

# POLICY & PRACTICE

## Neurology Outlook for 2006

Malpractice reform will continue to be a top priority for the American Academy of Neurology in 2006, according to Mike Amery, AAN's federal affairs manager, in Washington. Also high on the agenda is Medicare reimbursement. Funding for the National Institutes of Health also is a concern for the academy; NIH ended up with an increase of 1%, to \$28.6 billion, in the budget passed by Congress. Ideally, "we'd like to see an 8-10% [increase], but that's not going to happen in these fiscal times," Mr. Amery said.

## Help for Vets with MS Proposed

Sen. Patty Murray (D-Wash.) has proposed legislation to help more veterans with multiple sclerosis qualify for disability benefits from the Department of Veterans Affairs. "A growing number of veterans from the first Gulf War are now developing symptoms of multiple sclerosis, but they often face an uphill battle in obtaining disability benefits from the VA," the senator's office noted in a press release. Under current law, veterans of the United States military have 7 years after discharge to connect multiple sclerosis to their mil-

itary service; however, many veterans don't start developing symptoms of the disease until after that time, forcing them to go through a long appeals process to prove their disability is related to their service. The bill would remove the 7-year limitation and make multiple sclerosis a "presumptive disability," entitling them to care no matter when their symptoms appear. So far, about 500 Gulf War veterans have been diagnosed with service-connected multiple sclerosis, and many more are symptomatic but not yet diagnosed, according to Julie Mock, president of the National Gulf War Resource Center and a patient with multiple sclerosis.

## Responders Need Epilepsy Training

The Epilepsy Foundation is calling for better training of first responders after the death of an epilepsy patient who was restrained by emergency personnel. "Unfortunately, first responders all too often employ forcible restraint methods as a means of subduing persons who may appear to be combative but are actually displaying typical symptoms of a seizure," said foundation president and CEO Eric Hargis. "Avoidable injuries and deaths will persist unless action is taken to educate and train first responders." In the case of an Arizona State University student, emergency medical technicians, thinking the patient was being combative, forcibly restrained him after he was handcuffed behind his back and left him prone for 20 minutes. The jury found that the technicians were not responsible for the patient's death.

## Neurologist Takes FDA Post

Dr. Gerald J. Dal Pan is the new director of the Food and Drug Administration's Office of Drug Safety. In his new position, Dr. Dal Pan is in charge of the FDA's post-marketing drug safety program.

## Neurointensive Subspecialty Approved

The United Council for Neurologic Subspecialties has approved neurointensive care for membership in its organization. The neurointensive care application was sponsored by the American Academy of Neurology's critical care and emergency neurology section as well as the Neurocritical Care Society and the Society of Neurosurgical Anesthesia and Critical Care. The council's accrediting body now will work with the subspecialty on requirements for fellowship programs. The programs will then be able to apply for accreditation by the council. The council also will help develop a neurointensive care certification exam. The subspecialty will be given a voting seat on the council's board of directors. Neurointensive care joins behavioral neurology and neuropsychiatry, neurooncology, clinical neuro-muscular pathology, and headache medicine on the list of council-approved subspecialties. The council itself is sponsored by five parent organizations: the AAN, the American Neurological Association, the Association of University Professors of Neurology, the Child Neurology Society, and Professors of Child Neurology. Its goal is "to recognize added competence and to assist subspecialties that have matured to the point where accreditation of training programs and certification of graduates is appropriate, yet these subspecialties are not able to seek, or have not grown sufficiently for, American Board of Psychiatry and Neurology certification."

