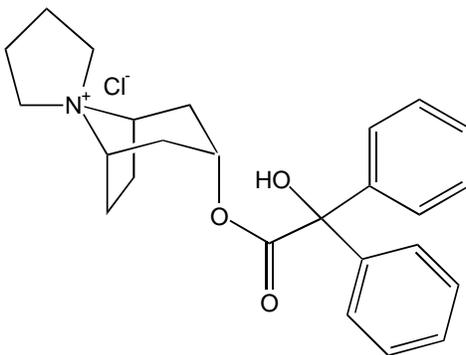


PRESCRIBING INFORMATION

SANCTURA[®] (trospium chloride) 20 mg tablets

DESCRIPTION

SANCTURA[®] (trospium chloride) is a quaternary ammonium compound with the chemical name of Spiro[8-azoniabicyclo[3.2.1]octane-8,1'-pyrrolidinium], 3-[(hydroxydiphenylacetyl)oxy]-, chloride, (1 α , 3 β , 5 α). The empirical formula of trospium chloride is C₂₅H₃₀ClNO₃ and its molecular weight is 427.97. The structural formula of trospium chloride is represented below:



Trospium chloride is a fine, colorless to slightly yellow, crystalline solid. The compound's solubility in water is approximately 1 g/2 mL.

Each SANCTURA[®] tablet contains 20 mg of trospium chloride and is to be given orally. Each tablet also contains the following inactive ingredients: sucrose, wheat starch, microcrystalline cellulose, talc, lactose monohydrate, calcium carbonate, titanium dioxide, stearic acid, croscarmellose sodium, povidone, polyethylene glycol 8000, colloidal silicon dioxide, ferric oxide, carboxymethylcellulose sodium, white wax, magnesium stearate, and carnauba wax.

CLINICAL PHARMACOLOGY

SANCTURA[®] is a muscarinic antagonist.

Trospium chloride antagonizes the effect of acetylcholine on muscarinic receptors in cholinergically innervated organs including the bladder. Its parasympatholytic action reduces the tonus of smooth muscle in the bladder. Receptor assays showed that trospium chloride has negligible affinity for nicotinic receptors as compared to muscarinic receptors at concentrations obtained from therapeutic doses.

Pharmacodynamics

Placebo-controlled studies employing urodynamic variables were conducted in patients with conditions characterized by involuntary detrusor contractions. The results demonstrate that SANCTURA[®] increases maximum cystometric bladder capacity and volume at first detrusor contraction.

Pharmacokinetics

Absorption: After oral administration, less than 10% of the dose is absorbed. Mean absolute bioavailability of a 20 mg dose is 9.6% (range: 4.0-16.1%). Peak plasma concentrations (C_{max}) occur between 5 to 6 hours post-dose. Mean C_{max} increases greater than dose-proportionally; a 3-fold and 4-fold increase in C_{max} was observed for dose increases from 20 mg to 40 mg and from 20 mg to 60 mg, respectively. AUC exhibits dose linearity for single doses up to 60 mg. SANCTURA[®] exhibits diurnal variability in exposure with a decrease in C_{max} and AUC of up to 59% and 33%, respectively, for evening relative to morning doses.

Effect of Food: Administration with a high fat meal resulted in reduced absorption, with AUC and C_{max} values 70-80% lower than those obtained when **SANCTURA**[®] was administered while fasting. Therefore, it is recommended that **SANCTURA**[®] should be taken at least one hour prior to meals or on an empty stomach. (See DOSAGE AND ADMINISTRATION and PRECAUTIONS: Information for Patients.)

Distribution: Protein binding ranged from 50 to 85% when concentration levels of trospium chloride (0.5-50 ng/mL) were incubated with human serum *in vitro*.

The ³H-trospium chloride ratio of plasma to whole blood was 1.6:1. This ratio indicates that the majority of ³H-trospium chloride is distributed in plasma. The apparent volume of distribution for a 20 mg oral dose is 395 (\pm 140) liters.

Metabolism: The metabolic pathway of trospium in humans has not been fully defined. Of the 10% of the dose absorbed, metabolites account for approximately 40% of the excreted dose following oral administration. The major metabolic pathway is hypothesized as ester hydrolysis with subsequent conjugation of benzylic acid to form azoniaspironortropanol with glucuronic acid. Cytochrome P450 is not expected to contribute significantly to the elimination of trospium. Data taken from *in vitro* human liver microsomes investigating the inhibitory effect of trospium on seven cytochrome P450 isoenzyme substrates (CYP1A2, 2A6, 2C9, 2C19, 2D6, 2E1, and 3A4) suggest a lack of inhibition at clinically relevant concentrations.

Excretion: The plasma half-life for **SANCTURA**[®] following oral administration is approximately 20 hours. After oral administration of an immediate-release formulation of ¹⁴C-trospium chloride, the majority of the dose (85.2%) was recovered in feces and a smaller amount (5.8% of the dose) was recovered in urine; 60% of the radioactivity excreted in urine was unchanged trospium.

