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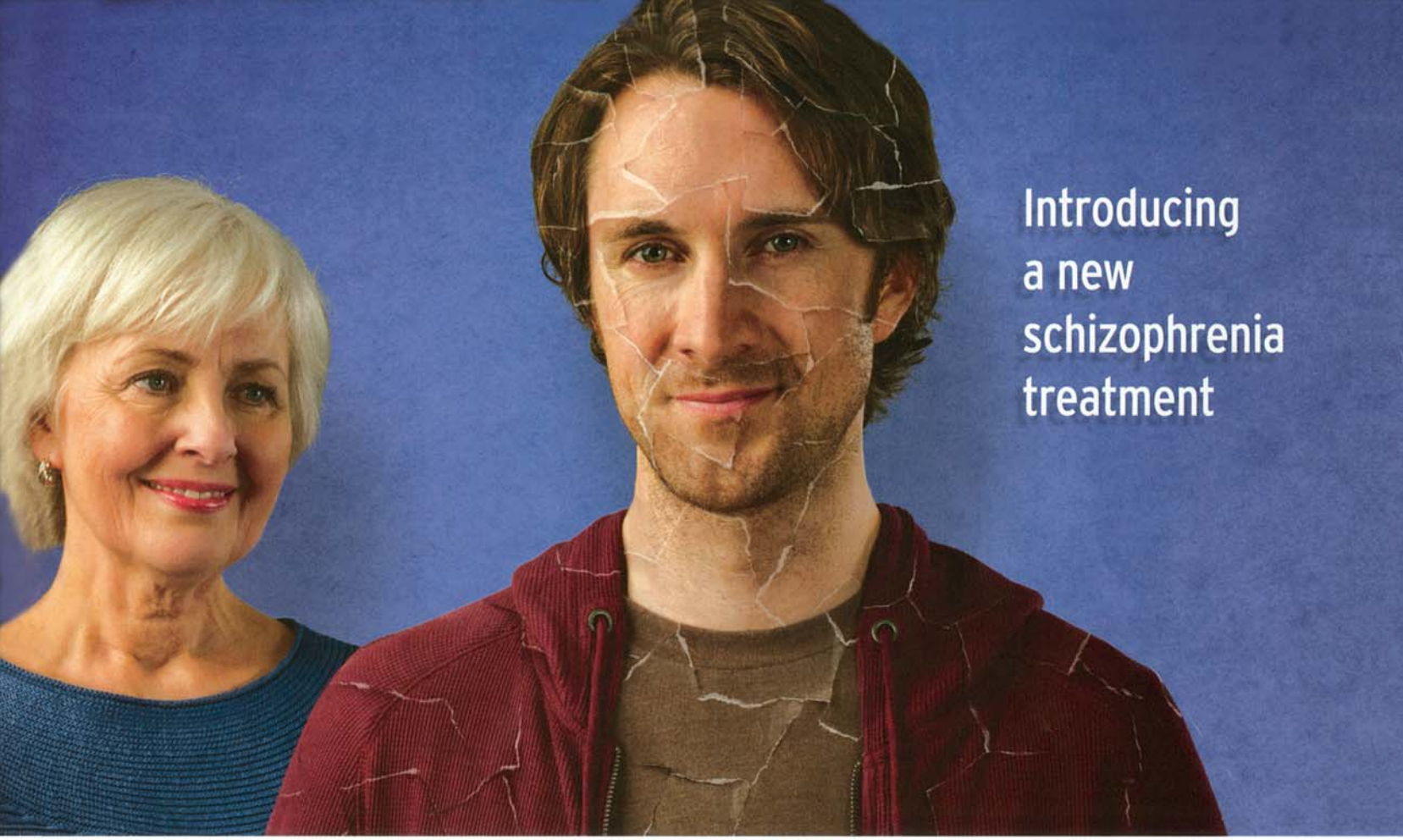

IMPORTANT SAFETY INFORMATION FOR LATUDA

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, 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. LATUDA is not approved for the treatment of patients with dementia-related psychosis.

CONTRAINDICATIONS

LATUDA is contraindicated in any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone. LATUDA is contraindicated with strong CYP3A4 inhibitors (e.g., ketoconazole) and strong CYP3A4 inducers (e.g., rifampin).

WARNINGS AND PRECAUTIONS

Cerebrovascular Adverse Reactions, Including Stroke: LATUDA is not approved for the treatment of patients with dementia-related psychosis.

Neuroleptic Malignant Syndrome (NMS): NMS, a potentially fatal symptom complex, has been reported with administration of antipsychotic drugs, including LATUDA. NMS can cause hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available.

Tardive Dyskinesia (TD): The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. Given these considerations, LATUDA should be prescribed in a manner that is most likely to minimize the occurrence of TD. If signs and symptoms appear in a patient on LATUDA, drug discontinuation should be considered.

Metabolic Changes

- **Hyperglycemia and Diabetes Mellitus:** Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.
- **Dyslipidemia:** Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics.
- **Weight Gain:** Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

LATUDA, a once-daily, oral atypical antipsychotic[1]

- The efficacy of LATUDA was established in 2 studies for each dose
- The safety and tolerability of LATUDA were evaluated in multiple studies
- The recommended starting dose is 40 mg/day taken with food (at least 350 calories) with no initial dose titration required. The maximum recommended dose is 80 mg/day
  - For patients with moderate and severe renal or hepatic impairment, the dose of LATUDA should not exceed 40 mg/day
  - When coadministered with a moderate CYP3A4 inhibitor such as diltiazem, the dose of LATUDA should not exceed 40 mg/day
  - LATUDA should not be administered with strong CYP3A4 inhibitors such as ketoconazole or strong CYP3A4 inducers such as rifampin

NEW

Latuda®

(lurasidone HCl) tablets

40mg and 80mg

INDICATION AND USAGE

LATUDA is an atypical antipsychotic agent indicated for the treatment of patients with schizophrenia. Efficacy was established in four 6-week controlled studies of adult patients with schizophrenia. The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

Please see Important Safety Information below, including **Boxed Warning**, and accompanying Brief Summary.

Hyperprolactinemia: As with other drugs that antagonize dopamine D2 receptors, LATUDA elevates prolactin levels. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported in patients receiving prolactin-elevating compounds.

Leukopenia, Neutropenia, and Agranulocytosis: Leukopenia/neutropenia has been reported during treatment with antipsychotic agents. Agranulocytosis (including fatal cases) has been reported with other agents in the class. Patients with a preexisting low white blood cell count (WBC) or a history of drug induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy, and LATUDA should be discontinued at the first sign of a decline in WBC in the absence of other causative factors.

