HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use Aciphex safely and effectively. See full prescribing information for Aciphex.
ACIPHEX® (rabeprazole sodium) Delayed-Release Tablets
Initial U.S. Approval: 1999

--- RECENT MAJOR CHANGES ---
Warnings and Precautions, Concomitant use of ACIPHEX with Methotrexate (5.8) 05/2012

--- INDICATIONS AND USAGE ---
ACIPHEX is a proton-pump inhibitor (PPI) indicated in adults for:
- Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD) (1.1)
- Maintenance of Healing of Erosive or Ulcerative GERD (1.2)
- Treatment of Symptomatic GERD (1.3)
- Healing of Duodenal Ulcers (1.4)
- Helicobacter pylori Eradication to Reduce the Risk of Duodenal Ulcer Recurrence (1.5)
- Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome (1.6)

Aciphex is a proton-pump inhibitor indicated for adolescent patients 12 years of age and above for: Short-term treatment of Symptomatic GERD (1.3)

--- DOSAGE AND ADMINISTRATION ---
Aciphex tablets should be swallowed whole. Do not be chew, crush, or split.

- Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD) (2.1) 20 mg once daily
- Maintenance of Healing of Erosive or Ulcerative GERD (2.2) 20 mg once daily
- Treatment of Symptomatic GERD (2.3) 20 mg once daily
- Healing of Duodenal Ulcers (2.4) 20 mg once daily after morning meal

Helicobacter pylori Eradication to Reduce the Risk of Duodenal Ulcer Recurrence (2.5)

Three Drug Regimen: All three medications should be taken twice daily with morning and evening meals for 7 days
- Aciphex 20 mg
- Amoxicillin 1000 mg
- Clarithromycin 500 mg

Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome (2.6) Starting dose 60 mg once daily then adjust to patient needs

--- DOSAGE FORMS AND STRENGTHS ---
Tablets: 20 mg (3)

--- CONTRAINDICATIONS ---
- History of hypersensitivity to rabeprazole (4.1)

--- WARNINGS AND PRECAUTIONS ---
- Symptomatic response to therapy with rabeprazole does not preclude the presence of gastric malignancy (5.4)
- Use with warfarin: monitor for increases in INR and prothrombin time (5.5)
- Bone Fracture: Long-term and multiple daily dose PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine (5.6)
- Hypomagnesemia has been reported rarely with prolonged treatment with PPIs (5.7)

--- ADVERSE REACTIONS ---
In the adult studies (4 to 8 weeks), there are no adverse reactions that occur at a rate greater than 5% and greater than placebo (6.1)

--- DRUG INTERACTIONS ---
- Increased INR and prothrombin times have been reported with concomitant use with warfarin. Patients need to be monitored (7.2)
- Aciphex has been shown to inhibit cyclosporine metabolism in vitro (7.3)
- Aciphex inhibits gastric acid secretion and may interfere with the absorption of drugs where gastric pH is an important determinant of bioavailability (e.g., ketoconazole, iron salts and digoxin) (7.4)
- Aciphex may reduce the plasma levels of atazanavir (7.4)
- Methotrexate: Aciphex may increase serum level of methotrexate (7.7)

--- USE IN SPECIFIC POPULATIONS ---
- The safety and efficacy of ACIPHEX for GERD have not been established for pediatric patients less than 12 years of age.
- The safety and efficacy of ACIPHEX for the other adult indications have not been established for pediatric patients

See 17 for PATIENT COUNSELING INFORMATION and FDA-Approved Patient Labeling

Revised: May 2012
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  1.2 Maintenance of Healing of Erosive or Ulcerative GERD
  1.3 Treatment of Symptomatic GERD
  1.4 Healing of Duodenal Ulcers
  1.5 Helicobacter pylori Eradication to Reduce the Risk of Duodenal Ulcer Recurrence
  1.6 Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome

2. DOSAGE AND ADMINISTRATION
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  2.3 Treatment of Symptomatic GERD
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  2.5 Helicobacter pylori Eradication to Reduce the Risk of Duodenal Ulcer Recurrence
  2.6 Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome
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     14.6 Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome

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16. HOW SUPPLIED/STORAGE AND HANDLING

17. PATIENT COUNSELING INFORMATION
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FULL PRESCRIBING INFORMATION

1. INDICATIONS AND USAGE

1.1 Healing of Erosive or Ulcerative GERD
ACIPHEX is indicated for short-term (4 to 8 weeks) treatment in the healing and symptomatic relief of erosive or ulcerative gastroesophageal reflux disease (GERD). For those patients who have not healed after 8 weeks of treatment, an additional 8-week course of ACIPHEX may be considered.

1.2 Maintenance of Healing of Erosive or Ulcerative GERD
ACIPHEX is indicated for maintaining healing and reduction in relapse rates of heartburn symptoms in patients with erosive or ulcerative gastroesophageal reflux disease (GERD Maintenance). Controlled studies do not extend beyond 12 months.

1.3 Treatment of Symptomatic GERD
ACIPHEX is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD in adults and adolescents 12 years of age and above.

1.4 Healing of Duodenal Ulcers
ACIPHEX is indicated for short-term (up to four weeks) treatment in the healing and symptomatic relief of duodenal ulcers. Most patients heal within four weeks.

1.5 Helicobacter pylori Eradication to Reduce the Risk of Duodenal Ulcer Recurrence
ACIPHEX in combination with amoxicillin and clarithromycin as a three drug regimen, is indicated for the treatment of patients with H. pylori infection and duodenal ulcer disease (active or history within the past 5 years) to eradicate H. pylori. Eradication of H. pylori has been shown to reduce the risk of duodenal ulcer recurrence. (See CLINICAL STUDIES (14.5) and DOSAGE AND ADMINISTRATION (2.5)).

In patients who fail therapy, susceptibility testing should be done. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted. (See CLINICAL PHARMACOLOGY, Microbiology.)

1.6 Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome
ACIPHEX is indicated for the long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome.

2. DOSAGE AND ADMINISTRATION
ACIPHEX tablets should be swallowed whole. The tablets should not be chewed, crushed, or split. ACIPHEX can be taken with or without food.

2.1 Healing of Erosive or Ulcerative GERD
The recommended adult oral dose is one ACIPHEX 20 mg delayed-release tablet to be taken once daily for four to eight weeks. (See INDICATIONS AND USAGE (1.1)). For those patients who have not healed after 8 weeks of treatment, an additional 8-week course of ACIPHEX may be considered.

2.2 Maintenance of Healing of Erosive or Ulcerative GERD
The recommended adult oral dose is one ACIPHEX 20 mg delayed-release tablet to be taken once daily. (See INDICATIONS AND USAGE (1.2)).

2.3 Treatment of Symptomatic GERD
The recommended adult oral dose is one ACIPHEX 20 mg delayed-release tablet to be taken once daily for 4 weeks. (See INDICATIONS AND USAGE (1.3)). If symptoms do not resolve completely after 4 weeks, an additional course of treatment may be considered. The recommended adolescent dosing is listed in Section 2.7.

2.4 Healing of Duodenal Ulcers
The recommended adult oral dose is one ACIPHEX 20 mg delayed-release tablet to be taken once daily after the morning meal for a period up to four weeks. (See INDICATIONS AND USAGE (1.4)). Most patients with duodenal ulcer heal within four weeks. A few patients may require additional therapy to achieve healing.

2.5 Helicobacter pylori Eradication to Reduce the Risk of Duodenal Ulcer Recurrence

2.6 Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome
ACIPHEX in combination with amoxicillin and clarithromycin is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD in adults and adolescents 12 years of age and above.

3. DOSAGE FORMS AND STRENGTHS
20 mg light yellow enteric-coated delayed-release tablets. The name and strength, in mg, (ACIPHEX 20) is imprinted on one side.

4. CONTRAINDICATIONS
4.1 Hypersensitivity to rabeprazole
Rabeprazole is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles or to any component of the formulation.

4.2 Use of Clarithromycin and hypersensitivity to macrolide antibiotics
Clarithromycin is contraindicated in patients with known hypersensitivity to any macrolide antibiotic.

4.3 Concomitant use of Clarithromycin with pimozide and cisapride
Clarithromycin is contraindicated in patients with known hypersensitivity to macrolide antibiotics. There have been post-marketing reports of drug interactions when clarithromycin and/or erythromycin are co-administered with pimozide resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsade de pointes) most likely due to inhibition of hepatic metabolism of pimozide by erythromycin and clarithromycin. Fatalities have been reported. (Please refer to full prescribing information for clarithromycin.)