—Joyce Frieden

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**References:** 1. Ambrosini PJ, Lopez FA, Chandler MC, et al. An open-label community assessment of ADDERALL XR in pediatric ADHD. Poster presented at: 155th Annual Meeting of the American Psychiatric Association; May 22, 2002; Philadelphia, Pa. 2. Data on file, Shire US Inc., 2006. 3. Biederman J, Lopez FA, Boellner SW, Chandler MC, et al. Randomized, double-blind, placebo-controlled, parallel-group study of SL1381 (Adderall XR) in children with attention-deficit/hyperactivity disorder. *Pediatrics*. 2002;110:258-266. 4. McCracken JT, Biederman J, Greenhill LL, et al. Analog classroom assessment of a once-daily mixed amphetamine formulation, SL1381 (ADDERALL XR), in children with ADHD. *J Am Acad Child Adolesc Psychiatry*. 2003;42:673-683. 5. Lopez FA, Ambrosini PJ, Chandler MC, et al. ADDERALL XR in pediatric ADHD: quality of life measures from an open-label community assessment trial. Poster presented at: 14th Annual CHADD International Conference; October 17, 2002; Miami Beach, Fla.

**BRIEF SUMMARY:** Consult the full prescribing information for complete product information.

### ADDERALL XR® CAPSULES

### Cl Rx Only

AMPHETAMINES HAVE A HIGH POTENTIAL FOR ABUSE. ADMINISTRATION OF AMPHETAMINES FOR PROLONGED PERIODS OF TIME MAY LEAD TO DRUG DEPENDENCE. PARTICULAR ATTENTION SHOULD BE PAID TO THE POSSIBILITY OF SUBJECTS OBTAINING AMPHETAMINES FOR NON-THERAPEUTIC USE OR DISTRIBUTION TO OTHERS AND THE DRUGS SHOULD BE PRESCRIBED OR DISPENSED SPARINGLY. MISUSE OF AMPHETAMINE MAY CAUSE SUDDEN DEATH AND SERIOUS CARDIOVASCULAR ADVERSE EVENTS.

### INDICATIONS

ADDERALL XR® is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). The efficacy of ADDERALL XR® in the treatment of ADHD was established on the basis of two controlled trials in children aged 6 to 12, one controlled trial in adolescents aged 13 to 17, and one controlled trial in adults who met DSM-IV® criteria for ADHD, along with extrapolation from the known efficacy of ADDERALL®, the immediate-release formulation of this substance.

### CONTRAINDICATIONS

Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

### WARNINGS

**Psychosis:** Clinical experience suggests that, in psychotic patients, administration of amphetamine may exacerbate symptoms of behavior disturbance and thought disorder.

**Long-Term Suppression of Growth:** Data are inadequate to determine whether chronic use of stimulants in children, including amphetamine, may be causally associated with suppression of growth. Therefore, growth should be monitored during treatment, and patients who are not growing or gaining weight as expected should have their treatment interrupted.

**Sudden Death and Pre-existing Structural Cardiac Abnormalities:** Sudden death has been reported in association with amphetamine treatment at usual doses in children with structural cardiac abnormalities. Adderall XR® generally should not be used in children, adolescents, or adults with structural cardiac abnormalities.

### PRECAUTIONS

**General:** The least amount of amphetamine feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose.

**Hypertension:** Caution is to be exercised in prescribing amphetamines for patients with even mild hypertension (see CONTRAINDICATIONS). Blood pressure and pulse should be monitored at appropriate intervals in patients taking ADDERALL XR®, especially patients with hypertension.

Sustained increases in blood pressure should be treated with dose reduction and/or appropriate medication. In a controlled 4-week outpatient clinical study of adolescents with ADHD, isolated systolic blood pressure elevations  $\geq 15$  mmHg were observed in 11% (17/154) placebo-treated patients receiving ADDERALL XR 10 or 20 mg. Isolated elevations in diastolic blood pressure  $\geq 8$  mmHg were observed in 16/64 (25%) placebo-treated patients and 22/100 (22%) ADDERALL XR-treated patients. Similar results were observed at higher doses.

In a single-dose pharmacokinetic study in 23 adolescents, isolated increases in systolic blood pressure (above the upper 95% CI for age, gender and stature) were observed in 2/17 (12%) and 8/23 (35%), subjects administered 10 mg and 20 mg ADDERALL XR®, respectively. Higher single doses were associated with a greater increase in systolic blood pressure. All increases were transient, appeared maximal at 2 to 4 hours post dose and not associated with symptoms.