The mean renal clearance for trospium (29.07 L/hour) is 4-fold higher than average glomerular filtration rate, indicating that active tubular secretion is a major route of elimination for trospium. There may be competition for elimination with other compounds that are also renally eliminated (See PRECAUTIONS: Drug Interactions).

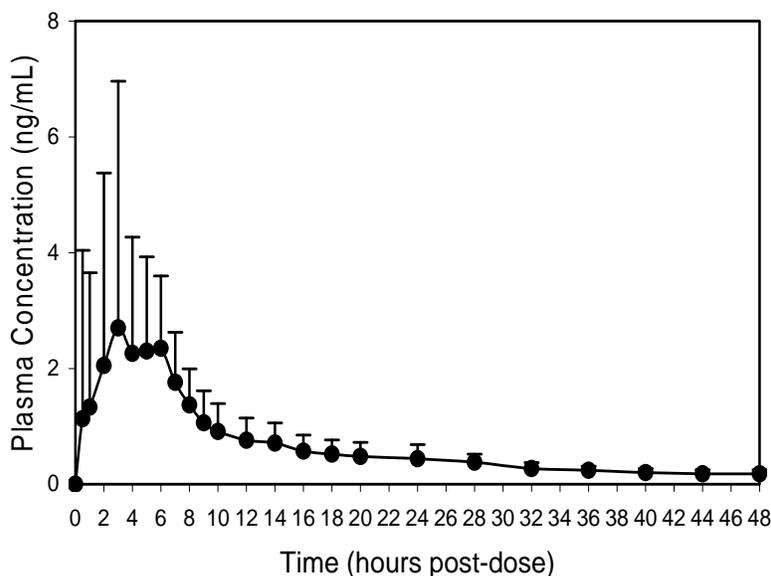
A summary of mean (\pm standard deviation) pharmacokinetic parameters for a single 20 mg dose of **SANCTURA**[®] is provided in Table 1.

Table 1. Mean (\pm SD) Pharmacokinetic Parameter Estimates for a Single 20 mg **SANCTURA[®] Dose in Healthy Volunteers**

C_{max} (ng/mL)	AUC _{0-∞} (ng/mL•hr)	T _{max} (hr)	t _{1/2} (hr)
3.5 \pm 4.0	36.4 \pm 21.8	5.3 \pm 1.2	18.3 \pm 3.2

The mean plasma concentration-time (+ SD) profile for **SANCTURA**[®] is shown in Figure 1.

Figure 1- Mean (+ SD) Concentration-Time Profile for a Single 20 mg Oral Dose of SANCTURA[®] in Healthy Volunteers



Pharmacokinetics in Special Populations

Age: Age did not appear to significantly affect the pharmacokinetics of SANCTURA[®], however, increased anticholinergic side effects unrelated to drug exposure were observed in patients ≥ 75 years of age. (See PRECAUTIONS: Geriatric Use and DOSAGE AND ADMINISTRATION.)

Pediatric: The pharmacokinetics of SANCTURA[®] were not evaluated in pediatric patients.

Gender: Studies comparing the pharmacokinetics in different genders had conflicting results. When a single 40 mg SANCTURA[®] dose was administered to 16 elderly subjects, exposure was 45% lower in elderly females compared to elderly males. When 20 mg SANCTURA[®] was dosed twice daily for 4 days to 6 elderly males and 6 elderly females (60 to 75 years), AUC and C_{max} were 26% and 68% higher, respectively, in females without hormone replacement therapy than in males.

Race: Pharmacokinetic differences due to race have not been studied.

Renal Impairment: Severe renal impairment significantly altered the disposition of SANCTURA[®]. A 4.2-fold and 1.8-fold increase in mean $AUC_{0-\infty}$ and mean C_{max} , respectively, and the appearance of an additional elimination phase with a long half-life (~ 33 hr) was detected in patients with severe renal impairment (creatinine clearance < 30 mL/min) compared with healthy, nearly age-matched subjects. The different pharmacokinetic behavior of SANCTURA[®] in patients with severe renal impairment necessitates adjustment of dosage frequency. The pharmacokinetics of SANCTURA[®] have not been studied in people with creatinine clearance ranging from 30-80 mL/min. (See PRECAUTIONS: General and DOSAGE AND ADMINISTRATION.)

Hepatic Impairment: There is no information regarding the effect of severe hepatic impairment on exposure to SANCTURA[®]. In a study of patients with mild (Child-Pugh score 5-6) and with moderate (Child-Pugh score 7-8) hepatic impairment, given 40 mg of immediate-release trospium chloride, mean C_{max} increased 12% and 63%, respectively, and mean $AUC_{0-\infty}$ decreased 5% and 15%, respectively, compared to healthy subjects. The

clinical significance of these findings is unknown. Caution should be used when administering **SANCTURA**[®] to patients with moderate and severe hepatic impairment. (See PRECAUTIONS: General.)