4.4 Amoxicillin and hypersensitivity to penicillin
Amoxicillin is contraindicated in patients with a known hypersensitivity to any penicillin. (Please refer to full prescribing information for amoxicillin.)

5. WARNINGS AND PRECAUTIONS
5.1 Clarithromycin use in pregnant women
CLARITHROMYCIN SHOULD NOT BE USED IN PREGNANT WOMEN EXCEPT IN CLINICAL CIRCUMSTANCES WHERE NO ALTERNATIVE THERAPY IS APPROPRIATE. If pregnancy occurs while taking clarithromycin, the patient should be apprised of the potential hazard to the fetus. (See WARNINGS in prescribing information for clarithromycin.)

5.2 Anaphylactic reactions associated with antibiotic use
Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens.

# TABLE 1
<table>
<thead>
<tr>
<th>ACIPHEX</th>
<th>20 mg</th>
<th>Twice Daily for 7 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>1000 mg</td>
<td>Twice Daily for 7 Days</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>500 mg</td>
<td>Twice Daily for 7 Days</td>
</tr>
</tbody>
</table>

All three medications should be taken twice daily with the morning and evening meals.

* It is important that patients comply with the full 7-day regimen. (See CLINICAL STUDIES section (14.5)).

3
There have been well-documented reports of individuals with a history of penicillin hypersensitivity reactions that have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before initiating therapy with any penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillin, cephalosporin, and other allergens. If an allergic reaction occurs, amoxicillin should be discontinued and the appropriate therapy instituted. (See WARNINGS in prescribing information for amoxicillin.)

SERIOUS ANAPHYLACTIC REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

5.3 Pseudomembranous colitis associated with antibiotic use

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin and amoxicillin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by Clostridium difficile is a primary cause of “antibiotic-associated colitis”.

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluid and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against Clostridium difficile colitis.

5.4 Presence of gastric malignancy

Symptomatic response to therapy with rabeprazole does not preclude the presence of gastric malignancy.

Patients with healed GERD were treated for up to 40 months with rabeprazole and monitored with serial gastric biopsies. Patients without H. pylori infection (221 of 326 patients) had no clinically important pathologic changes in the gastric mucosa. Patients with H. pylori infection at baseline (105 of 326 patients) had mild or moderate inflammation in the gastric body or mild inflammation in the gastric antrum. Patients with mild grades of infection or inflammation in the gastric body tended to change to moderate, whereas those graded moderate at baseline tended to remain stable. Patients with mild grades of infection or inflammation in the gastric antrum tended to remain stable. At baseline 8% of patients had atrophy of glands in the gastric body and 15% had atrophy in the gastric antrum. At endpoint, 15% of patients had atrophy of glands in the gastric body and 11% had atrophy in the gastric antrum. Approximately 4% of patients had intestinal metaplasia at some point during follow-up, but no consistent changes were seen.

5.5 Concomitant use with warfarin

Steady state interactions of rabeprazole and warfarin have not been adequately evaluated in patients. There have been reports of increased INR and prothrombin time in patients receiving a proton pump inhibitor and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

5.6 Bone Fracture

Several published observational studies suggest that proton pump inhibitor (PPI) therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine. The risk of fracture was increased in patients who received high-dose, defined as multiple daily doses, and long-term PPI therapy (a year or longer). Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated. Patients at risk for osteoporosis-related fractures should be managed according to established treatment guidelines. (See DOSAGE AND ADMINISTRATION (2) and ADVERSE REACTIONS (6.2).)

5.7 Hypomagnesemia

Hypomagnesemia, symptomatic and asymptomatic, has been reported rarely in patients treated with PPIs for at least three months, in most cases after a year of therapy. Serious adverse events include tetany, arrhythmias, and seizures. In most patients, treatment of hypomagnesemia required magnesium replacement and discontinuation of the PPI.

For patients expected to be on prolonged treatment or who take PPIs with medications such as diuretics, healthcare professionals may consider monitoring magnesium levels prior to initiation of PPI treatment and periodically (see Adverse Reactions (6.2)).

5.8 Concomitant use of ACIPHEX with Methotrexate

Literature suggests that concomitant use of PPIs with methotrexate (primarily at high dose; see methotrexate prescribing information) may elevate and prolong serum levels of methotrexate and/or its metabolite, possibly leading to methotrexate toxicities. In high-dose methotrexate administration, a temporary withdrawal of the PPI may be considered in some patients. (See Drug Interactions (7.7)).

6. ADVERSE REACTIONS

Worldwide, over 2000 patients have been treated with rabeprazole in Phase II-III clinical trials involving various dosages and durations of treatment.

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

6.1 Clinical Studies Experience

The data described below reflect exposure to ACIPHEX in 1064 patients exposed for up to 8 weeks. The studies were primarily placebo- and active-controlled trials in patients with Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD), Duodenal Ulcers and Gastric Ulcers. The population had a mean age of 53 years (range 18-89 years) and had a ratio of approximately 60% male/ 40% female. The racial distribution was 86% Caucasian, 8% African American, 2% Asian and 5% other. Most patients received either 10 mg, 20 mg or 40 mg/day of ACIPHEX.

An analysis of adverse reactions appearing in ≥ 2% of ACIPHEX patients (n=1064) and with a greater frequency than placebo (n=89) in controlled North American and European acute treatment trials, revealed the following adverse reactions: pain (3% vs. 1%), pharyngitis (3% vs. 2%), flatulence (3% vs. 1%), infection (2% vs. 1%), and constipation (2% vs. 1%).

The 3 long-term maintenance studies consisted of a total of 740 patients; at least 54% of patients were exposed to rabeprazole for 6 months while at least 33% were exposed for 12 months. Of the 740 patients, 247 (33%) and 241 (33%) patients received 10 mg and 20 mg of ACIPHEX, respectively, while 169 (23%) patients received placebo and 83 (11%) received omeprazole.

The safety profile of rabeprazole in the maintenance studies was consistent with what was observed in the acute studies.

Other adverse reactions that were seen in controlled clinical trials which do not meet the above criteria (≥ 2% of ACIPHEX treated patients > placebo) and for which there is a possibility of a causal relationship to rabeprazole include the following: headache, abdominal pain, diarrhea, dry mouth, dizziness, peripheral edema, hepatic enzyme increase, hepatitis, hepatic encephalopathy, myalgia, and arthralgia.

In a multicenter, open-label study of adolescent patients aged 12 to 16 years with a clinical diagnosis of symptomatic GERD or endoscopically proven GERD, the adverse event profile was similar to that of adults. The adverse reactions reported without regard to relationship to ACIPHEX that occurred in ≥ 2% of 111 patients were headache (9.9%), diarrhea (4.5%), nausea (4.5%), vomiting (3.6%), and abdominal pain (3.6%). The related reaction rates observed in the acute studies.

The safety profile of rabeprazole in the maintenance studies was consistent with what was observed in the acute studies.

Postmarketing Experience

The following adverse reactions have been identified after postapproval use of ACIPHEX. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure: sudden death; coma, hyperammonemia; jaundice; rhabdomyolysis; disorientation and delirium; anaphylaxis; angioedema; bullous and other drug eruptions of the skin; severe dermatologic reactions, including toxic epidermal necrolysis (some fatal), Stevens-Johnson syndrome, and erythema multiforme; interstitial pneumonia; interstitial nephritis; TSH elevations; bone fractures and hypomagnesemia. In addition, agranulocytosis, hemolytic anemia, leukopenia, pancytopenia, and thrombocytopenia have been reported.
Increases in prothrombin time/INR in patients treated with concomitant warfarin have been reported.

7. DRUG INTERACTIONS

7.1 Drugs metabolized by CYP450

Rabeprazole is metabolized by the cytochrome P450 (CYP450) drug metabolizing enzyme system. Studies in healthy subjects have shown that rabeprazole does not have clinically significant interactions with other drugs metabolized by the CYP450 system, such as warfarin and theophylline given as single oral doses, diazepam as a single intravenous dose, and phenytoin given as a single intravenous dose (with supplemental oral dosing). Steady state interactions of rabeprazole and other drugs metabolized by this enzyme system have not been studied in patients.

