

THIS MEETING IS INTENDED FOR HEALTHCARE PROFESSIONALS ONLY

# MANAGING ADVANCED PARKINSON'S DISEASE IN A GLOBAL EMERGENCY

LATEST THINKING, NEW CHALLENGES,  
FUTURE DIRECTIONS

An International Livestream Meeting sponsored by Britannia Pharmaceuticals

Friday 5 March 2021 – 15:00 GMT

TO REGISTER PLEASE GO TO: [www.britanniasponsoredmeeting.com](http://www.britanniasponsoredmeeting.com)

Chairmen

**Teus van Laar**, The Netherlands and **Andrew Lees**, UK

## INTRODUCTION

**15:00–15:05** Welcome  
(5 mins)  
*Teus van Laar, The Netherlands*

**15:05–15:25** Dopamine agonists and creativity  
(20 mins)  
*Andrew Lees, UK*

## SECTION A: COVID-19 and PD – learning to live together

Chairman: *Teus van Laar, The Netherlands*

**15:25–15:30** Chairman's introduction  
(5 mins)

**15:30–15:50** The impact of Covid-19 on the PD community  
(20 mins)  
*K Ray Chaudhuri, UK*

**15:50–16:00** Q&A  
(10 mins)

**16:00–16:20** PD healthcare provision during the Covid  
pandemic – the shape of the new normal?  
(20 mins)  
*Bastiaan Bloem, The Netherlands*

**16:20–16:30** Q&A  
(10 mins)

**16:30–16:50** SARS-CoV-2 and the dopaminergic system  
(20 mins)  
*Patrik Brundin, USA*

**16:50–17:00** Q&A  
(10 mins)

**17:00–17:15** Panel discussion  
(15 mins)  
*Teus van Laar, Andrew Lees, K Ray Chaudhuri,  
Bastiaan Bloem, Patrik Brundin*

## SECTION B: Managing advanced PD

Chairman: *Andrew Lees, UK*

**17:15–17:20** Chairman's introduction  
(5 mins)

**17:20–17:40** Continuous dopaminergic stimulation  
in advanced PD  
(20 mins)  
*Rajesh Pahwa, USA*

**17:40–17:50** Q&A  
(10 mins)

**17:50–18:10** Management challenges with advancing  
disease  
(20 mins)  
*Stuart Isaacson, USA*

**18:10–18:20** Q&A  
(10 mins)

**18:20–18:40** A guide to device-aided therapy options\*  
(20 mins)  
*Regina Katzenschlager, Austria*

OR  
A closer look at on-demand therapy options\*\*  
*Peter LeWitt, USA*

**18:40–18:50** Q&A at the end of each parallel session  
(10 mins)

**18:50–19:10** Selecting the right treatment for your patient\*  
(20 mins)  
*Tove Henriksen, Denmark*

OR  
Selecting the right treatment for your patient\*\*  
*Stuart Isaacson, USA*

**19:10–19:20** Q&A at the end of each parallel session  
(10 mins)

**19:20–19:40** A multidisciplinary approach to patient care –  
best practice in action  
(20 mins)  
*Teus van Laar, The Netherlands*

**19:40–19:55** Panel discussion  
(15 mins)  
*Andrew Lees, Stuart Isaacson, Rajesh Pahwa,  
Teus van Laar*

**19:55–20:00** Summary and Wrap up  
(5 mins)  
*Andrew Lees, UK*

Timing: GMT

Due to licensing restrictions in different countries:

\* Presentation not available to the US audience

\*\* Presentation only available to the US audience

This meeting has been created and funded by Britannia Pharmaceuticals Ltd.  
Honoraria have been provided to faculty members.

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## APO-go® Apomorphine hydrochloride. PRESCRIBING INFORMATION.

Consult Summary of Product Characteristics before prescribing.

**Indications** Treatment of motor fluctuations ("on-off" phenomena) in patients with Parkinson's disease which are not sufficiently controlled by oral anti-Parkinson medication.

**Dosage and Administration** Apomorphine hydrochloride is administered subcutaneously either as an intermittent bolus injection or by continuous subcutaneous infusion. Apomorphine should be initiated in the controlled environment of a specialist clinic. The patient should be supervised by a physician experienced in the treatment of Parkinson's disease (e.g. neurologist). The patient's treatment with levodopa, with or without dopamine agonists, should be optimised before starting APO-go treatment. The appropriate dose for each patient is established by incremental dosing schedules. For bolus injection it is suggested to start with 1 mg of apomorphine (0.1 ml) during a hypokinetic or 'off' period. If no response or an inadequate response is obtained after 30 minutes, a second dose of 2 mg is injected and the patient is observed for a further 30 minutes. The dosage may be increased by incremental injections with at least a forty minute interval between succeeding injections, until a satisfactory motor response is obtained. Patients who have shown a good 'on' period response during the initiation stage of apomorphine therapy, but whose overall control remains unsatisfactory using intermittent injections, or who require many and frequent injections (more than 10 per day), may be commenced on or transferred to continuous subcutaneous infusion by minipump and/or syringe driver. Continuous infusion is started at a rate of 1 mg apomorphine HCl (0.1 ml) per hour then increased according to the individual response. Increases in the infusion rate should not exceed 0.5 mg per hour at intervals of not less than 4 hours. Hourly infusion rates may range between 1 mg and 4 mg (0.1 ml and 0.4 ml), equivalent to 0.015 - 0.06 mg/kg/hour. Infusions should run for waking hours only. Patients treated with apomorphine will usually need to start domperidone at least two days prior to initiation of therapy. The domperidone dose should be titrated to the lowest effective dose and discontinued as soon as possible. Before the decision to initiate domperidone and apomorphine treatment, risk factors for QT interval prolongation in the individual patient should be carefully assessed to ensure that the benefit outweighs the risk. The optimal dosage of apomorphine HCl has to be determined on an individual patient basis; individual bolus injections should not exceed 10mg and the total daily dose should not exceed 100mg. Do not use if the solution has turned green. The solution should be inspected visually prior to use. Only clear, colourless and particle free solution should be used. Apomorphine must not be used via the intravenous route.