Electrophysiology

The effect of 20 mg twice daily and up to 100 mg twice daily **SANCTURA**[®] on QT interval was evaluated in a single-blind, randomized, placebo and active (moxifloxacin 400 mg once daily) controlled 5 day parallel trial in 170 male and female healthy volunteer subjects aged 18 to 45 years. The QT interval was measured over a 24-hour period at steady state. The 100 mg twice daily dose of **SANCTURA**[®] was chosen because this achieves the C_{max} expected in severe renal impairment. **SANCTURA**[®] was not associated with an increase in individual corrected (QTcI) or Fridericia corrected (QTcF) QT interval at any time during steady state measurement, while moxifloxacin was associated with a 6.4 msec increase in QTcF.

In this study, asymptomatic, non-specific T wave inversions were observed more often in subjects receiving **SANCTURA**[®] than in subjects receiving moxifloxacin or placebo following five days of treatment. This finding was not observed during routine safety monitoring in 2 other placebo-controlled clinical trials in 591 **SANCTURA**[®] treated overactive bladder patients (See CLINICAL STUDIES). The clinical significance of T wave inversion in this study is unknown. **SANCTURA**[®] is associated with an increase in heart rate that correlates with increasing plasma concentrations. In the study described above, **SANCTURA**[®] demonstrated a mean increase in heart rate compared to placebo of 9.1 bpm for the 20 mg dose and of 18.0 bpm for the 100 mg dose. In the two U.S. placebo-controlled trials in patients with overactive bladder, the mean increase in heart rate compared to placebo in Study 1 was observed to be 3.0 bpm and in Study 2 was 4.0 bpm.

CLINICAL STUDIES

SANCTURA[®] was evaluated for the treatment of patients with overactive bladder who had symptoms of urinary frequency, urgency, and urge incontinence in two U.S. 12-week, placebo-controlled studies and one 9-month open label extension.

Study 1 was a randomized, double-blind, placebo-controlled, parallel-group study in 523 patients. A total of 262 patients received **SANCTURA**[®] 20 mg twice daily and 261 patients received placebo. The majority of patients were Caucasian (85%) and female (74%) with a mean age of 61 years (range: 21 to 90 years). Entry criteria required that patients have urge or mixed incontinence (with a predominance of urge), urge incontinence episodes of at least 7 per week, and greater than 70 micturitions per week. The patient's medical history and urinary diary during the treatment-free baseline confirmed the diagnosis. Reductions in urinary frequency, urge incontinence episodes and urinary void volume for placebo and **SANCTURA**[®] treatment groups are summarized in Table 2 and Figures 2 and 3.

Table 2. Mean (SE) change from baseline to end of treatment (Week 12 or last observation carried forward) for urinary frequency, urge incontinence episodes, and void volume in Study 1

Efficacy endpoint	Placebo N=256	SANCTURA [®] N=253	P-value
Urinary frequency/24 hours a,*			
Mean baseline	12.9	12.7	
Mean change from baseline	-1.3 (0.2)	-2.4 (0.2)	<0.001
Urge incontinence episodes/week b,*			
Mean baseline	30.1	27.3	
Mean change from baseline	-13.9 (1.2)	-15.4 (1.1)	0.012
Urinary void volume/toilet void (mL) a,c			
Mean baseline	156.6	155.1	
Mean change from baseline	7.7 (3.1)	32.1 (3.1)	<0.001

a Treatment differences assessed by analysis of variance for ITT:LOCF data set.
 b Treatment differences assessed by ranked analysis of variance for ITT:LOCF data set.
 c Placebo N=253, SANCTURA[®] N=248.
 * Denotes co-primary endpoint
 ITT=intent-to-treat, LOCF=last observation carried forward.

Figure 2 – Mean Change from Baseline in Urinary Frequency/24 Hours, by Visit: Study 1