7.2 Warfarin

There have been reports of increased INR and prothrombin time in patients receiving proton pump inhibitors, including rabeprazole, and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. [See WARNINGS AND PRECAUTIONS (5.5)].

7.3 Cyclosporine

In vitro incubations employing human liver microsomes indicated that rabeprazole inhibited cyclosporine metabolism with an IC50 of 62 micromolar, a concentration that is over 50 times higher than the Cmax in healthy volunteers following 14 days of dosing with 20 mg of rabeprazole. This degree of inhibition is similar to that by omeprazole at equivalent concentrations.

7.4 Compounds dependent on gastric pH for absorption

Rabeprazole produces sustained inhibition of gastric acid secretion. An interaction with compounds which are dependent on gastric pH for absorption is possible. This interaction may be enhanced by the magnitude of acid suppression observed with rabeprazole. For example, in normal subjects, co-administration of rabeprazole inhibited cyclosporine metabolism with an IC50 of 62 micromolar, 19% and 29%, respectively. Therefore, patients may need to be monitored when such drugs are taken concomitantly with rabeprazole. Co-administration of rabeprazole and antacids produced no clinically relevant changes in plasma rabeprazole concentrations.

Concomitant use of atazanavir and proton pump inhibitors is not recommended. Co-administration of atazanavir with proton pump inhibitors is expected to substantially decrease atazanavir plasma concentrations and thereby reduce its therapeutic effect.

7.5 Drugs metabolized by CYP2C19

In a clinical study in Japan evaluating rabeprazole in patients categorized by CYP2C19 genotype (n=6 per genotype category), gastric acid suppression was higher in poor metabolizers as compared to extensive metabolizers. This could be due to higher rabeprazole plasma levels in poor metabolizers. Whether or not interactions of rabeprazole sodium with other drugs metabolized by CYP2C19 would be different between extensive metabolizers and poor metabolizers has not been studied.

7.6 Combined Administration with Clarithromycin

Combined administration consisting of rabeprazole, amoxicillin, and clarithromycin resulted in increases in plasma concentrations of rabeprazole and 14-hydroxylclarithromycin. [See CLINICAL PHARMACOLOGY, Combination Therapy with Antimicrobials (12.3)].

Concomitant administration of clarithromycin with pimozone and cisapride is contraindicated. [See PRECAUTIONS in prescribing information for clarithromycin. (See PRECAUTIONS in prescribing information for amoxicillin)].

7.7 Methotrexate

Case reports, published population pharmacokinetic studies, and retrospective analyses suggest that concomitant administration of PPIs and methotrexate (primarily at high dose; see methotrexate prescribing information) may elevate and prolong serum levels of methotrexate and/or its metabolite hydroxymethotrexate. However, no formal drug interaction studies of methotrexate with PPIs have been conducted. [See Warnings and Precautions (5.8)].

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Teratogenic Effects. Pregnancy Category B: Teratology studies have been performed in rats at intravenous doses up to 50 mg/kg/day (plasma AUC of 11.8 µg•hr/mL, about 13 times the human exposure at the recommended dose for GERD) and rabbits at intravenous doses up to 30 mg/kg/day (plasma AUC of 7.3 µg•hr/mL, about 8 times the human exposure at the recommended dose for GERD) and have revealed no evidence of impaired fertility or harm to the fetus due to rabeprazole. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

8.3 Nursing Mothers

Following intravenous administration of 14C-labeled rabeprazole to lactating rats, radioactivity in milk reached levels that were 2- to 7-fold higher than levels in the blood. It is not known if unmetabolized rabeprazole is excreted in human breast milk. Administration of rabeprazole to rats in late gestation and during lactation at doses of 400 mg/kg/day (about 195-times the human dose based on mg/m²) resulted in decreases in body weight gain of the pups. Since many drugs are excreted in milk, and because of the potential for adverse reactions to nursing infants from rabeprazole, a decision should be made to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

Use of ACIPHEX in adolescent patients 12 years of age and above for short-term treatment of GERD is supported by a) extrapolation of results from adequate and well-controlled studies that supported the approval of ACIPHEX for adults; (see CLINICAL STUDIES (14.1, 14.2, 14.3) and INDICATIONS AND USAGE (1.1, 1.2, 1.3)); b) safety and pharmacokinetic studies performed in adolescent patients (see Pharmacokinetics, Pediatric (12.3)). The safety and effectiveness of ACIPHEX for the treatment of GERD patients <12 years of age have not been established. The safety and effectiveness of ACIPHEX for other uses have not been established in pediatric patients.

In a multicenter, randomized, open-label, parallel-group study, 111 adolescent patients 12 to 16 years of age with a clinical diagnosis of symptomatic GERD or suspected or endoscopically proven GERD were randomized and treated with either ACIPHEX 10 mg or ACIPHEX 20 mg once daily for up to 8 weeks for the evaluation of safety and efficacy. The adverse event profile in adolescent patients was similar to that of adults. The related reported adverse reactions that occurred in ≥2% of patients were headache (5.4%) and nausea (1.8%). There were no adverse reactions reported in these studies that were not previously observed in adults.

8.5 Geriatric Use

Of the total number of subjects in clinical studies of ACIPHEX, 19% were 65 years and over, while 4% were 75 years and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

8.6 Gender

Duodenal ulcer and erosive esophagitis healing rates in women are similar to those in men. Adverse reactions and laboratory test abnormalities in women occurred at rates similar to those in men.

10. OVERDOSAGE

Because strategies for the management of overdose are continually evolving, it is advisable to contact a Poison Control Center to determine the latest recommendations for the management of an overdose of any drug. There has been no experience with large overdoses with rabeprazole. Seven reports of accidental overdose with rabeprazole have been received. The maximum reported overdose was 80 mg. There were no clinical signs or symptoms associated with any reported overdose. Patients with Zollinger-Ellison syndrome have been treated with up to 120 mg rabeprazole QD. No specific antidote for rabeprazole is known. Rabeprazole is extensively protein bound and is not readily dialyzable. In the event of overdose, treatment should be symptomatic and supportive.

Single oral doses of rabeprazole at 786 mg/kg and 1024 mg/kg were lethal to mice and rats, respectively. The single oral dose of 2000 mg/kg was not lethal to dogs. The major symptoms of acute toxicity were hypoxia, labored respiration, lateral or prone position and convulsion in mice and rats. The major symptoms associated with any reported overdose. Patients with Zollinger-Ellison syndrome have been treated with up to 120 mg rabeprazole QD. No specific antidote for rabeprazole is known. Rabeprazole is extensively protein bound and is not readily dialyzable. In the event of overdose, treatment should be symptomatic and supportive.

11. DESCRIPTION

The active ingredient in ACIPHEX Delayed-Release Tablets is rabeprazole sodium, a substituted benzimidazole that inhibits gastric acid secretion. Rabeprazole sodium is known chemically as 2-[[4-(3-methoxypropoxy)-3-methyl-2-pyridinyl]-methyl][sulfinyl]-1H-benzimidazole sodium salt. It has an empirical formula of C19H16N3NaO2S and a molecular weight of 381.43. Rabeprazole sodium is a white to slightly yellowish-white solid. It is very soluble in water and methanol, freely soluble in ethanol, chloroform and ethyl acetate and insoluble in ether and n-hexane. The stability of rabeprazole sodium is a function of pH; it is rapidly degraded in acid media, and is more stable under alkaline conditions. The structural formula is:
ACIPHEX is available for oral administration as delayed-release, enteric-coated tablets containing 20 mg of rabeprazole sodium.

Inactive ingredients of the 20 mg tablet are carnauba wax, crospovidone, diacetylated monoglycerides, ethylcellulose, hydroxypropyl cellulose, hypromellose phthalate, magnesium stearate, mannitol, propylene glycol, sodium hydroxide, sodium stearyl fumarate, talc, and titanium dioxide. Iron oxide yellow is the coloring agent for the tablet coating. Iron oxide red is the ink pigment.

12. CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Rabeprazole belongs to a class of antisecretory compounds (substituted benzimidazole proton-pump inhibitors) that do not exhibit anticholinergic or histamine H2-receptor antagonist properties, but suppress gastric acid secretion by inhibiting the gastric H+ K+ ATPase at the secretory surface of the gastric parietal cell. Because this enzyme is regarded as the acid (proton) pump within the parietal cell, rabeprazole has been characterized as a gastric proton-pump inhibitor. Rabeprazole blocks the final step of gastric acid secretion.

