u>Usual Dose</u> 4 drops in affected ear(s) 3—4 times daily. Treatment should not be continued longer than 10 days</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names begin with the letter string ‘Vit’</p> <p>The letter string ‘ar’ when scripted appears similar to the letter string ‘uz’.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription</p>	<p><u>Differences</u></p> <p><u>Usual Dose</u> 4 drops vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> 3-4 times daily vs. Every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>15 Utac- discontinued but other therapeutic equivalents available (Methenamine; Sodium Acid Phosphate)</p> <p><u>Tablets</u> 500 mg;500mg</p> <p><u>Usual Dose</u> Take 2-4 tablets four times daily.</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names contain two upstrokes ('U', 't' vs. 'V', 't') in a similar position.</p> <p>The letter string 'tac' when scripted appears similar to the letter string 'tuz'.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription.</p> <p><u>Frequency of Administration</u> Four times daily</p>	<p><u>Differences</u></p> <p><u>Usual Dose</u> 2-4 tablets vs. 5 mL or 1 tsp</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>16 Vidaza (Azacitidine)</p> <p><u>Powder for Injection</u> 100 mg</p> <p><u>Usual Dose</u> 75 mg/m² subcutaneously once daily every 5-7 days for 4 weeks or 150 mg/m² intravenously once daily for 5 days</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names contain two upstrokes ('V', 't' vs. 'V', 'd') in the same position.</p> <p>The letter string 'az' when scripted appears similar to the letter string 'uz'.</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription.</p>	<p><u>Differences</u></p> <p><u>Orthographics</u> The ending letter 'a' in the name Vidaza provides differentiation between the name Vituz by elongating the name.</p> <p><u>Usual Dose</u> 75 mg/m² or 150 mg/m² vs. 5 mL or 1 tsp</p> <p><u>Frequency of Administration</u> once daily every 5-7 days for 4 weeks or once daily for vs. Every 4-6 hours or as needed</p>

<p>Proposed name: Vituz (hydrocodone bitartrate and chlorpheniramine maleate)</p> <p>Dosage form(s):Solution</p> <p>Strength(s): 5 mg hydrocodone bitartrate; 4 mg chlorpheniramine maleate per 5 mL</p> <p>Usual dose: 5 mL every 4 to 6 hour as needed, not to exceed 4 doses (20 mL) in 24 hours</p>	<p>Failure Mode: Incorrect Product Ordered/ Selected/Dispensed or Administered because of Name confusion</p> <p>Causes (could be multiple)</p>	<p>Prevention of Failure Mode</p> <p>In the conditions outlined below, the following combination of factors, are expected to minimize the risk of confusion between these two names</p>
<p>17 V-tuss (codeine; guafenesin;pseudoephedrine)</p> <p><u>Syrup</u> 10 mg; 100 mg; 30 mg</p> <p><u>Usual Dose</u> 1.25 mL-10 mL every 4-6 hours or as needed</p>	<p><u>Similarities</u></p> <p><u>Orthographics</u> Both names contain two upstrokes ('V', 't') in a similar position.</p> <p>Both names contain the letter string 'us' in a similar position.</p> <p><u>Phonetics</u> Both names begin the 'V' sound and end with the 'tuss' vs. 'tuz'</p> <p>Both have two syllables</p> <p><u>Strength</u> Both products are available as a single strength which does not require a strength to be written on the prescription.</p> <p><u>Usual Dose</u> 5 mL</p>	<p><u>Differences</u></p> <p>This name could only be found via Google Rxlist, and WebMD and could not be found in Redbook, Orange Book, and the NDC Directory. Thus this product cannot be obtained or ordered from any site. Additionally, the product characteristics for V-tuss were not listed in these databases. The links for Rxlist and WebMD only provide general consumer information and the links for the healthcare professional are inactive. The Google link [http://www.medhelp.org/tags/show/179134/v-tuss] seems to infer that V-tuss is synonymously known as Mytussin DAC. However, the name V-tuss could only be found on these sites.</p>

		<u>Frequency of Administration</u> Every 4-6 hours or as needed	
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/s/

TERESA S MCMILLAN
10/24/2012

LUBNA A MERCHANT
10/25/2012

CAROL A HOLQUIST
10/26/2012

**Department of Health and Human Services
Public Health Service
Food and Drug Administration
Center for Drug Evaluation and Research
Office of Surveillance and Epidemiology
Office of Medication Error Prevention and Risk Management**

Proprietary Name Review

Date: July 24, 2012

Reviewer(s): Teresa McMillan, PharmD
Division of Medication Error Prevention & Analysis

Team Leader Lubna Merchant, M.S., PharmD
Division of Medication Error Prevention & Analysis

Deputy Director Kellie Taylor, PharmD, MPH
Division of Medication Error Prevention & Analysis

Division Director Carol Holquist, RPh
Division of Medication Error Prevention & Analysis

Drug Name(s) and Strength(s): (b) (4) (Hydrocodone Bitartrate and
Chlorpheniramine Maleate) Oral Solution
5 mg/4 mg per 5 mL

Application Type/Number: NDA 204307

Applicant/Sponsor: Cypress Pharmaceutical, Inc

OSE RCM #: 2012-1055

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