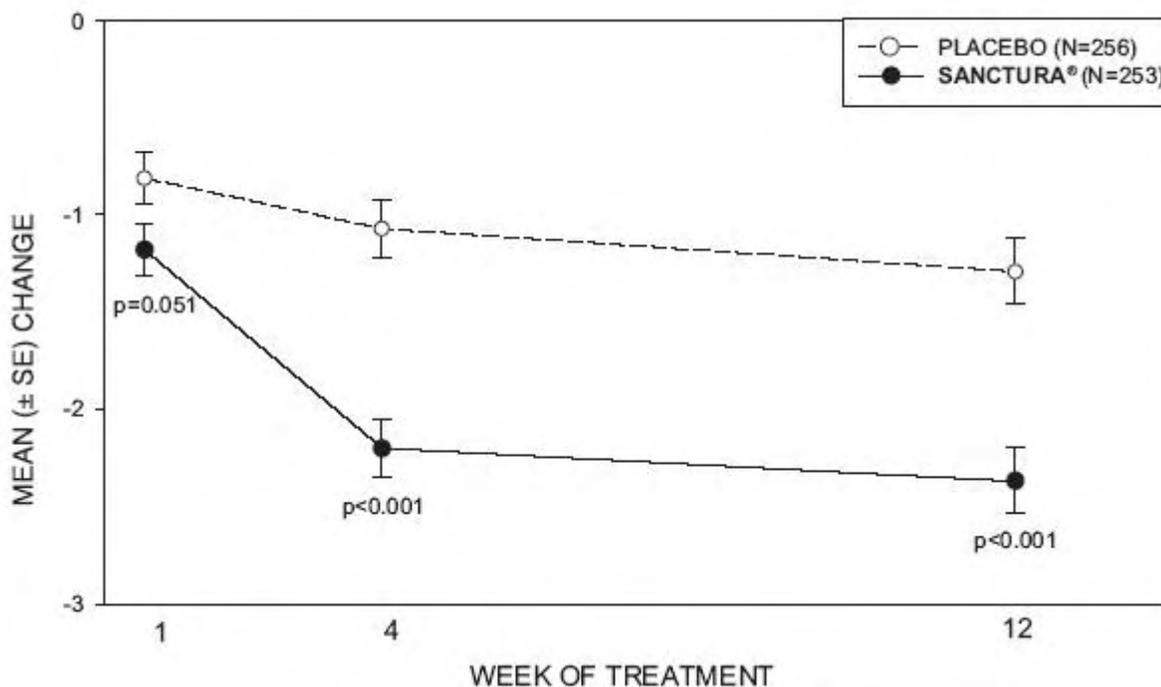
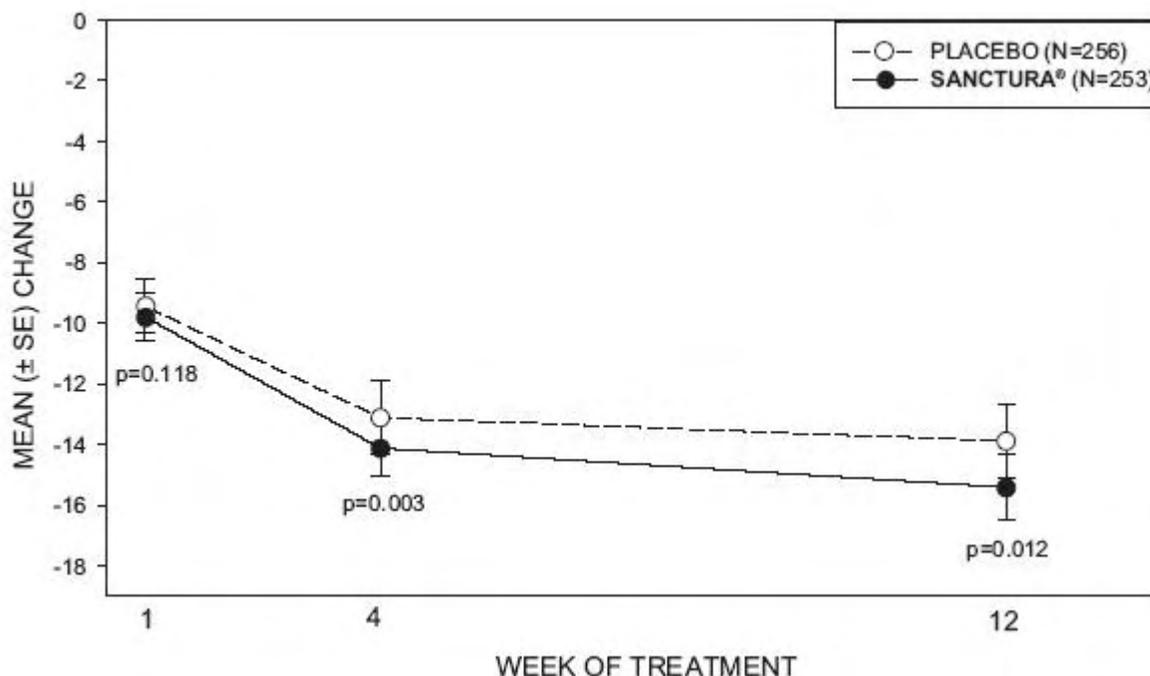


Figure 3 – Mean Change from Baseline in Urge Incontinence/Week, by Visit: Study 1



Study 2 was nearly identical in design to Study 1. A total of 329 patients received **SANCTURA**® 20 mg twice daily and 329 patients received placebo. The majority of patients were Caucasian (88%) and female (82%) with a mean age of 61 years (range: 19 to 94 years). Entry criteria were identical to Study 1. Reductions in urinary frequency, urge incontinence episodes, and urinary void volume for placebo and **SANCTURA**® treatment groups are summarized in Table 3 and Figures 4 and 5.