In gastric parietal cells, rabeprazole is protonated, accumulates, and is transformed to an active sulfenamide. When studied in vitro, rabeprazole is chemically activated at pH 1.2 with a half-life of 90 seconds.

12.2 Pharmacodynamics

Antisecretory Activity

The antisecretory effect begins within one hour after oral administration of 20 mg ACIPHEX. The median inhibitory effect of ACIPHEX on 24-hour gastric acidity is 88% of maximal after the first dose. ACIPHEX 20 mg of 20 mg ACIPHEX. The median inhibitory effect of ACIPHEX on 24-hour gastric acidity is illustrated below.

Compared to placebo, ACIPHEX, 10 mg, 20 mg, and 40 mg, administered once daily for 7 days significantly decreased intragastric acidity with all doses for each of four meal-related intervals and the 24-hour time period overall. In this study, there were no statistically significant differences between doses; however, there was a significant dose-related decrease in intragastric acidity. The ability of rabeprazole to cause a dose-related decrease in mean intragastric acidity is illustrated below.

12.3 Pharmacokinetics

Rabeprazole is rapidly and almost completely absorbed after oral administration. ACIPHEX is available for oral administration as delayed-release, enteric-coated tablets containing 20 mg of rabeprazole sodium.

In patients with gastroesophageal reflux disease (GERD) and moderate to severe esophageal acid exposure, ACIPHEX 20 mg and 40 mg per day decreased 24-hour esophageal acid exposure. After seven days of treatment, the percentage of time that esophageal pH<4 decreased from baselines of 24.7% for 20 mg and 23.7% for 40 mg, to 5.1% and 2.0%, respectively. Normalization of 24-hour intragastric acid exposure was correlated to gastric pH<4 for at least 55% of the 24-hour period; this level was achieved in 35% of these treated subjects.

Effects on Esophageal Acid Exposure

In patients with gastroesophageal reflux disease (GERD) and moderate to severe esophageal acid exposure, ACIPHEX 20 mg and 40 mg per day decreased 24-hour esophageal acid exposure. After seven days of treatment, the percentage of time that esophageal pH<4 decreased from baselines of 24.7% for 20 mg and 23.7% for 40 mg, to 5.1% and 2.0%, respectively. Normalization of 24-hour intragastric acid exposure was correlated to gastric pH<4 for at least 55% of the 24-hour period; this level was achieved in 90% of subjects receiving ACIPHEX 20 mg and in 100% of subjects receiving ACIPHEX 40 mg. With ACIPHEX 20 mg and 40 mg per day, significant effects on gastric and esophageal pH were noted after one day of treatment, and more pronounced after seven days of treatment.

Effects on Serum Gastrin

In patients given daily doses of ACIPHEX for up to eight weeks to treat ulcerative or erosive esophagitis and in patients treated for up to 52 weeks to prevent recurrence of disease the median fasting gastrin level increased in a dose-related manner. The group median values stayed within the normal range.

In a group of subjects treated daily with ACIPHEX 20 mg for 4 weeks a doubling of mean serum gastrin concentrations were observed. Approximately 35% of these treated subjects developed serum gastrin concentrations above the upper limit of normal.

After administration of 20 mg ACIPHEX once daily for eight days, the mean percent of time that gastric pH>3 or gastric pH>4 after a single dose (Day 1) and multiple doses (Day 8) was significantly greater than placebo (see table below). The decrease in gastric acidity and the increase in gastric pH observed with 20 mg ACIPHEX administered once daily for eight days were compared to the same parameters for placebo, as illustrated below:

Effects on Esophageal Acid Exposure

In patients with gastroesophageal reflux disease (GERD) and moderate to severe esophageal acid exposure, ACIPHEX 20 mg and 40 mg per day decreased 24-hour esophageal acid exposure. After seven days of treatment, the percentage of time that esophageal pH<4 decreased from baselines of 24.7% for 20 mg and 23.7% for 40 mg, to 5.1% and 2.0%, respectively. Normalization of 24-hour intragastric acid exposure was correlated to gastric pH<4 for at least 55% of the 24-hour period; this level was achieved in 90% of subjects receiving ACIPHEX 20 mg and in 100% of subjects receiving ACIPHEX 40 mg. With ACIPHEX 20 mg and 40 mg per day, significant effects on gastric and esophageal pH were noted after one day of treatment, and more pronounced after seven days of treatment.

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In a group of subjects treated daily with ACIPHEX 20 mg for 4 weeks a doubling of mean serum gastrin concentrations were observed. Approximately 35% of these treated subjects developed serum gastrin concentrations above the upper limit of normal. In a study of CYP2C19 genotyped subjects in

TABLE 4

GASTRIC ACID PARAMETERS

ACIPHEX ONCE DAILY DOSING VERSUS PLACEBO ON DAY 1 AND DAY 8

<table>
<thead>
<tr>
<th>Parameter</th>
<th>ACIPHEX 20 mg</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median AUC</td>
<td>3408*</td>
<td>1769*</td>
</tr>
<tr>
<td>Acidity</td>
<td>3.77</td>
<td>3.51</td>
</tr>
<tr>
<td>pH (23 hr)*</td>
<td>54.6*</td>
<td>68.7*</td>
</tr>
<tr>
<td>% Time Gastric pH&lt;3</td>
<td>44.1*</td>
<td>60.3*</td>
</tr>
<tr>
<td>% Time Gastric pH&lt;4</td>
<td>7.6</td>
<td>11.0</td>
</tr>
</tbody>
</table>

* No inferential statistics conducted for this parameter.
* (p<0.001 versus placebo)
* (p<0.001 versus placebo)

Effects on Esophageal Acid Exposure

In patients with gastroesophageal reflux disease (GERD) and moderate to severe esophageal acid exposure, ACIPHEX 20 mg and 40 mg per day decreased 24-hour esophageal acid exposure. After seven days of treatment, the percentage of time that esophageal pH<4 decreased from baselines of 24.7% for 20 mg and 23.7% for 40 mg, to 5.1% and 2.0%, respectively. Normalization of 24-hour intragastric acid exposure was correlated to gastric pH<4 for at least 55% of the 24-hour period; this level was achieved in 90% of subjects receiving ACIPHEX 20 mg and in 100% of subjects receiving ACIPHEX 40 mg. With ACIPHEX 20 mg and 40 mg per day, significant effects on gastric and esophageal pH were noted after one day of treatment, and more pronounced after seven days of treatment.

Effects on Serum Gastrin

In patients given daily doses of ACIPHEX for up to eight weeks to treat ulcerative or erosive esophagitis and in patients treated for up to 52 weeks to prevent recurrence of disease the median fasting gastrin level increased in a dose-related manner. The group median values stayed within the normal range.

In a group of subjects treated daily with ACIPHEX 20 mg for 4 weeks a doubling of mean serum gastrin concentrations were observed. Approximately 35% of these treated subjects developed serum gastrin concentrations above the upper limit of normal. In a study of CYP2C19 genotyped subjects in

TABLE 3

AUC ACIDITY (MMOL/HR/L)

ACIPHEX VERSUS PLACEBO ON DAY 7 OF ONCE DAILY DOSING (MEAN±SD)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>ACIPHEX 20 mg RBP</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median AUC</td>
<td>340.8*</td>
<td>176.9*</td>
</tr>
<tr>
<td>Acidity</td>
<td>3.77</td>
<td>3.51</td>
</tr>
<tr>
<td>pH (23 hr)*</td>
<td>54.6*</td>
<td>68.7*</td>
</tr>
<tr>
<td>% Time Gastric pH&lt;3</td>
<td>44.1*</td>
<td>60.3*</td>
</tr>
<tr>
<td>% Time Gastric pH&lt;4</td>
<td>7.6</td>
<td>11.0</td>
</tr>
</tbody>
</table>

*No inferential statistics conducted for this parameter.
* (p<0.001 versus placebo)

Median trough AUC 0-24 = 155.5±90. 130.9±81 85.8±64.3 678.5±21

* (p<0.001 versus placebo)
Japan, poor metabolizers developed statistically significantly higher serum gastrin concentrations than extensive metabolizers.