**Tics:** Amphetamines have been reported to exacerbate motor and phonic tics and Tourette's syndrome. Therefore, clinical evaluation for tics and Tourette's syndrome in children and their families should precede use of stimulant medications.

**Effects on Weight:** Amphetamines have been associated with decreased appetite. Absolute weight increases in treated children over time, but the increases are smaller than expected based on CDC normative values. These reductions in expected weight attenuate over time and are greatest in the heaviest children. In the controlled trial in adolescents, mean weight change from baseline within the initial 4 weeks of therapy was -1.1 lbs. and -2.8 lbs., respectively, for patients receiving 10 mg and 20 mg ADDERALL XR®. Higher doses were associated with greater weight loss within the initial 4 weeks of treatment.

**Information for Patients:** Amphetamines may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or vehicles; the patient should therefore be cautioned accordingly.

**Drug Interactions:** **Acidifying agents**—Gastrointestinal acidifying agents (guanethidine, reserpine, glutamic acid HCl, ascorbic acid, etc.) lower absorption of amphetamines. **Urinary acidifying agents**—These agents (ammonium chloride, sodium acid phosphate, etc.) increase the concentration of the ionized species of the amphetamine molecule, thereby increasing urinary excretion. Both groups of agents lower blood levels and efficacy of amphetamines. **Adrenergic blockers**—Adrenergic blockers are inhibited by amphetamines. **Alkalinizing agents**—Gastrointestinal alkalinizing agents (sodium bicarbonate, etc.) increase absorption of amphetamines. Co-administration of ADDERALL XR® and gastrointestinal alkalinizing agents, such as antacids, should be avoided. Urinary alkalinizing agents (acetazolamide, some thiazides) increase the concentration of the non-ionized species of the amphetamine molecule, thereby decreasing urinary excretion. Both groups of agents increase blood levels and therefore potentiate the actions of amphetamines. **Antidepressants**—Tricyclic antidepressants may enhance the activity of tricyclic antidepressants or sympathomimetic agents; d-amphetamine with desipramine or protriptyline and possibly other tricyclics cause striking and sustained increases in the concentration of d-amphetamine in the brain; cardiovascular effects can be potentiated. **MAO inhibitors**—MAOI antidepressants, as well as a metabolite of furazolidone, slow amphetamine metabolism. This slowing potentiates amphetamines, increasing their effect on the release of norepinephrine and other monoamines from adrenergic nerve endings; this can cause headaches and other signs of hypertensive crisis. A variety of toxic neurological effects and malignant hyperpyrexia can occur, sometimes with fatal results. **Antihistamines**—Amphetamines may counteract the sedative effect of antihistamines. **Antihypertensives**—Amphetamines may antagonize the hypotensive effects of antihypertensives. **Chlorpromazine**—Chlorpromazine blocks dopamine and norepinephrine receptors, thus inhibiting the central stimulant effects of amphetamines, and can be used to treat amphetamine poisoning. **Ethosuximide**—Amphetamines may delay intestinal absorption of ethosuximide.

**Haloperidol**—Haloperidol blocks dopamine receptors, thus inhibiting the central stimulant effects of amphetamines. **Lithium carbonate**—The anorectic and stimulatory effects of amphetamines may be inhibited by lithium carbonate. **Meprobamate**—Amphetamines potentiate the effects of meprobamate. **Methamphetamine**—Urinary excretion of amphetamines is increased, and efficacy is reduced by acidifying agents used in methamphetamine therapy. **Norepinephrine**—Amphetamines enhance the adrenergic effect of norepinephrine. **Phenobarbital**—Amphetamines may delay intestinal absorption of phenobarbital; co-administration of phenobarbital may produce a synergistic anticonvulsant action. **Phenylethylamine**—Amphetamines may delay intestinal absorption of phenylethylamine; co-administration of phenylethylamine may produce a synergistic anticonvulsant action. **Propoxyphene**—In cases of propoxyphene overdose, amphetamine CNS stimulation is potentiated and fatal convulsions can occur. **Verapamil**—Amphetamines inhibit the hypotensive effect of verapamil.