Orthostatic Hypotension and Syncope: LATUDA may cause orthostatic hypotension. LATUDA should be used with caution in patients with known cardiovascular disease (e.g., heart failure, history of myocardial infarction, ischemia, or conduction abnormalities), cerebrovascular disease, or conditions that predispose the patient to hypotension (e.g., dehydration, hypovolemia, and treatment with antihypertensive medications). Monitoring of orthostatic vital signs should be considered in all patients who are vulnerable to hypotension.

Seizures: LATUDA should be used cautiously in patients with a history of seizures or with conditions that lower seizure threshold (e.g., Alzheimer's dementia).

Potential for Cognitive and Motor Impairment: In short-term, placebo-controlled trials, somnolence was reported in 22.3% (224/1004) of patients treated with LATUDA compared to 9.9% (45/455) of placebo patients, respectively. The frequency of somnolence increases with dose. Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with LATUDA does not affect them adversely.

Body Temperature Regulation: Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing LATUDA for patients who will be experiencing conditions that may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration.

Suicide: The possibility of suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. Prescriptions for LATUDA should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

Dysphagia: Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. LATUDA is not indicated for the treatment of dementia-related psychosis, and should not be used in patients at risk for aspiration pneumonia.

DRUG INTERACTIONS

Drug Interactions: Given the primary CNS effects of LATUDA, caution should be used when it is taken in combination with other centrally acting drugs and alcohol.

ADVERSE REACTIONS

Commonly Observed Adverse Reactions (≥5% and at least twice that for placebo): The most commonly observed adverse reactions in patients treated with LATUDA in short-term clinical studies were somnolence, akathisia, nausea, parkinsonism, and agitation.

Reference: 1. LATUDA prescribing information. Sunovion Pharmaceuticals Inc. October 2010.

FOR MORE INFORMATION, PLEASE CALL 1-888-394-7377 OR VISIT **www.LatudaHCP.com**.

LATUDA® (lurasidone HCl) Tablets

Brief Summary (for full prescribing information, see package insert)

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death 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.

Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear.

LATUDA is not approved for the treatment of patients with dementia-related psychosis. *[see Warnings and Precautions (5.1)]*

1. INDICATIONS AND USAGE

LATUDA is indicated for the treatment of patients with schizophrenia.

The efficacy of LATUDA in schizophrenia was established in four 6-week controlled studies of adult patients with schizophrenia *[see Clinical Studies]*.

The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient *[see Dosage and Administration]*.

4. CONTRAINDICATIONS

LATUDA is contraindicated in any patient with a known hypersensitivity to lurasidone HCl or any components in the formulation. Angioedema has been observed with lurasidone [*see Adverse Reactions (6.6)*].

LATUDA is contraindicated with strong CYP3A4 inhibitors (e.g., ketoconazole) and strong CYP3A4 inducers (e.g., rifampin) [*see Drug Interactions (7.1)*].

5. WARNINGS AND PRECAUTIONS

5.1 Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. LATUDA is not approved for the treatment of dementia-related psychosis [*see Boxed Warning*].

5.2 Cerebrovascular Adverse Reactions, Including Stroke

In placebo-controlled trials with risperidone, aripiprazole, and olanzapine in elderly subjects with dementia, there was a higher incidence of cerebrovascular adverse reactions (cerebrovascular accidents and transient ischemic attacks), including fatalities, compared to placebo-treated subjects. LATUDA is not approved for the treatment of patients with dementia-related psychosis *[see also Boxed Warning and Warnings and Precautions (5.1)]*.

5.3 Neuroleptic Malignant Syndrome

A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with administration of antipsychotic drugs, including LATUDA.

Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatinine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure.

The diagnostic evaluation of patients with this syndrome is complicated. It is important to exclude cases where the clinical presentation includes both serious medical illness (e.g. pneumonia, systemic infection) and untreated or inadequately treated extrapyramidal signs and symptoms (EPS). Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever, and primary central nervous system pathology.

The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimens for NMS.

If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. If reintroduced, the patient should be carefully monitored, since recurrences of NMS have been reported.

5.4 Tardive Dyskinesia

Tardive Dyskinesia is a syndrome consisting of potentially irreversible, involuntary, dyskinetic movements that can develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

The risk of developing tardive dyskinesia and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses.

There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown.

Given these considerations, LATUDA should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who suffer from a chronic illness that (1) is known to respond to antipsychotic drugs, and (2) for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically.

If signs and symptoms of tardive dyskinesia appear in a patient on LATUDA, drug discontinuation should be considered. However, some patients may require treatment with LATUDA despite the presence of the syndrome.

5.5 Metabolic Changes

Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and body weight gain. While all of the drugs in the class have been shown to produce some metabolic changes, each drug has its own specific risk profile.

Hyperglycemia and Diabetes Mellitus

Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Because LATUDA was not marketed at the time these studies were performed, it is not known if LATUDA is associated with this increased risk.

Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

Pooled data from short-term, placebo-controlled studies are presented in Table 1.

Table 1: Change in Fasting Glucose

	Placebo	LATUDA 20 mg/day	LATUDA 40 mg/day	LATUDA 80 mg/day	LATUDA 120 mg/day
Mean Change from Baseline (mg/dL)					
	n=438	**n=71**	**n=352**	**n=270**	**n=283**
Serum Glucose	-0.7	-0.6	2.5	-0.9	2.5
Proportion of Patients with Shifts to ≥ 126 mg/dL					
Serum Glucose (≥ 126 mg/dL)	8.6% (34/397)	11.7% (7/60)	14.3% (47/328)	10.0% (24/241)	10.0% (26/260)

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in glucose of +1.6 mg/dL at week 24 (n=186), +0.3 mg/dL at week 36 (n=236) and +1.2 mg/dL at week 52 (n=244).

Dyslipidemia

Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics. Pooled data from short-term, placebo-controlled studies are presented in Table 2.

Table 2: Change in Fasting Lipids

	Placebo	LATUDA 20 mg/day	LATUDA 40 mg/day	LATUDA 80 mg/day	LATUDA 120 mg/day
Mean Change from Baseline (mg/dL)					
	n=418	**n=71**	**n=341**	**n=263**	**n=268**
Total cholesterol	-8.5	-12.3	-9.4	-9.8	-3.8
Triglycerides	-15.7	-29.1	-6.2	-14.2	-3.1
Proportion of Patients with Shifts					
Total Cholesterol (≥ 240 mg/dL)	6.6% (23/350)	13.8% (8/58)	7.3% (21/287)	6.9% (15/216)	3.8% (9/238)
Triglycerides (≥ 200 mg/dL)	12.5% (39/312)	14.3% (7/49)	14.0% (37/264)	8.7% (17/196)	10.5% (22/209)

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in total cholesterol and triglycerides of -4.2 (n=186) and -13.6 (n=187) mg/dL at week 24, -1.9 (n=238) and -3.5 (n=238) mg/dL at week 36 and -3.6 (n=243) and -6.5 (n=243) mg/dL at week 52, respectively.