Table 3. Mean (SE) change from baseline to end of treatment (Week 12 or last observation carried forward) for urinary frequency, urge incontinence episodes, and void volume in Study 2

Efficacy endpoint	Placebo N=325	SANCTURA® N=323	P-value
Urinary frequency/24 hours a,*			
Mean baseline	13.2	12.9	
Mean change from baseline	-1.8 (0.2)	-2.7 (0.2)	<0.001
Urge incontinence episodes/week b			
Mean baseline	27.3	26.9	
Mean change from baseline	-12.1 (1.0)	-16.1 (1.0)	<0.001
Urinary void volume/toilet void (mL) a, c			
Mean baseline	154.6	154.8	
Mean change from baseline	9.4 (2.8)	35.6 (2.8)	<0.001
a Treatment differences assessed by analysis of variance for ITT:LOCF data set.			
b Treatment differences assessed by ranked analysis of variance for ITT:LOCF data set.			
c Placebo N=320, SANCTURA® N=319.			
* Denotes primary endpoint			
ITT=intent-to-treat, LOCF=last observation carried forward.			

Figure 4 – Mean Change from Baseline in Urinary Frequency/24 Hours, by Visit: Study 2

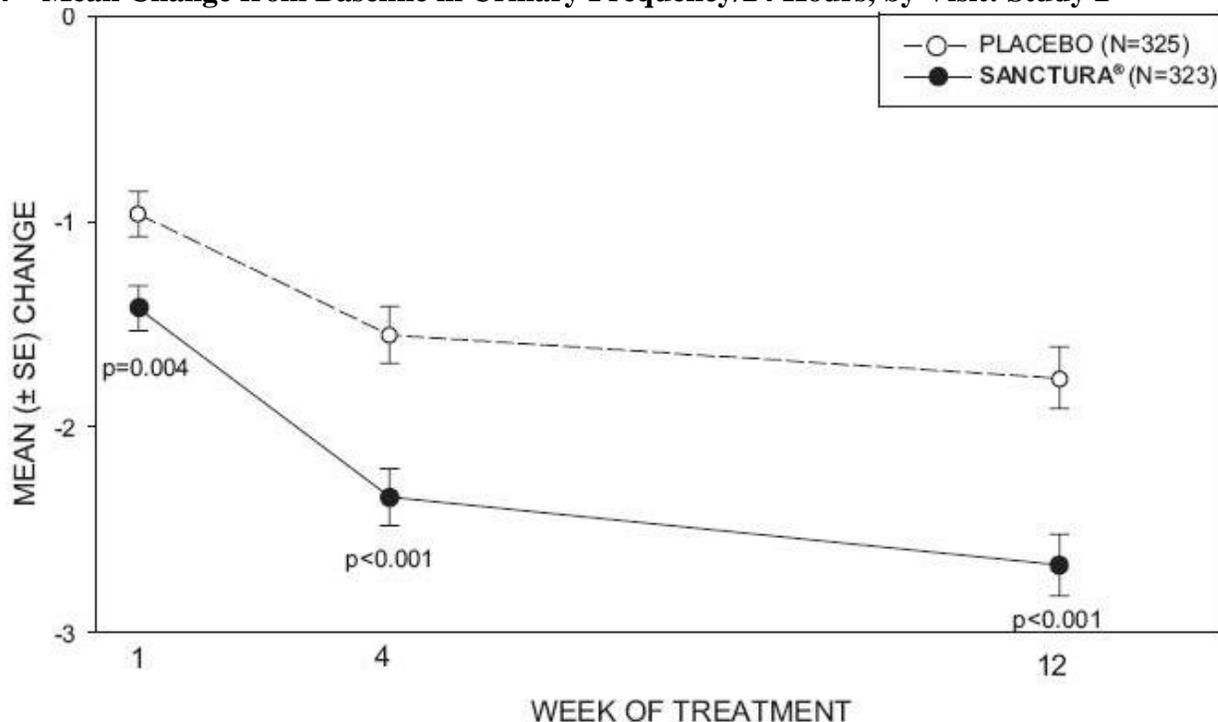
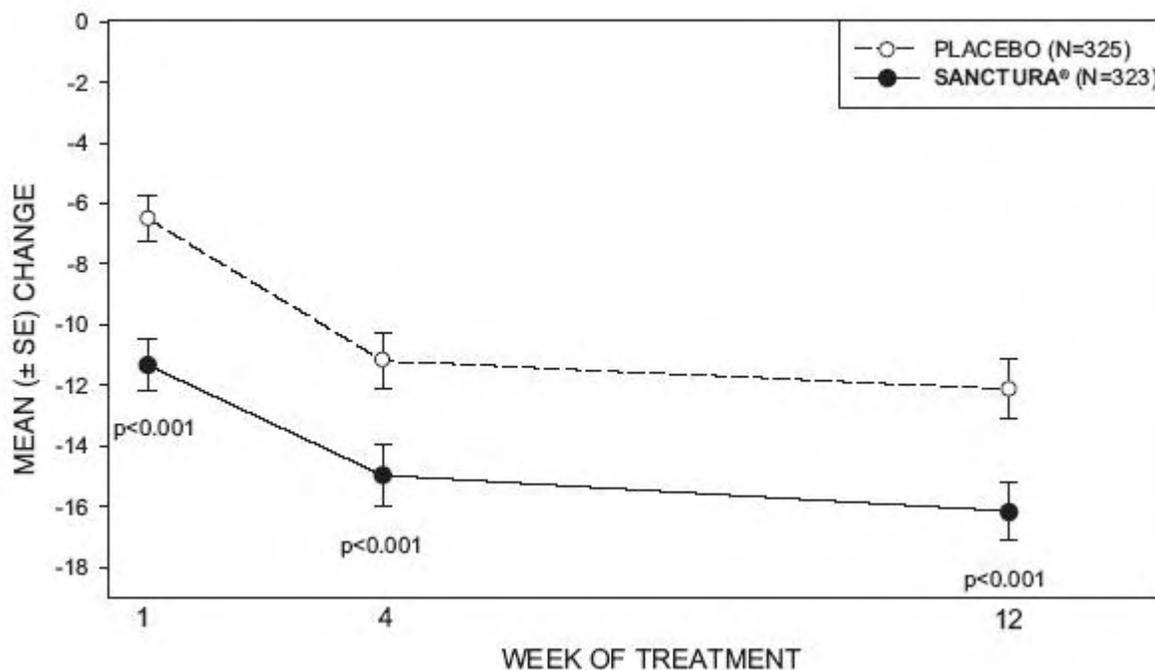