**Drug/Laboratory Test Interactions:** Amphetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amphetamines may interfere with urinary steroid determinations.

**Carcinogenesis/Mutagenesis and Impairment of Fertility:** No evidence of carcinogenicity was found in studies in which d,l-amphetamine (enantiomer ratio of 1:1) was administered to mice and rats in the diet for 2 years at doses of up to 30 mg/kg/day in male mice, 19 mg/kg/day in female mice, and 5 mg/kg/day in male and female rats. These doses are approximately 2.4, 1.5, and 0.8 times, respectively, the maximum recommended human dose of 30 mg/day [child] on a mg/m<sup>2</sup> body surface area basis.

Amphetamine, in the enantiomer ratio present in ADDERALL® (immediate-release) (d- to l- ratio of 3:1), was not clastogenic in the mouse bone marrow micronucleus test *in vivo* and was negative when tested in the *E. coli* component of the Ames test *in vitro*. d,l-Amphetamine (1:1 enantiomer ratio) has been reported to produce a positive response in the mouse bone marrow micronucleus test, an equivocal response in the Ames test, and negative responses in the *in vitro* sister chromatid exchange and chromosomal aberration assays.

Amphetamine, in the enantiomer ratio present in ADDERALL® (immediate-release) (d- to l- ratio of 3:1), did not adversely affect fertility or early embryonic development in the rat at doses of up to 20 mg/kg/day (approximately 5 times the maximum recommended human dose of 30 mg/day on a mg/m<sup>2</sup> body surface area basis).

**Pregnancy:** Pregnancy Category C. Amphetamine, in the enantiomer ratio present in ADDERALL® (d- to l- ratio of 3:1), had no apparent effects on embryonal morphological development or survival when orally administered to pregnant rats and rabbits throughout the period of organogenesis at doses of up to 6 and 16 mg/kg/day, respectively. These doses are approximately 1.5 and 8 times, respectively, the maximum recommended human dose of 30 mg/day [child] on a mg/m<sup>2</sup> body surface area basis. Fetal malformations and death have been reported in mice following parenteral administration of d-amphetamine doses of 50 mg/kg/day (approximately 6 times that of a human dose of 30 mg/day [child] on a mg/m<sup>2</sup> basis) or greater to pregnant animals. Administration of these doses was also associated with severe maternal toxicity. A number of studies in rodents indicate that prenatal or early postnatal exposure to amphetamine (d- or d,l-), at doses similar to those used clinically, can result in long-term neurochemical and behavioral alterations. Reported behavioral effects include learning and memory deficits, altered locomotor activity, and changes in sexual function.

There are no adequate and well-controlled studies in pregnant women. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (vater association) in a baby born to a woman who took dextroamphetamine sulfate with levostatin during the first trimester of pregnancy. Amphetamines should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic Effects:** Infants born to mothers dependent on amphetamines have an increased risk of premature delivery and low birth weight. Also, these infants may experience symptoms of withdrawal as demonstrated by dysphoria, including agitation, and significant lassitude.

**Usage in Nursing Mothers:** Amphetamines are excreted in human milk. Mothers taking amphetamines should be advised to refrain from nursing.

**Pediatric Use:** ADDERALL XR® is indicated for use in children 6 years of age and older.

**Use in Children Under Six Years of Age:** Effects of ADDERALL XR® in 3-5 year olds have not been studied. Long-term effects of amphetamines in children have not been well established. Amphetamines are not recommended for use in children under 3 years of age.