Weight Gain

Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Pooled data from short-term, placebo-controlled studies are presented in Table 3. The mean weight gain was 0.75 kg for LATUDA-treated patients compared to 0.26 kg for placebo-treated patients. In study 3 [*see Clinical Studies (14.1)*] change in weight from baseline for olanzapine was 4.15 kg. The proportion of patients with a ≥ 7% increase in body weight (at Endpoint) was 5.6% for LATUDA-treated patients versus 4.0% for placebo-treated patients.

Table 3: Mean Change in Weight (kg) from Baseline

	Placebo (n=450)	LATUDA 20 mg/day (n=71)	LATUDA 40 mg/day (n=358)	LATUDA 80 mg/day (n=279)	LATUDA 120 mg/day (n=291)
All Patients	0.26	-0.15	0.67	1.14	0.68

In the uncontrolled, longer-term studies (primarily open-label extension studies), LATUDA was associated with a mean change in weight of -0.38 kg at week 24 (n=531), -0.47 kg at week 36 (n=303) and -0.71 kg at week 52 (n=244).

5.6 Hyperprolactinemia

As with other drugs that antagonize dopamine D_2 receptors, LATUDA elevates prolactin levels.

Hyperprolactinemia may suppress hypothalamic GnRH, resulting in reduced pituitary gonadotrophin secretion. This, in turn, may inhibit reproductive function by impairing gonadal steroidogenesis in both female and male patients. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported with prolactin-elevating compounds. Long-standing hyperprolactinemia when associated with hypogonadism may lead to decreased bone density in both female and male patients *[see Adverse Reactions (6)]*.

In short-term placebo-controlled studies, the median change from baseline to endpoint in prolactin levels for LATUDA-treated patients was 1.1 ng/mL and was -0.6 ng/mL in the placebo-treated patients. The increase in prolactin was greater in female patients; the median change from baseline to endpoint for females was 1.5 ng/mL and was 1.1 ng/mL in males. The increase in prolactin concentrations was dose-dependent (Table 4).

Table 4: Median Change in Prolactin (ng/mL) from Baseline

	Placebo	LATUDA 20 mg/day	LATUDA 40 mg/day	LATUDA 80 mg/day	LATUDA 120 mg/day
All Patients	-0.6 (n=430)	-1.1 (n=70)	0.3 (n=351)	1.1 (n=259)	3.3 (n=284)
Females	-1.5 (n=102)	-0.7 (n=19)	-0.9 (n=99)	2.0 (n=78)	6.7 (n=70)
Males	-0.5 (n=328)	-1.2 (n=51)	0.5 (n=252)	0.9 (n=181)	3.1 (n=214)

The proportion of patients with prolactin elevations ≥ 5x ULN was 3.6% for LATUDA-treated patients versus 0.7% for placebo-treated patients. The proportion of female patients with prolactin elevations ≥ 5x ULN was 8.3% for LATUDA-treated patients versus 1% for placebo-treated female patients. The proportion of male patients with prolactin elevations ≥ 5x ULN was 1.9% versus 0.6% for placebo-treated male patients.

In the uncontrolled longer-term studies (primarily open-label extension studies), LATUDA was associated with a median change in prolactin of -1.9 ng/mL at week 24 (n=188), -5.4 ng/mL at week 36 (n=189) and -3.3 ng/mL at week 52 (n=243).

Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent in vitro, a factor of potential importance if the prescription of these drugs is considered in a patient with previously detected breast cancer. As is common with compounds which increase prolactin release, an increase in mammary gland neoplasia was observed in a LATUDA carcinogenicity study conducted in rats and mice *[see Nonclinical Toxicology]*. Neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans, but the available evidence is too limited to be conclusive.

5.7 Leukopenia, Neutropenia and Agranulocytosis

Leukopenia/neutropenia has been reported during treatment with antipsychotic agents. Agranulocytosis (including fatal cases) has been reported with other agents in the class.

Possible risk factors for leukopenia/neutropenia include pre-existing low white blood cell count (WBC) and history of drug induced leukopenia/neutropenia. Patients with a pre-existing low WBC or a history of drug induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and LATUDA should be discontinued at the first sign of decline in WBC, in the absence of other causative factors.

Patients with neutropenia should be carefully monitored for fever or other symptoms or signs of infection and treated promptly if such symptoms or signs occur. Patients with severe neutropenia (absolute neutrophil count < 1000/mm^3) should discontinue LATUDA and have their WBC followed until recovery.

5.8 Orthostatic Hypotension and Syncope

LATUDA may cause orthostatic hypotension, perhaps due to its α1-adrenergic receptor antagonism. The incidence of orthostatic hypotension and syncope events from short-term, placebo-controlled studies was (LATUDA incidence, placebo incidence): orthostatic hypotension [0.4% (4/1004), 0.2% (1/455)] and syncope [< 0.1% (1/1004), 0%]. Assessment of orthostatic hypotension defined by vital sign changes (≥ 20 mm Hg decrease in systolic blood pressure and ≥ 10 bpm increase in pulse from sitting to standing or supine to standing positions). In short-term clinical trials orthostatic hypotension occurred with a frequency of 0.8% with LATUDA 40 mg, 1.4% with LATUDA 80 mg and 1.7% with LATUDA 120 mg compared to 0.9% with placebo.

LATUDA should be used with caution in patients with known cardiovascular disease (e.g., heart failure, history of myocardial infarction, ischemia, or conduction abnormalities), cerebrovascular disease, or conditions that predispose the patient to hypotension (e.g., dehydration, hypovolemia, and treatment with antihypertensive medications). Monitoring of orthostatic vital signs should be considered in patients who are vulnerable to hypotension.

5.9 Seizures

As with other antipsychotic drugs, LATUDA should be used cautiously in patients with a history of seizures or with conditions that lower the seizure threshold, e.g., Alzheimer's dementia. Conditions that lower the seizure threshold may be more prevalent in patients 65 years or older.

In short-term placebo-controlled trials, seizures/convulsions occurred in < 0.1% (1/1004) of patients treated with LATUDA compared to 0.2% (1/455) placebo-treated patients.

5.10 Potential for Cognitive and Motor Impairment

LATUDA, like other antipsychotics, has the potential to impair judgment, thinking or motor skills.