Figure 5 – Mean Change from Baseline in Urge Incontinence/Week, by Visit: Study 2



INDICATIONS AND USAGE

SANCTURA®, a muscarinic antagonist, is indicated for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency.

CONTRAINDICATIONS

SANCTURA[®] is contraindicated in patients with urinary retention, gastric retention, or uncontrolled narrow-angle glaucoma and in patients who are at risk for these conditions. **SANCTURA**[®] is also contraindicated in patients who have demonstrated hypersensitivity to the drug or its ingredients.

WARNINGS

Angioedema of the face, lips, tongue and/or larynx has been reported with trospium chloride. In one case, angioedema occurred after the first dose. Angioedema associated with upper airway swelling may be life threatening. If involvement of the tongue, hypopharynx, or larynx occurs, trospium chloride should be promptly discontinued and appropriate therapy and/or measures necessary to ensure a patent airway should be promptly provided.

PRECAUTIONS

General

Risk of Urinary Retention: **SANCTURA**[®] should be administered with caution to patients with clinically significant bladder outflow obstruction because of the risk of urinary retention.

Decreased Gastrointestinal Motility: **SANCTURA**[®] should be administered with caution to patients with gastrointestinal obstructive disorders because of the risk of gastric retention (See CONTRAINDICATIONS). **SANCTURA**[®], like other anticholinergic drugs, may decrease gastrointestinal motility and should be used with caution in patients with conditions such as ulcerative colitis, intestinal atony and myasthenia gravis.

Controlled Narrow-angle Glaucoma: In patients being treated for narrow-angle glaucoma, **SANCTURA**[®] should only be used if the potential benefits outweigh the risks and in that circumstance only with careful monitoring.

Patients with Renal Impairment: Dose modification is recommended in patients with severe renal impairment (creatinine clearance < 30 mL/min). In such patients, **SANCTURA**[®] should be administered as 20 mg once a day at bedtime (See DOSAGE AND ADMINISTRATION).

Patients with Hepatic Impairment: Caution should be used when administering **SANCTURA**[®] in patients with moderate or severe hepatic impairment (See CLINICAL PHARMACOLOGY: Pharmacokinetics in Specific Populations).

Information for Patients

Patients should be informed that trospium chloride may produce angioedema which could result in life-threatening airway obstruction. Patients should be advised to promptly discontinue trospium chloride and seek immediate medical attention if they experience edema of the tongue, edema of the laryngopharynx, or difficulty breathing.

Patients should be informed that anticholinergic agents, such as **SANCTURA**[®], may produce clinically significant adverse effects related to anticholinergic pharmacological activity. For example, heat prostration (fever and heat stroke due to decreased sweating) can occur when anticholinergics such as **SANCTURA**[®] are used in a hot environment. Because anticholinergics such as **SANCTURA**[®] may also produce dizziness or blurred vision, patients should be advised to exercise caution. Patients should be informed that alcohol may enhance the drowsiness caused by anticholinergic agents.

SANCTURA[®] should be taken 1 hour prior to meals or on an empty stomach. If a dose is skipped, patients are advised to take their next dose 1 hour prior to their next meal.

Drug-Drug Interactions

SANCTURA[®] is metabolized by ester hydrolysis and excreted by the kidneys through a combination of tubular secretion and glomerular filtration. Based on *in vitro* data, no clinically relevant metabolic drug-drug interactions are expected with trospium. However, some drugs which are actively secreted by the kidney may interact with trospium by competing for renal tubular secretion. Co-administration of 500 mg metformin immediate release tablets twice daily with **SANCTURA XR**[®] (trospium chloride 60 mg extended release) reduced the steady-state systemic exposure of trospium by approximately 29% for mean AUC₀₋₂₄ and by 34% for mean C_{max}.