Effects on Enterochromaffin-like (ECL) Cells

Increased serum gastrin secondary to antisecretory agents stimulates proliferation of gastric ECL cells which, over time, may result in ECL cell hyperplasia in rats and mice and gastric carcinoids in rats, especially in females [see Carcinogenesis, Mutagenesis, Impairment of Fertility (13.1)].

In over 400 patients treated with ACIPHEX (10 or 20 mg/day) for up to one year, the incidence of ECL cell hyperplasia increased with time and dose, which is consistent with the pharmacological action of the proton-pump inhibitor. No patient developed the adenomatoid, dysplastic or neoplastic changes of ECL cells in the gastric mucosa. No patient developed the carcinoid tumors observed in rats.

Endocrine Effects

Studies in humans for up to one year have not revealed clinically significant effects on the endocrine system. In healthy male volunteers treated with ACIPHEX for 13 days, no clinically relevant changes have been detected in the following endocrine parameters examined: 17-β-estradiol, thyroid stimulating hormone, tri-iodothyronine, thyroxine, thyroxine-binding protein, parathyroid hormone, insulin, glucagon, renin, aldosterone, follicle-stimulating hormone, luteotrophic hormone, prolactin, somatotrophic hormone, dehydroepiandrosterone, cortisol-binding globulin, and urinary 6β-hydroxycortisol, serum testosterone and circadian cortisol profile.

Other Effects

In humans treated with ACIPHEX for up to one year, no systemic effects have been observed on the central nervous, lymphoid, hematopoietic, renal, hepatic, cardiovascular, or respiratory systems. No data are available on long-term treatment with ACIPHEX and ocular effects.

Microbiology

The following in vitro data are available but the clinical significance is unknown.

Rabeprazole sodium, amoxicillin and clarithromycin as a three drug regimen has been shown to be active against most strains of Helicobacter pylori in vitro and in clinical infections as described in the CLINICAL STUDIES (14) and INDICATIONS AND USAGE (1) sections.

Helicobacter pylori Susceptibility testing of H. pylori isolates was performed for amoxicillin and clarithromycin using agar dilution methodology, and minimum inhibitory concentrations (MICs) were determined. The clarithromycin and amoxicillin MIC values should be interpreted according to the following criteria:

### TABLE 5

INTERPRETATION OF CLARITHROMYCIN AND AMOXICILLIN MIC VALUES

<table>
<thead>
<tr>
<th>Clarithromycin MIC (μg/mL)</th>
<th>Interpretation</th>
<th>Amoxicillin MIC (μg/mL)</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 0.25</td>
<td>Susceptible (S)</td>
<td>≤ 0.25</td>
<td>Susceptible (S)</td>
</tr>
<tr>
<td>0.5</td>
<td>Intermediate (I)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 1.0</td>
<td>Resistant (R)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a These are breakpoints for the agar dilution methodology and they should not be used to interpret results using alternative methods.

b There were not enough organisms with MICs > 0.25 μg/mL to determine a resistance breakpoint.

Standardized susceptibility test procedures require the use of laboratory control microorganisms to control the technical aspects of the laboratory procedures. Standard clarithromycin and amoxicillin powders should provide the following MIC values:

### TABLE 6

MIC VALUES FOR STANDARD CLARITHROMYCIN AND AMOXICILLIN POWDERS

<table>
<thead>
<tr>
<th>Microorganism</th>
<th>Antimicrobial Agent</th>
<th>MIC (μg/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H. pylori ATCC 43504</td>
<td>Clarithromycin</td>
<td>0.015 – 0.12 μg/mL</td>
</tr>
<tr>
<td>H. pylori ATCC 43504</td>
<td>Amoxicillin</td>
<td>0.015 – 0.12 μg/mL</td>
</tr>
</tbody>
</table>

Patients with persistent H. pylori infection following rabeprazole, amoxicillin, and clarithromycin therapy will likely have clarithromycin resistant clinical isolates. Therefore, clarithromycin susceptibility testing should be done when possible. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted.

**Amoxicillin Susceptibility Test Results and Clinical/Bacteriologic Outcomes:** In the U.S. multicenter study, a total of >99% (558/560) of patients had H. pylori isolates which were considered to be susceptible (MIC ≤ 0.25 μg/mL) to amoxicillin at baseline. Two patients had baseline H. pylori isolates with an amoxicillin MIC of 0.5 μg/mL.

**Clarithromycin Susceptibility Test Results and Clinical/Bacteriologic Outcomes:** For the U.S. multicenter study, the baseline H. pylori clarithromycin susceptibility results and the H. pylori eradication results post-treatment are shown in the table below:

### TABLE 7

CLARITHROMYCIN SUSCEPTIBILITY TEST RESULTS AND CLINICAL/BACTERIOLOGIC OUTCOMES† FOR A THREE DRUG REGIMEN (RABEPRAZOLE 20 MG TWICE DAILY, AMOXICILLIN 1000 MG TWICE DAILY, AND CLARITHROMYCIN 500 MG TWICE DAILY FOR 7 OR 10 DAYS)

<table>
<thead>
<tr>
<th>Days of RAC Therapy</th>
<th>Clarithromycin in Pretreatment Results</th>
<th>Total Number</th>
<th>H. pylori Negative (Eradicated)</th>
<th>H. pylori Positive (Persistant) Post-Treatment Susceptibility Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clarithromycin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive (P)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Susceptible (S)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intermediate (I)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resistant (R)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† These are quality control ranges for the agar dilution methodology and they should not be used to control test results obtained using alternative methods.

Patients with persistent H. pylori infection following rabeprazole, amoxicillin, and clarithromycin therapy will likely have clarithromycin resistant clinical isolates. Therefore, clarithromycin susceptibility testing should be done when possible. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted.

Clarithromycin Susceptibility Test Results and Clinical/Bacteriologic Outcomes: In the U.S. multicenter study, a total of >99% (558/560) of patients had H. pylori isolates which were considered to be susceptible (MIC ≤ 0.25 μg/mL) to amoxicillin at baseline. The other 2 patients had baseline H. pylori isolates with an amoxicillin MIC of 0.5 μg/mL, and both isolates were clarithromycin-resistant at baseline; in one case the H. pylori was eradicated. In the 7- and 10-day treatment groups 75% (107/145) and 79% (112/142), respectively, of the patients who had pretreatment amoxicillin susceptible MICs (≤ 0.25 μg/mL) were eradicated of H. pylori. No patients developed amoxicillin-resistant H. pylori during therapy.

12.3 Pharmacokinetics

ACIPHEX delayed-release tablets are enteric-coated to allow rabeprazole sodium, which is acid labile, to pass through the stomach relatively intact. After oral administration of 20 mg ACIPHEX, peak plasma concentrations (Cmax) of rabeprazole occur over a range of 2.0 to 5.0 hours (Tmax). The rabeprazole Cmax and AUC are linear over an oral dose range of 10 mg to 40 mg. There is no appreciable accumulation when doses of 10 mg to 40 mg are administered every 24 hours; the pharmacokinetics of rabeprazole is not altered by multiple dosing. The plasma half-life ranges from 1 to 2 hours.

Absorption: Absolute bioavailability for a 20 mg oral tablet of rabeprazole (compared to intravenous administration) is approximately 52%. When rabeprazole is administered with a high fat meal, its Tmax is variable and may delay its absorption up to 4 hours or longer, however, the Cmax and the
extent of rabeprazole absorption (AUC) are not significantly altered. Thus rabeprazole may be taken without regard to timing of meals.

**Distribution:** Rabeprazole is 96.3% bound to human plasma proteins.

**Metabolism:** Rabeprazole is extensively metabolized. A significant portion of rabeprazole is metabolized via systemic nonenzymatic reduction to a thioether compound. Rabeprazole is also metabolized to sulphone and desmethyl compounds via cytochrome P450 in the liver. The thioether and sulphone are the primary metabolites measured in human plasma. These metabolites were not observed to have significant antisecretory activity. In vitro studies have demonstrated that rabeprazole is metabolized in the liver primarily by cytochromes P450 3A (CYP3A) to a sulphone metabolite and cytochrome P450 2C19 (CYP2C19) to desmethyl rabeprazole. CYP2C19 exhibits a known genetic polymorphism due to its deficiency in some sub-populations (e.g. 3 to 5% of Caucasians and 17 to 20% of Asians). Rabeprazole metabolism is slow in these sub-populations, therefore, they are referred to as poor metabolizers of the drug.