In short-term, placebo-controlled trials, somnolence was reported in 22.3% (224/1004) of patients treated with LATUDA compared to 9.9% (45/455) of placebo patients, respectively. The frequency of somnolence increases with dose; somnolence was reported in 26.5% (77/291) of patients receiving LATUDA 120 mg/day. In these short-term trials, somnolence included: hypersomnia, hypersomnolence, sedation and somnolence.

Patients should be cautioned about operating hazardous machinery, including motor vehicles, until they are reasonably certain that therapy with LATUDA does not affect them adversely.

5.11 Body Temperature Regulation

Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing LATUDA for patients who will be experiencing conditions that may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration *[see Patient Counseling Information (17.9)]*.

5.12 Suicide

The possibility of a suicide attempt is inherent in psychotic illness and close supervision of high-risk patients should accompany drug therapy. Prescriptions for LATUDA should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

In short-term, placebo-controlled studies in patients with schizophrenia, the incidence of treatment-emergent suicidal ideation was 0.6% (6/1004) for LATUDA treated patients compared to 0.4% (2/455) on placebo. No suicide attempts or completed suicides were reported in these studies.

5.13 Dysphagia

Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. LATUDA is not indicated for the treatment of dementia-related psychosis, and should not be used in patients at risk for aspiration pneumonia.

5.14 Use in Patients with Concomitant Illness

Clinical experience with LATUDA in patients with certain concomitant systemic illnesses is limited *[see Use in Specific Populations (8.7, 8.8)]*. LATUDA has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from premarketing clinical studies *[see Warnings and Precautions (5.1, 5.8)]*.

6 ADVERSE REACTIONS

6.1 Overall Adverse Reaction Profile

The following adverse reactions are discussed in more detail in other sections of the labeling:

- Use in Elderly Patients with Dementia-Related Psychosis *[see Boxed Warning and Warnings and Precautions (5.1)]*
- Cerebrovascular Adverse Reactions, Including Stroke *[see Warnings and Precautions (5.2)]*
- Neuroleptic Malignant Syndrome *[see Warnings and Precautions (5.3)]*
- Tardive Dyskinesia *[see Warnings and Precautions (5.4)]*
- Hyperglycemia and Diabetes Mellitus *[see Warnings and Precautions (5.5)]*
- Hyperprolactinemia *[see Warnings and Precautions (5.6)]*
- Leukopenia, Neutropenia, and Agranulocytosis *[see Warnings and Precautions (5.7)]*
- Orthostatic Hypotension and Syncope *[see Warnings and Precautions (5.8)]*
- Seizures *[see Warnings and Precautions (5.9)]*
- Potential for Cognitive and Motor Impairment *[see Warnings and Precautions (5.10)]*
- Body Temperature Regulation *[see Warnings and Precautions (5.11)]*
- Suicide *[see Warnings and Precautions (5.12)]*
- Dysphagia *[see Warnings and Precautions (5.13)]*
- Use in Patients with Concomitant Illness *[see Warnings and Precautions (5.14)]*

The information below is derived from a clinical study database for LATUDA consisting of over 2096 patients with schizophrenia exposed to one or more doses with a total experience of 624 patient-years. Of these patients, 1004 participated in short-term placebo-controlled schizophrenia studies with doses of 20 mg, 40 mg, 80 mg or 120 mg once daily. A total of 533 LATUDA-treated patients had at least 24 weeks and 238 LATUDA-treated patients had at least 52 weeks of exposure.

Adverse events during exposure to study treatment were obtained by general inquiry and voluntarily reported adverse experiences, as well as results from physical examinations, vital signs, ECGs, weights and laboratory investigations. Adverse experiences were recorded by clinical investigators using their own terminology. In order to provide a meaningful estimate of the proportion of individuals experiencing adverse events, events were grouped in standardized categories using MedDRA terminology.

The stated frequencies of adverse reactions represent the proportion of individuals who experienced at least once, a treatment-emergent adverse event of the type listed. Treatment-emergent adverse events were defined as adverse experiences, which started or worsened on or after the date of the first dose through seven days after study medication discontinuation. There was no attempt to use investigator causality assessments; i.e., all events meeting the defined criteria, regardless of investigator causality are included. It is important to emphasize that, although the reactions occurred during treatment with LATUDA, they were not necessarily caused by it. The label should be read in its entirety to gain an understanding of the safety profile of LATUDA.

The figures in the tables and tabulations cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical studies. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatment, uses and investigators. The cited figures, however, do provide the prescriber with some basis for estimating the relative contribution of drug and nondrug factors to the adverse reaction incidence in the population studied.

6.2 Clinical Studies Experience

The following findings are based on the short-term placebo-controlled premarketing studies for schizophrenia in which LATUDA was administered at daily doses ranging from 20 to 120 mg (n = 1004).

Commonly Observed Adverse Reactions: The most common adverse reactions (incidence ≥ 5% and at least twice the rate of placebo) in patients treated with LATUDA were somnolence, akathisia, nausea, parkinsonism and agitation.

Adverse Reactions Associated with Discontinuation of Treatment: A total of 9.4% (94/1004) LATUDA-treated patients and 5.9% (27/455) of placebo-treated patients discontinued due to adverse reactions. There were no adverse reactions associated with discontinuation in subjects treated with LATUDA that were at least 2% and at least twice the placebo rate.

Adverse Reactions Occurring at an Incidence of 2% or More in LATUDA-Treated Patients: Adverse reactions associated with the use of LATUDA (incidence of 2% or greater, rounded to the nearest percent and LATUDA incidence greater than placebo) that occurred during acute therapy (up to 6-weeks in patients with schizophrenia) are shown in Table 5.

Table 5: Adverse Reaction in 2% or More of LATUDA-Treated Patients and That Occurred at Greater Incidence than in the Placebo-Treated Patients in Short-term Schizophrenia Studies

	Percentage of Patients Reporting Reaction	
Body System or Organ Class Dictionary-derived Term	**Placebo (N=455)**	**All LATUDA (N=1004)**
Gastrointestinal Disorders		
Nausea	6	12
Vomiting	6	8
Dyspepsia	6	8
Salivary hypersecretion	<1	2
General Disorders and Administration Site Conditions		
Fatigue	3	4
Musculoskeletal and Connective Tissue Disorders		
Back Pain	3	4
Nervous System Disorders		
Somnolence*	10	22
Akathisia	3	15
Parkinsonism**	5	11
Dystonia***	1	5
Dizziness	3	5
Psychiatric Disorders		
Insomnia	7	8
Agitation	3	6
Anxiety	3	6
Restlessness	2	3

Note: Figures rounded to the nearest integer
*Somnolence includes adverse event terms: hypersomnia, hypersomnolence, sedation, and somnolence
**Parkinsonism includes adverse event terms: bradykinesia, cogwheel rigidity, drooling, extrapyramidal disorder, hypokinesia, muscle rigidity, parkinsonism, psychomotor retardation, and tremor
***Dystonia includes adverse event terms: dystonia, oculogyric crisis, oromandibular dystonia, tongue spasm, torticollis, and trismus

6.3 Dose-Related Adverse Reactions

Based on the pooled data from the placebo-controlled, short-term, fixed-dose studies, among the adverse reactions that occurred with a greater than 5% incidence in the patients treated with LATUDA, the apparent dose-related adverse reactions were akathisia and somnolence (Table 6).

