

FOR THE TREATMENT OF SCHIZOPHRENIA

NEW



INTRODUCING  
**INVEGA**<sup>TM</sup>  
PALIPERIDONE  
*Extended-Release Tablets*

## A New Oral Atypical Antipsychotic

**INVEGA is specifically created to combine:**

- The active metabolite of RISPARDAL<sup>®</sup> (risperidone)
- Innovative OROS<sup>®</sup> extended-release technology

**INVEGA has delivered in clinical trials:**

- Significant efficacy in the positive and negative symptoms of schizophrenia<sup>1\*</sup>
- Low weight gain and EPS rates comparable with placebo at 6 weeks with the recommended 6-mg dose<sup>1\*†</sup>

Please see Important Safety Information, including Boxed Warning, inside.

Please see accompanying full Prescribing Information for INVEGA and RISPARDAL.

Tablet shown actual size.

<sup>\*</sup>Results from three 6-week, double-blind, placebo-controlled studies involving 1665 patients with acute schizophrenia. Efficacy was evaluated for INVEGA 3 mg, 6 mg, 9 mg, and 12 mg using Positive and Negative Syndrome Scale total scores. Safety and tolerability were derived from pooled data.<sup>1</sup>

<sup>†</sup>In 6-week clinical trials, the incidence of weight change was similar to that for placebo at all doses (3-mg and 6-mg doses [1.3 lb], 9 mg [2.2 lb], 12 mg [2.4 lb], placebo [-0.9 lb]). The percentage of EPS-related adverse events at the 3-mg and 6-mg doses was comparable with placebo (3 mg [12.6%], 6 mg [10.2%], placebo [11.0%]). Rates at the 9-mg and 12-mg doses were 25.2% and 26.0%, respectively.<sup>1</sup>



## IMPORTANT SAFETY INFORMATION FOR INVEGA™

### Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Neither INVEGA™ (paliperidone) nor RISPERDAL® (risperidone) are approved for the treatment of patients with Dementia-Related Psychosis.

**Commonly observed adverse events:** The most commonly observed adverse events occurring at an incidence of  $\geq 5\%$  and at least 2 times placebo were: **INVEGA:** akathisia and extrapyramidal disorder; **RISPERDAL:** anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, nausea, dyspepsia, rhinitis, rash, and tachycardia.

**QT Prolongation:** INVEGA causes a modest increase in the corrected QT (QTc) interval. INVEGA should be avoided in combination with other drugs that are known to prolong the QTc interval, in patients with congenital long QT syndrome or a history of cardiac arrhythmias. Certain circumstances may increase the risk of torsades de pointes and/or sudden death in association with the use of drugs that prolong the QTc interval.

**Neuroleptic malignant syndrome (NMS):** NMS, a potentially fatal symptom complex, has been reported with the use of antipsychotic medications, including INVEGA and RISPERDAL. Clinical manifestations include muscle rigidity, fever, altered mental status and evidence of autonomic instability (see full Prescribing Information). Management should include immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy, intensive symptomatic treatment and medical monitoring, and treatment of any concomitant serious medical problems.

**Tardive dyskinesia (TD):** TD is a syndrome of potentially irreversible, involuntary, dyskinetic movements that may develop in patients treated with antipsychotic medications. The risk of developing TD and the likelihood that dyskinetic movements will become irreversible are believed to increase with duration of treatment and total cumulative dose. Elderly patients appeared to be at increased risk for TD. Prescribing should be consistent with the need to minimize the risk of TD. The syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn.

**Hyperglycemia and Diabetes:** Hyperglycemia, some cases extreme and associated with ketoacidosis, hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics (APS). Patients starting treatment with APS who have or are at risk for diabetes, should undergo fasting blood glucose testing at the beginning of and during treatment. Patients who develop symptoms of hyperglycemia should also undergo fasting blood glucose testing.

**Gastrointestinal:** INVEGA should ordinarily not be administered to patients with pre-existing severe gastrointestinal narrowing. Rare instances of obstructive symptoms have been reported in patients with known strictures taking non-deformable formulations. INVEGA should only be used in patients who are able to swallow the tablet whole.

**Cerebrovascular adverse events (CAEs):** CAEs, including fatalities, have been reported in elderly patients with dementia-related psychosis taking atypical antipsychotics in clinical trials. Neither INVEGA nor RISPERDAL are approved for treating these patients.

**Orthostatic hypotension and Syncope:** INVEGA and RISPERDAL can cause orthostatic hypotension and syncope in some patients. Appropriate monitoring of orthostatic vital signs should be considered.

**Seizures:** INVEGA and RISPERDAL should be used cautiously in patients with a history of seizures.

**Hyperprolactinemia:** As with other drugs that antagonize dopamine D<sub>2</sub> receptors, INVEGA and RISPERDAL elevate prolactin levels and the elevation persists during chronic administration.

**Suicide:** The possibility of suicide attempt is inherent in psychotic illnesses and close supervision of high-risk patients should accompany drug therapy.

**Maintenance treatment:** Physicians who elect to use INVEGA and RISPERDAL for extended periods should periodically re-evaluate the long-term risks and benefits of the drug for the individual patient.

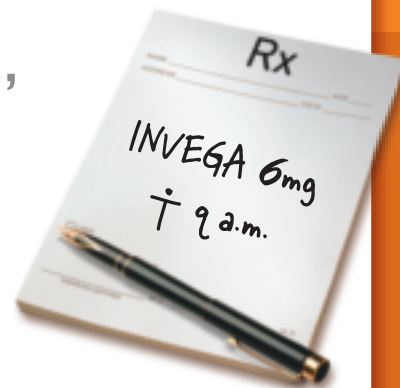
**Extrapyramidal symptoms (EPS):** Total EPS-related adverse events in the higher 9-mg and 12-mg treatment groups were 25% and 26%, respectively, versus 11% for the placebo group.

**Weight gain:** The proportion of subjects having a weight gain of  $\geq 7\%$  body weight were comparable to placebo (5%) for 3 mg (7%) and 6 mg (6%). A higher incidence was seen for 9 mg (9%) and 12 mg (9%).

# NEW INVEGA—Easy to Prescribe, Easy to Dose

## Convenient once-daily dosing

- Dosing flexibility is available from 3 mg to 12 mg
- Patients can start with the recommended 6-mg dose; no initial dose titration necessary
- Due to the extended-release formulation, morning administration is recommended



### AVAILABLE IN 3 TABLET STRENGTHS\*



For more information about INVEGA, contact your Janssen Sales Representative at 1-800-JANSSEN (1-800-526-7736) or visit [www.INVEGA.com](http://www.INVEGA.com).

Tablet shell is eliminated in stool unchanged.

\*Due to the properties of the molecule and the extended-release delivery technology of INVEGA, the milligram dosing for INVEGA is independent of dosing for RISPERDAL.

**Reference: 1.** Data on file. Janssen LP, Titusville, NJ.

OROS is a registered trademark of ALZA Corporation.  
RISPERDAL is a registered trademark of Janssen, L.P.

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