The concomitant use of **SANCTURA**[®] with other antimuscarinic agents that produce dry mouth, constipation, and other anticholinergic pharmacological effects may increase the frequency and/or severity of such effects. **SANCTURA**[®] may potentially alter the absorption of some concomitantly administered drugs due to anticholinergic effects on gastrointestinal motility.

Concomitant use of **SANCTURA**[®] and digoxin did not affect the pharmacokinetics of either drug.

Drugs Eliminated by Active Tubular Secretion: Although demonstrated in a drug-drug interaction study not to affect the pharmacokinetics of digoxin, **SANCTURA**[®] has the potential for pharmacokinetic interactions with other drugs that are eliminated by active tubular secretion (e.g. procainamide, pancuronium, morphine, vancomycin, and tenofovir). Coadministration of **SANCTURA**[®] with these drugs may increase the serum concentration of **SANCTURA**[®] and/or the coadministered drug due to competition for this elimination pathway. Careful patient monitoring is recommended in patients receiving such drugs (See CLINICAL PHARMACOLOGY: Excretion).

Drug-Laboratory-Test Interactions

Interactions between **SANCTURA**[®] and laboratory tests have not been studied.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenicity studies with trospium chloride were conducted in mice and rats for 78 weeks and 104 weeks, respectively, at maximally tolerated doses. No evidence of a carcinogenic effect was found in either mice or rats administered up to 200 mg/kg/day, approximately 9 times the expected clinical exposure levels at the maximum recommended human dose (MRHD) of 40 mg.

Trospium chloride was not mutagenic nor genotoxic in tests *in vitro* in bacteria (Ames test) and mammalian cells (L5178Y mouse lymphoma and CHO cells) or *in vivo* in the rat micronucleus test.

No evidence of impaired fertility was observed in rats administered doses up to 200 mg/kg/day (about 16 times the expected clinical exposure at the MRHD, based on AUC)

Pregnancy: Teratogenic Effects

Pregnancy Category C: There are no adequate and well-controlled studies of **SANCTURA**[®] in pregnant women.

Trospium chloride was not teratogenic at statistically significant levels in rats or rabbits administered doses up to 200 mg/kg/day. This corresponds to systemic exposures up to approximately 9 and 16 times, respectively (based on AUC), the clinical exposure at the maximum recommended human dose (MRHD) of 40 mg. However, in rabbits, one fetus in each of the three treated dose groups (0.5, 0.3, and 16 times the exposures at the MRHD) demonstrated multiple malformations, including umbilical hernia and skeletal malformations. A no effect level (20 mg/kg/day in rats and rabbits) for maternal and fetal toxicity was observed at levels approximately equivalent to the clinical exposure at the MRHD. No developmental toxicity was observed in the

offspring of female rats exposed pre- and post-natally to up to 200 mg/kg/day. **SANCTURA**[®] should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers

Trospium chloride (2 mg/kg PO and 50 µg/kg IV) was excreted, to a limited extent (<1%), into the milk of lactating rats (primarily parent compound). It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when **SANCTURA**[®] is administered to a nursing woman. **SANCTURA**[®] should be used during lactation only if the potential benefit justifies the potential risk to the newborn.

Pediatric Use

The safety and effectiveness of **SANCTURA**[®] in pediatric patients have not been established.

Geriatric Use

Of the 591 patients with overactive bladder who received treatment with **SANCTURA**[®] in the two U.S., placebo-controlled, efficacy and safety studies, 249 patients (42%) were 65 years of age and older. Eighty-eight **SANCTURA**[®] treated patients (15%) were ≥75 years of age.

In these 2 studies, the incidence of commonly reported anticholinergic adverse events in patients treated with **SANCTURA**[®] (including dry mouth, constipation, dyspepsia, UTI, and urinary retention) was higher in patients 75 years of age and older as compared to younger patients. This effect may be related to an enhanced sensitivity to anticholinergic agents in this patient population (See CLINICAL PHARMACOLOGY: Pharmacokinetics in Special Populations and DOSAGE AND ADMINISTRATION). Therefore, based upon tolerability, the dose frequency of **SANCTURA**[®] may be reduced to 20 mg once daily in patients 75 years of age and older.

ADVERSE REACTIONS

The safety of **SANCTURA**[®] was evaluated in Phase 2 and 3 controlled clinical trials in a total of 2975 patients, who were treated with **SANCTURA**[®] (N=1673), placebo (N=1056) or active control medications (N=246). Of this total, 1181 patients participated in two, 12-week, Phase 3, U.S., efficacy and safety studies and a 9-month open-label extension. Of this total, 591 patients received **SANCTURA**[®] 20 mg twice daily. In all controlled trials combined, 232 and 208 patients received treatment with **SANCTURA**[®] for at least 24 and 52 weeks, respectively.