Table 6: Dose-Related Adverse Events

	Percentage of Subjects Reporting Reaction				
Adverse Event Term	**Placebo (N=455) (%)**	**LATUDA 20 mg/day (N=71) (%)**	**LATUDA 40 mg/day (N=360) (%)**	**LATUDA 80 mg/day (N=282) (%)**	**LATUDA 120 mg/day (N=291) (%)**
Akathisia	3	6	11	15	22
Somnolence*	10	15	19	23	26

Note: Figures rounded to the nearest integer
*Somnolence includes adverse event terms: hypersomnia, hypersomnolence, sedation, and somnolence

6.4 Extrapyramidal Symptoms

In the short-term, placebo-controlled schizophrenia studies, for LATUDA-treated patients, the incidence of reported EPS-related events, excluding akathisia and restlessness, was 14.7% versus 5.1% for placebo-treated patients; and the incidence of akathisia for LATUDA-treated patients was 15.0% versus 3.3% for placebo-treated patients. Akathisia appeared to be dose-related and the greatest frequency of parkinsonism and dystonia occurred with the highest dose of LATUDA, 120 mg/day (Table 7).

Table 7: Percentage of EPS Compared to Placebo

Adverse Event Term	Placebo (N=455) (%)	LATUDA 20 mg/day (N=71) (%)	LATUDA 40 mg/day (N=360) (%)	LATUDA 80 mg/day (N=282) (%)	LATUDA 120 mg/day (N=291) (%)
All EPS events	9	10	24	26	39
All EPS events, excluding Akathisia/ Restlessness	5	6	13	11	22
Akathisia	3	6	11	15	22
Dystonia*	1	0	4	5	7
Parkinsonism**	5	6	10	7	17
Restlessness	2	1	4	1	3

Note: Figures rounded to the nearest integer
*Dystonia includes adverse event terms: dystonia, oculogyric crisis, oromandibular dystonia, tongue spasm, torticollis, and trismus
**Parkinsonism includes adverse event terms: bradykinesia, cogwheel rigidity, drooling, extrapyramidal disorder, hypokinesia, muscle rigidity, parkinsonism, psychomotor retardation, and tremor

In the short-term, placebo-controlled schizophrenia studies, data was objectively collected on the Simpson Angus Rating Scale for extrapyramidal symptoms (EPS), the Barnes Akathisia Scale (for akathisia) and the Abnormal Involuntary Movement Scale (for dyskinesias). The mean change from baseline for LATUDA-treated patients was comparable to placebo-treated patients, with the exception of the Barnes Akathisia Scale global score (LATUDA, 0.2; placebo, 0.0). The percentage of patients who shifted from normal to abnormal was greater in LATUDA-treated patients versus placebo for the BAS (LATUDA, 16.0%; placebo, 7.6%) and the SAS (LATUDA, 5.3%; placebo, 2.5%).

Dystonia

Class Effect: Symptoms of dystonia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during the first few days of treatment. Dystonic symptoms include: spasm of the neck muscles, sometimes progressing to tightness of the throat, swallowing difficulty, difficulty breathing, and/or protrusion of the tongue. While these symptoms can occur at low doses, they occur more frequently and with greater severity with high potency and at higher doses of first generation antipsychotic drugs. An elevated risk of acute dystonia is observed in males and younger age groups.

In the short-term, placebo-controlled clinical trials, dystonia occurred in 4.7% of LATUDA-treated subjects (0.0% LATUDA 20 mg, 4.2% LATUDA 40 mg, 4.6% LATUDA 80 mg and 6.5% LATUDA 120 mg) compared to 0.7% of subjects receiving placebo. Seven subjects (0.7%, 7/1004) discontinued clinical trials due to dystonic events – 4 were receiving LATUDA 80 mg/day and 3 were receiving LATUDA 120 mg/day.

6.5 Laboratory Test Abnormalities and ECG Changes in Clinical Studies

Laboratory Test Abnormalities

In a between-group comparison of the pooled data from short-term, placebo-controlled studies, there were no clinically important changes in total cholesterol measurements; triglycerides or glucose from Baseline to Endpoint [*see Warnings and Precautions (5.5)*]. There were also no clinically important differences between LATUDA and placebo in mean change from baseline to endpoint in routine hematology, urinalysis, or serum chemistry. LATUDA was associated with a dose-related increase in prolactin concentration [*see Warnings and Precautions (5.6)*]

Creatinine: In short-term, placebo-controlled trials, the mean change from Baseline in creatinine was 0.06 mg/dL for LATUDA-treated patients compared to 0.03 mg/dL for placebo-treated patients. A creatinine shift from normal to high occurred in 3.1% (30/977) of LATUDA-treated patients and 1.4% (6/439) on placebo. The threshold for high creatinine value varied from ≥ 1.1 to ≥ 1.3 mg/dL based on the centralized laboratory definition for each study [*see Dosage in Special Population; Use in Specific Populations*].

Transaminases: The mean changes in AST and ALT for LATUDA- and placebo-treated patients were similar. The proportion of patients with transaminases (AST and ALT) elevations ≥ 3 times ULN was similar for all LATUDA-treated patients (0.8% and 0.8%, respectively) to placebo-treated patients (0.9% and 1.1%, respectively).

ECG Changes

Electrocardiogram (ECG) measurements were taken at various time points during the LATUDA clinical trial program. No post-baseline QT prolongations exceeding 500 msec were reported in patients treated with LATUDA. Within a subset of patients defined as having an increased cardiac risk, no potentially important changes in ECG parameters were observed. No cases of torsade de pointes or other severe cardiac arrhythmias were observed in the pre-marketing clinical program.

The effects of LATUDA on the QT/QTc interval were evaluated in a dedicated QT study involving 87 clinically stable patients with schizophrenia or schizoaffective disorder, who were treated with LATUDA doses of 120 mg daily, 600 mg daily, or ziprasidone 160 mg daily. Holter monitor-derived electrocardiographic assessments were obtained over an eight hour period at baseline and steady state. No patients treated with LATUDA experienced QTc increases > 60 msec from baseline, nor did any patient experience a QTc of > 500 msec.

