Brintellix® and Brilinta® — Safety Communication

• On July 30, 2015, the FDA announced that reports of confusion between the antidepressant Brintellix (vortioxetine) and anti-blood clotting medication Brilinta (ticagrelor) have resulted in the wrong medication being prescribed or dispensed.
  — Brintellix is indicated for the treatment of major depressive disorder.
  — Brilinta is indicated to reduce the rate of thrombotic cardiovascular events in patients with acute coronary syndrome (unstable angina, non-ST elevation myocardial infarction, or ST elevation myocardial infarction).

• The FDA has determined that the main reason for the confusion between these two medications is the similarity of their brand names. None of the FDA reviewed reports indicates that a patient ingested the wrong medication; however, reports of prescribing and dispensing errors continue.

• Other contributing factors to the name confusion included the following:
  — Both brand names begin with the same three letters.
  — The brand names look and sound similar.
  — Both brand names are presented as an option when selecting medications in a computerized physician order entry system.
  — The pharmacist was not familiar with the newer medication Brintellix and so dispensed Brilinta.

• Healthcare providers can reduce the risk of name confusion by including the brand and generic name of the medication, indication for use, correct dose, and directions for use when prescribing these medications.

• Patients should check their prescriptions to ensure that the correct medication was dispensed by verifying the name on the prescription, inspecting the appearance of the tablet, and understanding the reason for taking the medication.

• Brintellix is a tear-shaped tablet imprinted with “TL” on one side of the tablet and a number that indicates the tablet strength on the other side. It varies in color depending upon the strength prescribed.
  — 5 mg tablet: pink and imprinted with “5” and “TL”.
  — 10 mg tablet: yellow and imprinted with “10” and “TL”.
  — 15 mg tablet: orange and imprinted with “15” and “TL”.
  — 20 mg tablet: red and imprinted with “20” and “TL”.

• Brilinta is a 90 mg, round, yellow tablet with a “90” above “T” imprinted on one side.

• Additional FDA recommendations for healthcare providers:
— If prescribing Brintellix:
  ▪ Tell patients what the medication is used to treat.
  ▪ Caution patients about clinical worsening and suicide risk, especially early during treatment and when adjusting the dose of the medication.
  ▪ Caution patients about the increased risk of bleeding or bruising when Brintellix is co-administered with nonsteroidal anti-inflammatory drugs (NSAIDs), aspirin, or other medications that affect coagulation.
  ▪ Caution patients about the risk of serotonin syndrome.

— If prescribing Brilinta:
  ▪ Inform patients about the increased risk of bleeding and bruising.
  ▪ Advise patients to report any unanticipated, prolonged or excessive bleeding, or blood in their stool or urine.

• As of June 2015, the FDA has received 50 reports of medication error cases describing brand name confusion with Brintellix and Brilinta.
  — Twelve cases resulted in the wrong medication being dispensed to a patient.
  — In one case, a pharmacist misinterpreted Brintellix as Brilinta and did not dispense any medication because the patient had a contraindication to antiplatelet therapy.