In all placebo-controlled trials combined, the incidence of serious adverse events was 2.9% among patients receiving **SANCTURA**[®] 20 mg twice daily and 1.5% among patients receiving placebo. Of these, 0.2% and 0.3% were judged to be at least possibly related to treatment with **SANCTURA**[®] or placebo, respectively, by the investigator.

Table 4 lists treatment emergent adverse events from the combined 12-week U.S. safety and efficacy trials that were judged to be at least possibly related to treatment with **SANCTURA**[®] by the investigator, were reported by at least 1% of patients, and were reported more frequently in the **SANCTURA**[®] group than in the placebo group.

The two most common adverse events reported by patients receiving **SANCTURA**[®] 20 mg twice daily were dry mouth and constipation. The single most frequently reported adverse event for **SANCTURA**[®], dry mouth, occurred in 20.1% of **SANCTURA**[®] treated patients and 5.8% of patients receiving placebo. In the two Phase 3 U.S. studies, dry mouth led to discontinuation in 1.9% of patients treated with **SANCTURA**[®] 20 mg twice daily. For the patients who reported dry mouth, most had their first occurrence of the event within the first month of treatment.

Table 4. Incidence (%) of adverse events judged at least possibly related to treatment with SANCTURA[®], reported in ≥1% of all patients treated with SANCTURA[®] and more frequent with SANCTURA[®] (20 mg twice daily) than placebo in Studies 1 and 2 combined

Adverse Event	Placebo (N=590)	SANCTURA [®] 20 mg twice daily (N= 591)
Gastrointestinal disorders		
Dry mouth	34 (5.8)	119 (20.1)
Constipation	27 (4.6)	57 (9.6)
Abdominal pain upper	7 (1.2)	9 (1.5)
Constipation aggravated	5 (0.8)	8 (1.4)
Dyspepsia	2 (0.3)	7 (1.2)
Flatulence	5 (0.8)	7 (1.2)
Nervous System Disorders		
Headache	12 (2.0)	25 (4.2)
General Disorders		
Fatigue	8 (1.4)	11 (1.9)
Renal and Urinary Disorders		
Urinary retention	2 (0.3)	7 (1.2)
Eye Disorders		
Dry eyes NOS	2 (0.3)	7 (1.2)
Abbreviations: NOS=not otherwise specified.		

Other adverse events from the Phase 3, U.S., placebo-controlled trials judged possibly related to treatment with SANCTURA[®] by the investigator, occurring in ≥0.5% of SANCTURA[®]-treated patients, and more common with SANCTURA[®] than placebo are: tachycardia NOS, vision blurred, abdominal distension, vomiting NOS, dysgeusia, dry throat, and dry skin.

During controlled clinical studies, one event of angioneurotic edema was reported.

Postmarketing Surveillance

Additional spontaneous adverse events, regardless of relationship to drug, reported from marketing experience with trospium chloride include: Gastrointestinal – gastritis; Cardiovascular – palpitations, supraventricular tachycardia, chest pain, syncope, “hypertensive crisis”; Immunological – Stevens-Johnson syndrome, anaphylactic reaction, angioedema; Nervous System – vision abnormal, hallucinations and delirium; Musculoskeletal – rhabdomyolysis; General – rash.

OVERDOSAGE

Management of Overdosage

Overdosage with antimuscarinic agents, including SANCTURA[®], can result in severe anticholinergic effects. Supportive treatment should be provided according to symptoms. In the event of overdosage, ECG monitoring is recommended.

A 7-month-old baby experienced tachycardia and mydriasis after administration of a single dose of trospium 10 mg given by a sibling. The baby’s weight was reported as 5 kg. Following admission into the hospital and about 1 hour after ingestion of the trospium, medicinal charcoal was administered for detoxification. While hospitalized, the baby experienced mydriasis and tachycardia up to 230 beats per minute. Therapeutic intervention was not deemed necessary. The baby was discharged as completely recovered the following day.

DOSAGE AND ADMINISTRATION

The recommended dose is 20 mg twice daily. **SANCTURA**[®] should be dosed at least one hour before meals or given on an empty stomach.

Dosage modification is recommended in the following patient populations:

- For patients with severe renal impairment (creatinine clearance < 30 mL/min), the recommended dose is 20 mg once daily at bedtime (See PRECAUTIONS: General).
- In geriatric patients ≥75 years of age, dose may be titrated down to 20 mg once daily based upon tolerability (See PRECAUTIONS: Geriatric Use).

HOW SUPPLIED

SANCTURA[®] tablets 20 mg (brownish yellow, biconvex, glossy coated tablets printed with black ink) are supplied as follows: 60 count HDPE bottle - NDC 0023-3513-60

Store at controlled room temperature 20° to 25°C (68° to 77°F) (see USP).

Rx only

Manufactured for:
Allergan, Inc.
Irvine, CA
92612

Manufactured by:
Madaus GmbH
Troisdorf, Germany

Address Medical Inquiries to:
1-800-433-8871

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