6.6 Other Adverse Reactions Observed During the Premarketing Evaluation of LATUDA

Following is a list of MedDRA terms that reflect adverse reactions reported by patients treated with LATUDA at multiple doses of ≥ 20 mg once daily during any phase of a study within the database of 2096 patients. The reactions listed are those that could be of clinical importance, as well as reactions that are plausibly drug-related on pharmacologic or other grounds. Reactions listed in Table 5 are not included. Although the reactions reported occurred during treatment with LATUDA, they were not necessarily caused by it.

Reactions are further categorized by MedDRA system organ class and listed in order of decreasing frequency according to the following definitions: those occurring in at least 1/100 patients (frequent) (only those not already listed in the tabulated results from placebo-controlled studies appear in this listing); those occurring in 1/100 to 1/1000 patients (infrequent); and those occurring in fewer than 1/1000 patients (rare).

Blood and Lymphatic System Disorders: ***Infrequent:*** *anemia;* ***Rare:*** *leukopenia, neutropenia*
Cardiac Disorders: ***Frequent:*** *tachycardia;* ***Infrequent:*** *AV block 1st degree, angina pectoris, bradycardia*
Ear and Labyrinth Disorders: ***Infrequent:*** *vertigo*
Eye disorders: ***Frequent:*** *blurred vision*
Gastrointestinal Disorders: ***Frequent:*** *abdominal pain, diarrhea;* ***Infrequent:*** *gastritis, dysphagia*
General Disorders and Administrative Site Conditions: ***Rare:*** *Sudden death*
Investigations: ***Frequent:*** *CPK increased*
Metabolic and Nutritional System Disorders: ***Frequent:*** *decreased appetite*
Musculoskeletal and Connective Tissue Disorders: ***Rare:*** *rhabdomyolysis*
Nervous System Disorders: ***Infrequent:*** *tardive dyskinesia, cerebrovascular accident, dysarthria, syncope;* ***Rare:*** *neuroleptic malignant syndrome, seizure*
Psychiatric Disorders: ***Infrequent:*** *abnormal dreams, panic attack, sleep disorder;* ***Rare:*** *suicidal behavior*
Renal and Urinary Disorders: ***Infrequent:*** *dysuria;* ***Rare:*** *renal failure*
Reproductive System and Breast Disorders: ***Infrequent:*** *amenorrhea, dysmenorrhea;* ***Rare:*** *breast enlargement, breast pain, galactorrhea, erectile dysfunction*
Skin and Subcutaneous Tissue Disorders: ***Frequent:*** *rash, pruritus;* ***Rare:*** *angioedema*
Vascular Disorders: ***Infrequent:*** *hypertension, orthostatic hypotension*

7 DRUG INTERACTIONS

Given the primary CNS effects of LATUDA, caution should be used when it is taken in combination with other centrally acting drugs and alcohol.

7.1 Potential for Other Drugs to Affect LATUDA

LATUDA is not a substrate of CYP1A1, CYP1A2, CYP2A6, CYP4A11, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6 or CYP2E1 enzymes. This suggests that an interaction of LATUDA with drugs that are inhibitors or inducers of these enzymes is unlikely.

LATUDA is predominantly metabolized by CYP3A4; interaction of LATUDA with strong and moderate inhibitors or inducers of this enzyme has been observed (Table 8). LATUDA should not be used in combination with strong inhibitors or inducers of this enzyme *[see Contraindications (4)]*.

Table 8: Summary of Effect of Coadministered Drugs on Exposure to LATUDA in Healthy Subjects or Patients with Schizophrenia

Coadministered drug	Dose schedule		Effect on LATUDA pharmacokinetics		Recommendation
	Coadministered drug	LATUDA	C_{max}	AUC	
Ketoconazole (strong CYP3A4 inhibitor)	400 mg/day for 5 days	10 mg single dose	6.9-times LATUDA alone	9-times LATUDA alone	Should not be coadministered with LATUDA
Diltiazem (moderate CYP3A4 inhibitor)	240 mg/day for 5 days	20 mg single dose	2.1-times LATUDA alone	2.2-times LATUDA alone	LATUDA dose should not exceed 40 mg/day if coadministered
Rifampin (strong CYP3A4 inducer)	600 mg/day for 8 days	40 mg single dose	1/7th of LATUDA alone	1/5th of LATUDA alone	Should not be coadministered with LATUDA
Lithium	600 mg BID for 8 days	120 mg/day for 8 days	0.9-times LATUDA alone	1.1- times LATUDA alone	No LATUDA dose adjustment required.

7.2 Potential for LATUDA to Affect Other Drugs

Digoxin (P-gp substrate): Coadministration of LATUDA (120 mg/day) at steady state with a single dose of digoxin (0.25 mg) increased C_{max} and $AUC_{(0-24)}$ for digoxin by approximately 9% and 13%, respectively relative to digoxin alone. Digoxin dose adjustment is not required when coadministered with LATUDA.

Midazolam (CYP3A4 substrate): Coadministration of LATUDA (120 mg/day) at steady state with a single dose of 5 mg midazolam increased midazolam C_{max} and $AUC_{(0-24)}$ by approximately 21% and 44%, respectively relative to midazolam alone. Midazolam dose adjustment is not required when coadministered with LATUDA.

Oral Contraceptive (estrogen/progesterone): Coadministration of LATUDA (40 mg/day) at steady state with an oral contraceptive (OC) containing ethinyl estradiol and norelgestimate resulted in equivalent $AUC_{(0-24)}$ and C_{max} of ethinyl estradiol and norelgestromin relative to OC administration alone. Also, sex hormone binding globulin levels were not meaningfully affected by coadministration of LATUDA and OC. Dose adjustment of OC dose is not required when coadministered with LATUDA.

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Teratogenic Effects

Pregnancy Category B

Lurasidone was not teratogenic in rats and rabbits. There are no adequate and well-controlled studies of LATUDA in pregnant women.

No teratogenic effects were seen in studies in which pregnant rats and rabbits were given lurasidone during the period of organogenesis at doses up to 25 and 50 mg/kg/day, respectively. These doses are 3 and 12 times, in rats and rabbits respectively, the maximum recommended human dose (MRHD) of 80 mg/day based on body surface area.

No adverse developmental effects were seen in a study in which pregnant rats were given lurasidone during the period of organogenesis and continuing through weaning at doses up to 10 mg/kg/day; this dose is approximately equal to the MRHD based on body surface area.

Non-teratogenic Effects

Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress and feeding disorder in these neonates. These complications have varied in severity; while in some cases symptoms have been self-limited, in other cases neonates have required intensive care unit support and prolonged hospitalization.

LATUDA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

8.3 Labor and Delivery

The effect of LATUDA on labor and delivery in humans is unknown.