**Elimination:** Following a single 20 mg oral dose of 14C-labeled rabeprazole, approximately 90% of the drug was eliminated in the urine, primarily as thioether carboxylic acid; its glucuronide, and mercapturic acid metabolites. The remainder of the dose was recovered in the feces. Total recovery of radioactivity was 99.8%. No unchanged rabeprazole was recovered in the urine or feces.

**Geriatric:** In 20 healthy elderly subjects administered 20 mg rabeprazole once daily for seven days, AUC values approximately doubled and the Cmax increased by 60% compared to values in a parallel younger control group. There was no evidence of drug accumulation after once daily administration. [see USE IN SPECIAL POPULATIONS Geriatric Use (8.5)].

**Pediatric:** The pharmacokinetics of rabeprazole was studied in 12 adolescent patients with GERD 12 to 16 years of age, in a multicenter study. Patients received rabeprazole 20 mg once daily for five or seven days. An approximate 40% increase in exposure was noted following 5 to 7 days of dosing compared with the exposure after 1 day dosing. Pharmacokinetic parameters in adolescent patients with GERD 12 to 16 years of age were within the range observed in healthy adult volunteers.

**Gender and Race:** In analyses adjusted for body mass and height, rabeprazole pharmacokinetics showed no clinically significant differences between male and female subjects. In studies that used different formulations of rabeprazole, AUCCmax values for healthy Japanese men were approximately 50-60% greater than values derived from pooled data from healthy men in the United States.

**Renal Disease:** In 10 patients with stable end-stage renal disease requiring maintenance hemodialysis (creatinine clearance ≤5 mL/min/1.73 m²), no clinically significant differences were observed in the pharmacokinetics of rabeprazole. In patients with GERD 12 to 16 years of age, in a multicenter study. Patients received rabeprazole 20 mg once daily for five or seven days. An approximate 40% increase in exposure was noted following 5 to 7 days of dosing compared with the exposure after 1 day dosing. Pharmacokinetic parameters in adolescent patients with GERD 12 to 16 years of age were within the range observed in healthy adult volunteers. [see DOSAGE AND ADMINISTRATION (2.7)].

**Hepatic Disease:** In a single dose study of 10 patients with chronic mild to moderate compensated cirrhosis of the liver who were administered a 20 mg dose of rabeprazole, AUC(0-24) was approximately doubled, the elimination half-life was 2- to 3-fold higher, and total body clearance was decreased to less than 30% as compared to values in healthy volunteers.

In a multiple dose study of 12 patients with mild to moderate hepatic impairment administered 20 mg rabeprazole once daily for eight days, AUC(0-24) and Cmax values increased approximately 20% compared to values in healthy age- and gender-matched subjects. These increases were not statistically significant.

No information exists on rabeprazole disposition in patients with severe hepatic impairment. Please refer to the DOSAGE AND ADMINISTRATION section (2.7) for information on dosage adjustment in patients with hepatic impairment.

**Combined Administration with Antimicrobials:** Sixteen healthy volunteers genotyped as extensive metabolizers with respect to CYP2C19 were given 20 mg rabeprazole sodium, 1000 mg amoxicillin, 500 mg clarithromycin, or all 3 drugs in a four-way crossover study. Each of the four regimens was administered twice daily for 6 days. The AUC and Cmax for clarithromycin and amoxicillin were measured following administration of the rabeprazole and Cmax of clarithromycin were measured following the administration of CYP2C19 inhibitors. AUC and Cmax for clarithromycin were determined to be significantly lower than that of the control arm. AUC and Cmax for amoxicillin were not significantly different between the control arm and the regimen with rabeprazole.

**Clinical Studies**

**14.1 Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)**

**14.1.1 Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)**

In a U.S., multicenter, randomized, double-blind, placebo-controlled study, 103 patients were treated for up to eight weeks with placebo, 10 mg, 20 mg or 40 mg ACIPHEX QD. For this and all studies of GERD healing, only patients with GERD symptoms and at least grade 2 esophagitis (modified Hetzel-Dent grading scale) were eligible for entry. Endoscopic healing was defined as grade 0 or 1. Each ACIPHEX dose was significantly superior to placebo in producing endoscopic healing after four and eight weeks of treatment. The percentage of patients demonstrating endoscopic healing was as follows:

<table>
<thead>
<tr>
<th>Week</th>
<th>10 mg ACIPHEX QD</th>
<th>20 mg ACIPHEQ X QD</th>
<th>40 mg ACIPHEQ X QD</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>63%*</td>
<td>56%*</td>
<td>54%*</td>
<td>0%</td>
</tr>
<tr>
<td>8</td>
<td>93%*</td>
<td>84%*</td>
<td>85%*</td>
<td>12%</td>
</tr>
</tbody>
</table>

*(p<0.001 versus placebo)

In addition, there was a statistically significant difference in favor of the ACIPHEX 10 mg, 20 mg, and 40 mg doses compared to placebo at Weeks 4 and 8 regarding complete resolution of GERD heartburn frequency (p≤0.026). All ACIPHEX groups reported significantly greater rates of complete resolution of GERD daytime heartburn severity compared to placebo at Weeks 4 and 8 (p≤0.036). Mean reductions from baseline in daily antacid dose were statistically significant for all ACIPHEX groups when compared to placebo at both Weeks 4 and 8 (p≤0.007).

In a North American multicenter, randomized, double-blind, active-controlled study of 336 patients, ACIPHEX was statistically superior to ranitidine with respect to the percentage of patients healed at endoscopy after four and eight weeks of treatment (see table below):
ACIPHEX 20 mg once daily was significantly more effective than ranitidine 150 mg QID in the percentage of patients with complete resolution of heartburn at Weeks 4 and 8 (p<0.001). ACIPHEX 20 mg once daily was also more effective in complete resolution of daytime heartburn (p=0.025), and nighttime heartburn (p=0.012) at both Weeks 4 and 8, with significant differences by the end of the first week of the study.

14.2 Long-term Maintenance of Healing of Erosive or Ulcerative GERD

The long-term maintenance of healing in patients with erosive or ulcerative GERD previously healed with gastric antisecretory therapy was assessed in two U.S., multicenter, randomized, double-blind, placebo-controlled studies of identical design of 52 weeks duration. The two studies randomized 209 and 285 patients, respectively, to receive either 10 mg or 20 mg of ACIPHEX QD or placebo. As demonstrated in the tables below, ACIPHEX was significantly superior to placebo in both studies with respect to the maintenance of healing of GERD and the proportions of patients remaining free of heartburn symptoms at 52 weeks:

TABLE 10
PERCENT OF PATIENTS IN ENDOSCOPIC REMISSION

<table>
<thead>
<tr>
<th></th>
<th>ACIPHEX 10 mg</th>
<th>ACIPHEX 20 mg</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study 1</td>
<td>N=66</td>
<td>N=67</td>
<td>N=70</td>
</tr>
<tr>
<td>Week 4</td>
<td>83%*</td>
<td>96%*</td>
<td>44%</td>
</tr>
<tr>
<td>Week 13</td>
<td>79%*</td>
<td>93%*</td>
<td>39%</td>
</tr>
<tr>
<td>Week 26</td>
<td>77%*</td>
<td>93%*</td>
<td>31%</td>
</tr>
<tr>
<td>Week 39</td>
<td>76%*</td>
<td>91%*</td>
<td>31%</td>
</tr>
<tr>
<td>Week 52</td>
<td>73%*</td>
<td>90%*</td>
<td>29%</td>
</tr>
<tr>
<td>Study 2</td>
<td>N=93</td>
<td>N=93</td>
<td>N=99</td>
</tr>
<tr>
<td>Week 4</td>
<td>89%*</td>
<td>94%*</td>
<td>40%</td>
</tr>
<tr>
<td>Week 13</td>
<td>86%*</td>
<td>91%*</td>
<td>33%</td>
</tr>
<tr>
<td>Week 26</td>
<td>85%*</td>
<td>89%*</td>
<td>30%</td>
</tr>
<tr>
<td>Week 39</td>
<td>84%*</td>
<td>88%*</td>
<td>29%</td>
</tr>
<tr>
<td>Week 52</td>
<td>77%*</td>
<td>86%*</td>
<td>29%</td>
</tr>
<tr>
<td>COMBINED STUDIES</td>
<td>N=159</td>
<td>N=160</td>
<td>N=169</td>
</tr>
<tr>
<td>Week 4</td>
<td>87%*</td>
<td>94%*</td>
<td>42%</td>
</tr>
<tr>
<td>Week 13</td>
<td>83%*</td>
<td>92%*</td>
<td>36%</td>
</tr>
<tr>
<td>Week 26</td>
<td>82%*</td>
<td>91%*</td>
<td>31%</td>
</tr>
<tr>
<td>Week 39</td>
<td>81%*</td>
<td>89%*</td>
<td>30%</td>
</tr>
<tr>
<td>Week 52</td>
<td>75%*</td>
<td>87%*</td>
<td>29%</td>
</tr>
</tbody>
</table>