**Geriatric Use:** ADDERALL XR® has not been studied in the geriatric population.

### ADVERSE EVENTS

The premarketing development program for ADDERALL XR® included exposures in a total of 1315 participants in clinical trials (635 pediatric patients, 350 adolescent patients, 248 adult patients, 82 healthy adult subjects). Of these, 635 patients (ages 6 to 12) were evaluated in two controlled clinical studies, one open-label clinical study, and two single-dose clinical pharmacology studies (N=40). Safety data on all patients are included in the discussion that follows. Adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs. Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and listings that follow, COSTART terminology has been used to classify reported adverse events. The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed.

**Adverse events associated with discontinuation of treatment:** In two placebo-controlled studies of up to 5 weeks duration among children with ADHD, 2.4% (10/425) of ADDERALL XR® treated patients discontinued due to adverse events (including 3 patients with loss of appetite, one of whom also reported insomnia) compared to 2.7% (7/259) receiving placebo. The most frequent adverse events associated with discontinuation of ADDERALL XR® in controlled and uncontrolled, multiple-dose clinical trials of pediatric patients (N=595) are presented below. Over half of these patients were exposed to ADDERALL XR® for 12 months or more.

Adverse event	% of pediatric patients discontinuing (n=595)
Anorexia (loss of appetite)	2.9
Insomnia	1.5
Weight loss	1.2
Emotional lability	1.0
Depression	0.7

In a separate placebo-controlled 4-week study in adolescents with ADHD, eight patients (3.4%) discontinued treatment due to adverse events among ADDERALL XR®-treated patients (N=233). Three patients discontinued due to insomnia and one patient each for depression, motor tics, headaches, light-headedness, and anxiety.

In one placebo-controlled 4-week study among adults with ADHD, patients who discontinued treatment due to adverse events among ADDERALL XR®-treated patients (N=191) were 3.1% (n=6) for nervousness including anxiety and irritability, 2.6% (n=5) for insomnia, 1% (n=2) each for headache, palpitation, and somnolence; and, 0.5% (n=1) each for ALT increase, agitation, chest pain, cocaine craving, elevated blood pressure, and weight loss.

**Adverse events occurring in a controlled trial:** Adverse events reported in a 3-week clinical trial of pediatric patients and a 4-week clinical trial in adolescents and adults, respectively, treated with ADDERALL XR® or placebo are presented in the tables below. The prescribers should be aware that these figures cannot be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied.

**Table 1 Adverse Events Reported by More Than 1% of Pediatric Patients Receiving ADDERALL XR® with Higher Incidence Than on Placebo in a 584 Patient Clinical Study**

Body System	Preferred Term	ADDERALL XR® (n=374)	Placebo (n=210)
General	Abdominal Pain (stomachache)	14%	10%
	Accidental Injury	3%	2%
	Asthenia (fatigue)	2%	0%
	Fever	5%	2%
	Infection	4%	2%
	Viral Infection	2%	0%
	Digestive System	Loss of Appetite	22%
Diarrhea		2%	1%
Dyspepsia		2%	1%
Nausea		5%	3%
Vomiting		7%	4%
Nervous System	Dizziness	9%	2%
	Emotional Lability	2%	0%
	Insomnia	17%	2%
	Nervousness	6%	2%
Metabolic/Nutritional	Weight Loss	4%	0%

**Table 2 Adverse Events Reported by 5% or more of Adolescents Weighing  $\geq 75$  kg/165 lbs Receiving ADDERALL XR® with Higher Incidence Than Placebo in a 287 Patient Clinical Forced Weekly-Dose Titration Study\***

Body System	Preferred Term	ADDERALL XR® (n=233)	Placebo (n=24)
General	Abdominal Pain (stomachache)	11%	2%
Digestive System	Loss of Appetite <sup>†</sup>	36%	2%
Nervous System	Insomnia <sup>†</sup>	12%	4%
	Nervousness	6%	6%
	Weight Loss <sup>†</sup>	9%	0%