8.4 Nursing Mothers

LATUDA was excreted in milk of rats during lactation. It is not known whether LATUDA or its metabolites are excreted in human milk. Breast feeding in women receiving LATUDA should be considered only if the potential benefit justifies the potential risk to the child.

8.5 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.6 Geriatric Use

Clinical studies of LATUDA in the treatment of schizophrenia did not include sufficient numbers of patients aged 65 and older to determine whether or not they respond differently from younger patients. In elderly patients with psychosis (65 to 85), lurasidone concentrations (20 mg/day) were similar to those in young subjects *[see Clinical Pharmacology]*. No dose adjustment is necessary in elderly patients.

Elderly patients with dementia-related psychosis treated with LATUDA are at an increased risk of death compared to placebo. LATUDA is not approved for the treatment of patients with dementia-related psychosis *[see Boxed Warning]*.

8.7 Renal Impairment

It is recommended that LATUDA dose should not exceed 40 mg/day in patients with moderate and severe renal impairment ($Cl_{cr} \geq 10$ mL/min to < 50 mL/min).

After administration of a single dose of 40 mg LATUDA to patients with mild, moderate and severe renal impairment, mean C_{max} increased by 40%, 92% and 54%, respectively and mean $AUC_{(0-\infty)}$ increased by 53%, 91% and 2- times, respectively compared to healthy matched subjects.

8.8 Hepatic Impairment

It is recommended that LATUDA dose should not exceed 40 mg/day in patients with moderate and severe hepatic impairment (Child-Pugh Class B and C). In a single-dose study of LATUDA 20 mg, lurasidone mean $AUC_{(0-last)}$ was 1.5-times higher in subjects with mild hepatic impairment (Child-Pugh Class A), 1.7-times higher in subjects with moderate hepatic impairment (Child-Pugh Class B) and 3-times higher in subjects with severe hepatic impairment (Child-Pugh Class C) compared to the values for healthy matched subjects. Mean C_{max} was 1.3, 1.2 and 1.3-times higher for mild, moderate and severe hepatically impaired patients respectively, compared to the values for healthy matched subjects.

8.9 Gender

Population pharmacokinetic evaluation indicated that the mean AUC of LATUDA was 18% higher in women than in men, and correspondingly, the apparent oral clearance of LATUDA was lower in women. Mean C_{max} of LATUDA was similar between women and men. No dosage adjustment of LATUDA is recommended based on gender.

8.10 Race

Although no specific pharmacokinetic study was conducted to investigate the effects of race on the disposition of LATUDA, population pharmacokinetic evaluation revealed no evidence of clinically significant race-related differences in the pharmacokinetics of LATUDA. No dosage adjustment of LATUDA is recommended based on race.

8.11 Smoking Status

Based on in vitro studies utilizing human liver enzymes, LATUDA is not a substrate for CYP1A2; smoking is therefore not expected to have an effect on the pharmacokinetics of LATUDA.

10. OVERDOSAGE

10.1 Human Experience

In premarketing clinical studies involving more than 2096 patients and/or healthy subjects, accidental or intentional overdosage of LATUDA was identified in one patient who ingested an estimated 560 mg of LATUDA. This patient recovered without sequelae. This patient resumed LATUDA treatment for an additional two months.

10.2 Management of Overdosage

Consult a Certified Poison Control Center for up-to-date guidance and advice. There is no specific antidote to LATUDA, therefore, appropriate supportive measures should be instituted and close medical supervision and monitoring should continue until the patient recovers.

Cardiovascular monitoring should commence immediately, including continuous electrocardiographic monitoring for possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide, and quinidine carry a theoretical hazard of additive QT-prolonging effects when administered in patients with an acute overdose of LATUDA. Similarly the alpha-blocking properties of bretylium might be additive to those of LATUDA, resulting in problematic hypotension.

Hypotension and circulatory collapse should be treated with appropriate measures. Epinephrine and dopamine should not be used, or other sympathomimetics with beta-agonist activity, since beta stimulation may worsen hypotension in the setting of LATUDA-induced alpha blockade. In case of severe extrapyramidal symptoms, anticholinergic medication should be administered.

Gastric lavage (after intubation if patient is unconscious) and administration of activated charcoal together with a laxative should be considered.

The possibility of obtundation, seizures, or dystonic reaction of the head and neck following overdose may create a risk of aspiration with induced emesis.

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Human Rights Award

Purpose:

The Human Rights Award was established to recognize an individual and an organization whose efforts exemplify the capacity of human beings to act courageously and effectively to prevent human rights violations, to protect others from human rights violations and their psychiatric consequences, and to help victims recover from human rights abuses.

Nomination Procedures:

APA members are asked to submit nominations by **July 1, 2011** to:

Council on Psychiatry and Law
American Psychiatric Association
c/o Lori Klinedinst, Staff Liaison
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209
E-mail: advocacy@psych.org

The nomination letter should succinctly describe the contributions that are the basis for the nomination and be accompanied by a curriculum vitae of the nominee. The Council on Psychiatry and Law will serve as the award review panel in determining the recipients of this award. The recipients will receive a plaque which will be awarded during the Convocation at the APA's Annual Meeting in May.

Isaac Ray Award

The American Psychiatric Association and the American Academy of Psychiatry and the Law invites nominations for the Isaac Ray Award for 2012. This Award honors Dr. Isaac Ray, one of the original founders and the fourth President of the American Psychiatric Association, and is presented to a person who has made outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence. The Award, which will be presented at the Convocation of Fellows at the Annual Meeting of the American Psychiatric Association in Philadelphia, PA, in May 2012, includes an honorarium of $1,500. The recipient obligates him or herself to deliver a lecture or series of lectures on these subjects and to present the manuscript for publication.

Nominations are requested as follows: (1) a primary nominating letter (sent with the consent of the candidate), which includes a curriculum vitae and specific details regarding the candidate's qualifications for the Award, and (2) a supplemental letter from a second nominator in support of the candidate. Additional letters related to any particular candidate will not be accepted or reviewed by the Award Committee. Nominators should not submit letters on behalf of more than one candidate. The deadline for receipt of nominations is **July 1, 2011**. Nominations will be kept in the pool of applicants for two years. Nominations, as outlined above, should be submitted to:

Renee L. Binder, M.D., Chairperson, c/o Lori Klinedinst, Staff Liaison, Isaac Ray Award Committee, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209, E-mail: advocacy@psych.org

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LOUISIANA

FORENSIC PSYCHIATRY FELLOWSHIP DIRECTOR

The Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine is recruiting a forensic psychiatry fellowship training director for a full-time faculty position. The candidate selected for this position will assume the responsibilities for the Directorship of the fully accredited Forensic Fellowship Program. He/she will lead the forensic team responsible for supervision of residents, forensic fellows, and medical students during their rotations at Feliciana Forensic Facility and in various state mental health facilities where they will provide clinical services. He/she must be professionally competent and be board certified in general psychiatry and in forensic psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Salary will be competitive and commensurate with the level of the candidate's academic appointment. We will continue to accept applications for this position until a suitable qualified candidate is identified.