**Contraindications** Children and adolescents (up to 18 years of age). Known hypersensitivity to apomorphine or any excipients of the medicinal product. Respiratory depression, dementia, psychotic disease or hepatic insufficiency. Intermittent apomorphine HCl treatment is not suitable for patients who have an "on" response to levodopa which is marred by severe dyskinesia or dystonia.

**Pregnancy and lactation** Apomorphine should not be used in pregnancy unless clearly necessary. Breastfeeding: It is not known whether apomorphine is excreted in breast milk. A decision on whether to continue/discontinue breastfeeding or to continue/discontinue therapy with APO-go should be made taking into account the benefit of breast-feeding to the child and the benefit of APO-go to the woman.

**Ability to drive and operate machinery** Apomorphine has minor or moderate influence on the ability to drive and use machines. Patients being treated with apomorphine and presenting with somnolence and/or sudden sleep episodes must be informed to refrain from driving or engaging in activities (e.g. operating machines) where impaired alertness may put them or others at risk of serious injury or death until such recurrent episodes and somnolence have resolved.

**Interactions** Patients should be monitored during initiation with apomorphine therapy particularly when used with other medications that have a narrow therapeutic window. There is potential for interaction with neuroleptic and antihypertensive agents and cardiac active medicinal products. It is recommended to avoid the administration of apomorphine with other drugs known to prolong the QT interval.

**Precautions** Use with caution in patients with renal, pulmonary or cardiovascular disease, or who are prone to nausea or vomiting. Apomorphine may produce hypotension, exercise care in patients with cardiac disease or who are

taking vasoactive drugs. Neuropsychiatric disturbances may be exacerbated by apomorphine. Apomorphine has been associated with somnolence and episodes of sudden sleep onset (see advice on driving above). Haematology tests should be undertaken at regular intervals as haemolytic anaemia and thrombocytopenia have been reported. Monitor patients for the development of impulse control disorders. Dose reduction/tapered discontinuation should be considered if such symptoms develop. Dopamine dysregulation Syndrome (DDS) is an addictive disorder resulting in excessive use of the product seen in some patients treated with apomorphine; patients and caregivers should be warned of the potential risk of developing DDS. Apomorphine may have the potential for QT prolongation, exercise caution when treating patients at risk for torsades de pointes arrhythmia. Risk factors for use with domperidone include serious underlying heart conditions such as congestive cardiac failure, severe hepatic impairment or significant electrolyte disturbance. An ECG should be performed prior to treatment with domperidone, during the treatment initiation phase and as clinically indicated thereafter to monitor prolongation of QT interval. Patients should report possible cardiac symptoms; palpitations, syncope, or near-syncope and clinical changes that could lead to hypokalaemia, e.g. gastroenteritis or initiation of diuretic therapy. At each medical visit, risk factors should be revisited. Apomorphine has been associated with local subcutaneous effects that can be sometimes reduced by rotation of injection sites in order to avoid nodularity and induration. Contains sodium metabisulphite which may rarely cause severe allergic reactions and bronchospasm.

**Side Effects:** Very common: Hallucinations and injection site reactions. Common: Neuropsychiatric disturbances, somnolence, transient sedation, dizziness, yawning, nausea and vomiting. Rarely, injection site necrosis and ulceration have been reported. Severe drug-induced dyskinesias during "on" periods may require discontinuation. Postural hypotension is usually transient and infrequent. Positive Coombs' tests, haemolytic anaemia and thrombocytopenia have been reported. Eosinophilia occurs rarely. Dopamine agonists, including apomorphine, may cause impulse control disorders such as pathological gambling, increased libido, hypersexuality, compulsive spending or buying, binge eating or compulsive eating. Rarely, allergic reactions (including anaphylaxis and bronchospasm) due to sodium metabisulphite. Symptoms of overdose like excessive emesis, respiratory depression, hypotension and bradycardia may be treated empirically.

*Prescribers should consult the Summary of Product Characteristics in relation to other adverse reactions.*

**Presentation and Basic NHS Cost** APO-go pens (disposable multiple dosage injector system) contain apomorphine hydrochloride 10mg/ml, as follows: 30mg in 3ml – basic NHS cost £123.91 per carton of 5 pens. APO-go Pre-filled syringes contain apomorphine hydrochloride 5mg/ml, as follows: 50mg in 10ml – basic NHS cost £73.11 per carton of 5 syringes. APO-go ampoules contain apomorphine hydrochloride 10mg/ml as follows: 50mg in 5ml – basic NHS cost £73.11 per carton of 5 ampoules.

### Marketing Authorisation Numbers:

APO-go® Ampoules: PL 04483/0072, APO-go® Pen: PL 04483/0073, APO-go® Pre Filled Syringes: PL 04483/0074

### Legal Category POM

**SmPC Revision Date** January 2020

**API Revision date** April 2020

**Marketing Authorisation Holder in the UK** Britannia Pharmaceuticals, 200 Longwater Avenue, Green Park, Reading, Berkshire, RG2 6GP

**Full prescribing information** and further information is available from Britannia Pharmaceuticals at [Britannia@medinformation.co.uk](mailto:Britannia@medinformation.co.uk) or 01483 920 763.

**Adverse events should be reported. Reporting forms and information can be found at [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard) or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Britannia Pharmaceuticals Ltd at [dso@britannia-pharm.com](mailto:dso@britannia-pharm.com) or 01483 920 763.**

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