\* Appears the same due to rounding  
† Dose-related adverse events  
Note: The following events did not meet the criterion for inclusion in Table 2 but were reported by 2% to 4% of adolescent patients receiving ADDERALL XR® with a higher incidence than patients receiving placebo in this study: accidental injury, asthenia (fatigue), dry mouth, dyspepsia, emotional lability, nausea, somnolence, and vomiting.  
† Included doses up to 40 mg

**Table 3 Adverse Events Reported by 5% or More of Adults Receiving ADDERALL XR® with Higher Incidence Than on Placebo in a 255 Patient Clinical Forced Weekly-Dose Titration Study\***

Body System	Preferred Term	ADDERALL XR® (n=191)	Placebo (n=64)
General	Asthenia	6%	5%
	Headache	26%	13%
Digestive System	Loss of Appetite	33%	3%
	Diarrhea	6%	0%
	Dry Mouth	35%	5%
	Nausea	8%	3%
Nervous System	Agitation	8%	5%
	Anxiety	8%	5%
	Dizziness	7%	0%
	Insomnia	27%	13%
Cardiovascular System	Tachycardia	6%	3%
Metabolic/Nutritional	Weight Loss	11%	0%
Urogenital System	Urinary Tract Infection	5%	0%

Note: The following events did not meet the criterion for inclusion in Table 3 but were reported by 2% to 4% of adult patients receiving ADDERALL XR® with a higher incidence than patients receiving placebo in this study: photosensitivity reaction, constipation, tooth disorder, emotional lability, libido decreased, somnolence, speech disorder, palpitation, twitching, dyspnea, sweating, dysmenorrhea, and impotence.  
† Included doses up to 60 mg.

The following adverse reactions have been associated with amphetamine use: Cardiovascular: Palpitations, tachycardia, elevation of blood pressure, sudden death, myocardial infarction. There have been isolated reports of cardiomyopathy associated with chronic amphetamine use. Central Nervous System: Psychotic episodes at recommended doses, overstimulation, restlessness, dizziness, insomnia, euphoria, dyskinesia, depression, tremor, headache, exacerbation of motor and phonic tics and Tourette's syndrome, seizures, stroke. Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances. Anorexia and weight loss may occur as undesirable effects. Allergic: Urticaria. Endocrine: Impotence, changes in libido.

### DRUG ABUSE AND DEPENDENCE

ADDERALL XR® is a Schedule II controlled substance. Amphetamines have been extensively abused. Tolerance, extreme psychological dependence, and severe social disability have occurred. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with amphetamines may include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

### OVERDOSAGE

Individual patient response to amphetamines varies widely. Toxic symptoms may occur idiosyncratically at low doses. Symptoms: Manifestations of acute overdosage with amphetamines include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states, hyperpyrexia and rhabdomyolysis. In this study, fatigue and depression usually follow the central nervous system stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning is usually preceded by convulsions and coma. Treatment: Consult with a Certified Poison Control Center for up to date guidance and advice. Management of acute amphetamine intoxication is largely symptomatic and includes gastric lavage, administration of activated charcoal, administration of a cathartic and sedation. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases amphetamine excretion, but is believed to increase risk of acute renal failure if myoglobinuria is present. If acute severe hypertension complicates amphetamine overdosage, administration of intravenous phentolamine has been suggested. However, a gradual drop in blood pressure will usually result when sufficient sedation has been achieved. Chlorpromazine antagonizes the central stimulant effects of amphetamines and can be used to treat amphetamine intoxication. The prolonged release of mixed amphetamine salts from ADDERALL XR® should be considered when treating patients with overdosage. Dispense in a tight, light-resistant container as defined in the USP. Store at 25° C (77° F). Excursions permitted to 15-30° C (59-86° F) [see USP Controlled Room Temperature]. Manufactured for: Shire US Inc., Wayne, PA 19087 Made in USA For more information call 1-800-828-2088, or visit www.adderallxr.com. ADDERALL® and ADDERALL XR® are registered in the US Patent and Trademark Office. Copyright ©2005 Shire US Inc. 001766 381 0107 006 Rev. 8/05 ABFS11 Shire