Qualified applicants should send email of interest, updated CV and list of references to John W. Thompson, Jr, MD, Professor and Vice Chair for Adult Psychiatry, Director of the Division of Forensic Neuropsychiatry at jthomps3@tulane.edu.

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The Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine is recruiting a geriatric psychiatrist for a full-time faculty position. The candidate will spend part of their time at the Southeast Louisiana Veterans Health Care System (SLVHCS) and will also be involved in the new initiatives in both clinical geriatric care and special geriatric education programs at Tulane. Responsibilities include patient care as well as contributing to the various teaching and training programs of Tulane University's Department of Psychiatry and Behavioral Sciences at the SLVHCS. He/she will be provided the opportunity to pursue their research interests. The person selected for this position must be professionally competent and be board eligible/certified in general psychiatry and in geriatric psychiatry. She/he must be eligible for medical licensure in the State of Louisiana and have a current state and federal narcotics number. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Salary will be competitive and commensurate with the level of the candidate's academic appointment. Applications will be accepted until a suitable qualified candidate is found.

Applicants should email (winstead@tulane.edu) or send letter of interest, updated CV and list of references to Daniel K. Winstead, MD, Heath Professor and Chair, Department of Psychiatry and Behavioral Sciences, Tulane University School of Medicine, 1440 Canal Street TB48, New Orleans, LA 70112. Interested and eligible candidates may obtain further information by contacting Daniel K. Winstead, MD at 504-988-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admissions and in employment.

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American Psychiatric Association

164th ANNUAL MEETING MAY 14-18, 2011, HONOLULU, HAWAII

HIGHLIGHTS

Distinguished Psychiatrist Lecturers: Alan F. Schatzberg, M.D.; Laura W. Roberts, M.D.; Nancy C. Andreasen, M.D., Ph.D.; Loree K. Sutton, M.D.; Darrell G. Kirch, M.D.; and Sarah H. Lisanby, M.D.

Frontiers of Science Lecturers: Nora D. Volkow, M.D. Director, National Institute of Drug Abuse; Sabine Bahn, M.D., Ph.D. with The Cambridge Centre for Neuropsychiatric Research, The Bahn Laboratory; Ian Hickie, M.D., A.M. Executive Director, The Brain and Mind Research Institute.

Special Guest Lecturers: Barry C. Scheck, J.D., Director of the Innocence Project; Michael Owen, M.D., Ph.D., Director, Center for Neuropsychiatric Genetics and Genomics.

Advances in Series: Advances in Personality Disorders, John Oldham, M.D.; Advances in Psychotherapeutic Treatments, Glen O. Gabbard, M.D.; Advances in Substance Abuse Treatment, Marc Galanter, M.D. and Herbert Kleber, M.D.; Advances in Psychopharmacology, Alan F. Schatzberg, M.D., and Charles Nemeroff, M.D..

Advances in Medicine: Monique Yohanan, M.D., Internal Medicine; Robert McCarron, D.O., Medical Mysteries; Richard F. Arakaki, M.D., Seizure Disorders; Alan Stein, M.D., Diabetes.

Advances in Research: Herbert Pardes, M.D., CEO of the New York-Presbyterian Hospital.

- Come Early! Scientific Sessions will begin at 7:00 AM Sat., May 14, 2011 and end on Wed., May 18, 2011 at 12:30 PM
  Daily Programming Times: Scientific sessions run from 7:00 AM - 3:00 PM • Courses run from 7:00 AM - 3:30 PM
- Check for program updates by visiting our web site: **www.psych.org/2011program**
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A Vital Resource to Help You Treat Traumatic Brain Injury

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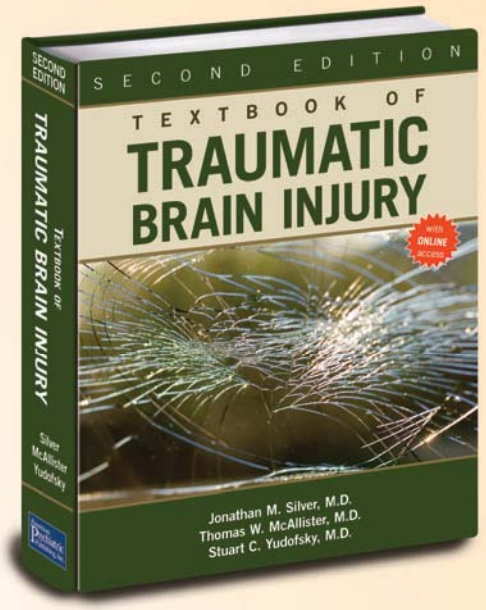

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As soldiers and combat veterans have returned from the wars in Iraq and Afghanistan traumatic brain injury (TBI) has been identified as the "signature injury" of those wars. This new edition of *Textbook of Traumatic Brain Injury* has been thoroughly revised and updated from the 2005 first edition to reflect the exponential expansion of research and clinical data amassed in the intervening years. Each chapter was written and reviewed by the foremost authorities in neuropsychiatry, neurology, rehabilitation medicine, and the other specialties who assess, diagnose, and treat these patients.

Key features include:

- New chapters on epidemiology, neuropathology, and genetics of TBI
- A new chapter on TBI in the military
- A new chapter on posttraumatic stress disorder (PTSD), which emphasizes the common co-occurrence of TBI and PTSD
- Enhanced coverage of psychopharmacology and psychotherapy for the psychiatric symptoms associated with TBI
- Information on the social ramifications of TBI so that clinicians will better understand and help their patients cope with the complex legal, financial, and insurance-based struggles their patients who have sustained TBI encounter
- Chapters that are complete, readable, and relevant in themselves, reflecting the editors' understanding that few readers digest a work of this magnitude in a single sitting
- A Foreword written by Bob Woodruff (the ABC World News correspondent who sustained a TBI while covering the war in Iraq) and his wife, Lee Woodruff, who underscore that although this volume is intended to be read primarily by professionals, patients and families may also find the information in the textbook to be of keen interest and practical application.

The book has been closely edited to achieve a level of writing that is consistent and engaging and that addresses the needs of all medical professionals—including the full range of mental health professionals—who care for people who suffer from TBI. This new edition of *Textbook of Traumatic Brain Injury* represents a huge step forward for the diagnosis and treatment of TBI.

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