(*p<0.001 versus placebo)

TABLE 11
PERCENT OF PATIENTS WITHOUT RELAPSE IN HEARTBURN FREQUENCY AND DAYTIME AND NIGHTTIME HEARTBURN SEVERITY AT WEEK 52

<table>
<thead>
<tr>
<th></th>
<th>ACIPHEX 10 mg</th>
<th>ACIPHEX 20 mg</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heartburn Frequency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study 1</td>
<td>46/55 (84%)*</td>
<td>48/52 (92%)*</td>
<td>17/45 (38%)</td>
</tr>
<tr>
<td>Study 2</td>
<td>50/72 (69%)*</td>
<td>57/72 (79%)*</td>
<td>22/79 (28%)</td>
</tr>
<tr>
<td>Daytime Heartburn</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p<0.001 versus placebo
† 0.001<p<0.05 versus placebo

14.3 Treatment of Symptomatic GERD

Two U.S., multicenter, double-blind, placebo controlled studies were conducted in 316 patients with daytime and nighttime heartburn. Patients reported 5 or more periods of moderate to very severe heartburn during the placebo treatment phase the week prior to randomization. Patients were confirmed by endoscopy to have no esophageal erosions.

The percentage of heartburn free daytime and/or nighttime periods was greater with ACIPHEX 20 mg compared to placebo over the 4 weeks of study in Study RAB-USA-2 (47% vs. 23%) and Study RAB-USA-3 (52% vs. 28%). The mean decreases from baseline in average daytime and nighttime heartburn scores were significantly greater for ACIPHEX 20 mg as compared to placebo at week 4. Graphical displays depicting the daily mean daytime and nighttime scores are provided in Figures 2 to 5.

FIGURE 2: MEAN DAYTIME HEARTBURN SCORES RAB-USA-2

FIGURE 3: MEAN NIGHTTIME HEARTBURN SCORES RAB-USA-2

FIGURE 4: MEAN DAYTIME HEARTBURN SCORES RAB-USA-3

Reference ID: 3127543
In addition, the combined analysis of these two studies showed ACIPHEX 20 mg significantly improved other GERD-associated symptoms (regurgitation, belching and early satiety) by week 4 compared with placebo (all p values < 0.005).

ACIPHEX 20 mg also significantly reduced daily antacid consumption versus placebo over 4 weeks (p<0.001).

### 14.4 Healing of Duodenal Ulcers

In a U.S., randomized, double-blind, multicenter study assessing the effectiveness of 20 mg and 40 mg of ACIPHEX QD versus placebo for endoscopic healing are presented below:

<table>
<thead>
<tr>
<th>Week</th>
<th>ACIPHEX 20 mg QD N=102</th>
<th>ACIPHEX 40 mg QD N=103</th>
<th>Placebo N=103</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>69%</td>
<td>61%</td>
<td>66%</td>
</tr>
<tr>
<td>4</td>
<td>98%</td>
<td>93%</td>
<td>92%</td>
</tr>
</tbody>
</table>

* p<0.001 versus placebo

At Weeks 2 and 4, significantly more patients in the ACIPHEX 20 and 40 mg groups reported complete resolution of ulcer pain frequency (p<0.018), daytime pain severity (p<0.023), and nighttime pain severity (p<0.035) compared with placebo patients. The only exception was the ACIPHEX 40 mg group versus placebo at Week 2 for duodenal ulcer pain frequency (p=0.094). Significant differences in resolution of daytime and nighttime pain were noted in both ACIPHEX groups relative to placebo by the end of the first week of the study. Significant reductions in daily antacid use were also noted in both ACIPHEX groups compared to placebo at Weeks 2 and 4 (p<0.001).

An international randomized, double-blind, active-controlled trial was conducted in 205 patients comparing 20 mg ACIPHEX QD with 20 mg omeprazole QD. The study was designed to provide at least 80% power to exclude a difference of at least 10% between ACIPHEX and omeprazole, assuming four-week healing response rates of 93% for both groups. In patients with endoscopically defined duodenal ulcers treated for up to four weeks, ACIPHEX was comparable to placebo in producing healing of duodenal ulcers. The percentages of patients with endoscopic healing are presented below:

<table>
<thead>
<tr>
<th>Week</th>
<th>ACIPHEX 20 mg QD N=34</th>
<th>ACIPHEX 40 mg QD N=33</th>
<th>Placebo N=33</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>44%</td>
<td>42%</td>
<td>21%</td>
</tr>
<tr>
<td>4</td>
<td>79%*</td>
<td>91%*</td>
<td>39%</td>
</tr>
</tbody>
</table>

* p<0.001 versus placebo

ACIPHEX and omeprazole were comparable in providing complete resolution of symptoms.

#### 14.5 Helicobacter pylori Eradication in Patients with Peptic Ulcer Disease or Symptomatic Non-Ulcer Disease

The U.S. multicenter study was a double-blind, parallel-group comparison of rabeprazole, amoxicillin, and clarithromycin for 3, 7, or 10 days vs. omeprazole, amoxicillin and clarithromycin for 10 days. Therapy consisted of rabeprazole 20 mg twice daily, amoxicillin 1000 mg twice daily, and clarithromycin 500 mg twice daily (RAC) or omeprazole 20 mg twice daily, amoxicillin 1000 mg twice daily, and clarithromycin 500 mg twice daily (OAC). Patients with H. pylori infection were stratified in a 1:1 ratio for those with peptic ulcer disease (active or a history of ulcer in the past five years) [PUD] and those who were symptomatic but without peptic ulcer disease [NPUD], as determined by upper gastrointestinal endoscopy. The overall H. pylori eradication rates, defined as negative 13C-UBT for H. pylori ≥ 6 weeks from the end of the treatment are shown in the following table. The eradication rates in the 7-day and 10-day RAC regimens were found to be similar to 10-day OAC regimen using either the Intent-to-Treat (ITT) or Per-Protocol (PP) populations. Eradication rates in the RAC 3-day regimen were inferior to the other regimens.

#### 14.6 Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome

Twelve patients with idiopathic gastric hypersecretion or Zollinger-Ellison syndrome have been treated successfully with ACIPHEX at doses from 20 to 120 mg for up to 12 months. ACIPHEX produced satisfactory...
inhibition of gastric acid secretion in all patients and complete resolution of
signs and symptoms of acid-peptic disease where present. ACIPHEX also
prevented recurrence of gastric hypersecretion and manifestations of acid-
peptic disease in all patients. The high doses of ACIPHEX used to treat this
small cohort of patients with gastric hypersecretion were well tolerated.

15. REFERENCES
   1. National Committee for Clinical Laboratory Standards. Methods for
   Dilution Antimicrobial Susceptibility Tests for Bacteria That Grow
   Aerobically—Fifth Edition. Approved Standard NCCLS Document M7-A5,

16. HOW SUPPLIED/STORAGE AND HANDLING
   ACIPHEX 20 mg is supplied as delayed-release light yellow enteric-
   coated tablets. The name and strength, in mg, (ACIPHEX 20) is imprinted on
   one side.
   Bottles of 30 (NDC#62856-243-30)
   Bottles of 90 (NDC#62856-243-90)
   Unit Dose Blisters Package of 100 (10 x 10) (NDC#62856-243-41)

   Store at 25°C (77°F); excursions permitted to 15-30°C (59-86°F). [see
   USP Controlled Room Temperature] Protect from moisture.

17. PATIENT COUNSELING INFORMATION
   How to Take ACIPHEX
   Patients should be cautioned that ACIPHEX delayed-release tablets
   should be swallowed whole. The tablets should not be chewed, crushed, or
   split. ACIPHEX can be taken with or without food.
   Advise patients to immediately report and seek care for any
   cardiovascular or neurological symptoms including palpitations, dizziness,
   and tateny as these may be signs of hypomagnesemia [see WARNINGS AND
   PRECAUTIONS (5.7)].

FDA-Approved Patient Labeling

   PATIENT INFORMATION
   ACIPHEX (a-se-feks)
   (rabeprazole sodium)
   Delayed-Release Tablets

Read the Patient Information that comes with ACIPHEX before you start
taking it and each time you get a refill. There may be new information. This
leaflet does not take the place of talking to your healthcare provider about
your medical condition or treatment.

   What is ACIPHEX?
   ACIPHEX is a medicine called a proton pump inhibitor. ACIPHEX reduces
   the amount of acid in your stomach.

   ACIPHEX is used in adults:
   • for up to 8 weeks to heal acid-related damage to the lining of the
     esophagus (called erosive esophagitis or EE) and to relieve
     symptoms, such as heartburn pain. If needed, your doctor may
     prescribe an additional 8 weeks of ACIPHEX.
   • to maintain the healing of the esophagus and relief of symptoms
     related to EE. ACIPHEX has not been studied for treatment
     lasting longer than 12 months (1 year).
   • for 4 weeks for the treatment of daytime and nighttime heartburn
     and other symptoms that happen with Gastroesophageal Reflux
     Disease (GERD). If needed your doctor may prescribe an
     additional 4 weeks of ACIPHEX.

   GERD happens when acid in your stomach backs up into the tube
   (esophagus) that connects your mouth to your stomach. This may
   cause a burning feeling in your chest or throat, sour taste, or
   burping.

   • for up to 4 weeks for the healing and relief of duodenal ulcers. The
     duodenal area is the area where food passes when it leaves the
     stomach.
   • with certain antibiotic medicines for the treatment of an infection
     caused by bacteria called H. pylori. Sometimes H. pylori bacteria
     can cause duodenal ulcers. The infection needs to be treated to
     prevent the ulcers from coming back.
   • for the long-term treatment of conditions where your stomach
     makes too much acid. This includes a rare condition called
     Zollinger-Ellison syndrome.

   ACIPHEX is used in adolescents 12 years of age and above:
   • for up to 8 weeks for the treatment of GERD.

   It is not known if ACIPHEX is safe and effective in children under the age of
   12.

   ACIPHEX may help your acid-related symptoms, but you could still have
   serious stomach problems. Talk with your doctor.

Who should not take ACIPHEX?

   Do not take ACIPHEX if you:
   • are allergic to any of the ingredients in ACIPHEX. See the end of
     this leaflet for a complete list of ingredients in ACIPHEX.
   • are allergic to any other Proton Pump Inhibitor (PPI) medicine.

   What should I tell my doctor before taking ACIPHEX?

   Before you take ACIPHEX tell your doctor about all of your medical
   conditions, including if you:
   • have been told that you have low magnesium levels in your blood.
   • have any liver problems.
   • have any allergies.
   • are pregnant or planning to become pregnant. It is not known if
     ACIPHEX can harm your unborn baby.
   • are breastfeeding. It is not known if ACIPHEX passes into your
     breast milk or if it can harm your baby. You should choose to
     breastfeed or take ACIPHEX, but not both. Talk to your doctor
     about other ways to feed your baby while taking ACIPHEX.

   Tell your doctor about all the medicines you take, including prescription
   and non-prescription medicines, vitamins and herbal supplements.
   ACIPHEX and certain medicines can affect each other. This can cause serious
   side effects. Know the medicines that you take. Keep a list of them with you
   and show it to your doctor when you get a new medicine. Be sure to tell your
   doctor if you are taking:
   • atazanavir (Reyataz)
   • cyclosporine (Sandimmune, Neoral)
   • digoxin (Lanoxin)
   • ketoconazole (Nizoral)
   • warfarin (Coumadin)
   • theophylline (THEO-24 Thelair)
   • diazepam (Valium)
   • phenytoin (Dilantin)
   • antibiotics
   • methotrexate

   Ask your doctor or pharmacist if you are not sure if your medicine is
   listed above.

   How should I take ACIPHEX?

   • Take ACIPHEX exactly as prescribed. Your doctor will prescribe
     the dose that is right for you and your medical condition. Do not
     change your dose or stop taking ACIPHEX unless you talk to your
     doctor. Take ACIPHEX for as long as it is prescribed even if you
     feel better.
   • ACIPHEX is usually taken once a day. Your doctor will tell you
     the time of day to take ACIPHEX, based on your medical
     condition.
ACIPHEX can be taken with or without food. Your healthcare provider will tell you whether to take this medicine with or without food based on your medical condition.

Swallow each ACIPHEX tablet whole with water. Do not chew, crush, or split ACIPHEX tablets because this will damage the tablet and the medicine will not work. Tell your doctor if you cannot swallow tablets whole. You may need a different medicine.

If you miss a dose of ACIPHEX, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your normal schedule. Do not take 2 doses at the same time.

If you take too much ACIPHEX, call your doctor or Poison Control Center right away, or go to the emergency department.

Your doctor may prescribe antibiotic medicines with ACIPHEX to help treat a stomach infection and heal stomach-area (duodenal) ulcers that are caused by bacteria called H. pylori. Make sure you read the patient information that comes with an antibiotic before you start taking it.

What are the possible side effects of ACIPHEX?

ACIPHEX, like other proton pump inhibitors, may cause serious allergic reactions. See the end of this leaflet for a complete list of ingredients in ACIPHEX.

- Serious allergic reactions. Tell your doctor if you have any of the following symptoms with ACIPHEX.
  - rash
  - face swelling
  - throat tightness
  - difficulty breathing

Your doctor may stop ACIPHEX if these symptoms happen.

- Low magnesium levels in your body. This problem can be serious. Low magnesium can happen in some people who take a proton pump inhibitor medicine for at least 3 months. If low magnesium levels happen, it is usually after a year of treatment. You may or may not have symptoms of low magnesium.

Tell your doctor right away if you have any of these symptoms:
  - seizures
  - dizziness
  - abnormal or fast heart beat
  - jitteriness
  - jerking movements or shaking (tremors)
  - muscle weakness
  - spasms of the hands and feet
  - cramps or muscle aches
  - spasm of the voice box

Your doctor may check the level of magnesium in your body before you start taking ACIPHEX, during treatment, or if you will be taking ACIPHEX for a long period of time.

The most common side effects with ACIPHEX may include:

- headache
- pain
- sore throat
- gas
- infection
- constipation

People who are taking multiple daily doses of Proton Pump Inhibitor medicines for a long period of time may have an increased risk of fractures of the hip, wrist, or spine.

Tell your doctor if you have any side effect that bothers you or that does not go away. These are not all the side effects of ACIPHEX. For more information, ask your doctor or pharmacist.

Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store ACIPHEX?

- Store ACIPHEX in a dry place at room temperature, 59°F to 86°F (15°C to 30°C).

Keep ACIPHEX and all medicines out of the reach of children.

General Information about ACIPHEX

Medicines are sometimes prescribed for conditions other than those described in patient information leaflets. Do not use ACIPHEX for any condition for which it was not prescribed by your doctor. Do not give ACIPHEX to other people, even if they have the same symptoms as you. It may harm them.

This leaflet summarizes the most important information about ACIPHEX. If you would like more information, talk to your doctor. You can also ask your doctor or pharmacist for information about ACIPHEX that is written for healthcare professionals. For full product information, visit the website at http://www.aciphex.com or call the toll-free numbers 1-888-4-ACIPHEX or 1-800 JANSSEN.

What are the ingredients in ACIPHEX?

Active Ingredient: rabeprazole sodium

Inactive ingredients of the 20 mg tablet are carnauba wax, crospovidone, diacetylated monoglycerides, ethylcellulose, hydroxypropyl cellulose, hypromellose phthalate, magnesium stearate, mannitol, propylene glycol, sodium hydroxide, sodium stearyl fumarate, talc, and titanium dioxide. Iron oxide yellow is the coloring agent for the tablet coating. Iron oxide red is the ink pigment.

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For prescription only

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ACIPHEX is a registered trademark of Eisai Co., Ltd., Tokyo, Japan.

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   Marketed by Janssen Pharmaceuticals Inc., Titusville, NJ 08560