

For the use of a Registered Medical Practitioner or Hospital or a Laboratory only

NEW MODLIP-ASG
(Atorvastatin And Aspirin Capsules)

COMPOSITION

New Modlip-ASG 75

Each hard gelatin capsule contains:

Atorvastatin Calcium I.P.
equivalent to Atorvastatin 10 mg

Aspirin I.P. 75 mg

(As enteric coated tablet)

Colours : Titanium Dioxide I.P. & Quinoline Yellow Lake.

Approved colours used in hard gelatin capsule shell.

New Modlip-ASG 150

Each hard gelatin capsule contains:

Atorvastatin Calcium I.P.
equivalent to Atorvastatin 10 mg

Aspirin I.P. 150 mg

(As enteric coated tablet)

Colours : Titanium Dioxide I.P. & Quinoline Yellow Lake.

Approved colours used in hard gelatin capsule shell.

DOSAGE FORM

Hard gelatin capsule

INDICATION

For the treatment of dyslipidemia associated with atherosclerotic arterial disease with risk of myocardial infarction, stroke or peripheral vascular disease.

DOSE AND METHOD OF ADMINISTRATION

Atorvastatin

Posology

The patient should be placed on a standard cholesterol-lowering diet before receiving atorvastatin and should continue on this diet during treatment with atorvastatin.

The dose should be individualised according to baseline LDL-C levels, the goal of therapy, and patient response.

The usual starting dose is 10 mg once a day. Adjustment of dose should be made at intervals of 4 weeks or more. The maximum dose is 80 mg once a day.

Patients with renal impairment

No adjustment of dose is required.

Patients with hepatic impairment

Atorvastatin should be used with caution in patients with hepatic impairment. Atorvastatin is contraindicated in patients with active liver disease.

Use in the elderly

Efficacy and safety in patients older than 70 using recommended doses are similar to those seen in the general population.

Method of administration

Atorvastatin is for oral administration. Each daily dose of atorvastatin is given all at once and may be given at any time of day with or without food.

Aspirin

Patients should seek the advice of a doctor before commencing therapy for the first time.

The usual dosage, for long-term use, is 75-150mg once daily. In some circumstances a higher dose may be appropriate, especially in the short term, and up to 300mg a day may be used on the advice of a doctor.

Antithrombotic action: 150mg at diagnosis and 75mg daily thereafter.

The elderly: The risk-benefit ratio of the antithrombotic action of aspirin has not been fully established.

Children:

Do not give to children aged under 16 years, unless specifically indicated (e.g. for Kawasaki's disease).

USE IN SPECIAL POPULATIONS

Atorvastatin

Women of childbearing potential

Women of child-bearing potential should use appropriate contraceptive measures during treatment.

Pregnancy

Atorvastatin is contraindicated during pregnancy. Safety in pregnant women has not been established. No controlled clinical trials with atorvastatin have been conducted in pregnant women. Rare reports of congenital anomalies following intrauterine exposure to HMG-CoA reductase inhibitors have been received. Animal studies have shown toxicity to reproduction.

Maternal treatment with atorvastatin may reduce the fetal levels of mevalonate which is a precursor of cholesterol biosynthesis. Atherosclerosis is a chronic process, and ordinarily discontinuation of lipid-lowering medicinal products during pregnancy should have little impact on the long-term risk associated with primary hypercholesterolaemia.

For these reasons, atorvastatin should not be used in women who are pregnant, trying to become pregnant or suspect they are pregnant. Treatment with atorvastatin should be suspended for the duration of pregnancy or until it has been determined that the woman is not pregnant.

Breastfeeding

It is not known whether atorvastatin or its metabolites are excreted in human milk. In rats, plasma concentrations of atorvastatin and its active metabolites are similar to those in milk. Because of the potential for serious adverse reactions, women taking atorvastatin should not breast-feed their infants. Atorvastatin is contraindicated during breastfeeding.

Fertility

In animal studies atorvastatin had no effect on male or female fertility.

Aspirin

Pregnancy: Although clinical and epidemiological evidence suggests the safety of aspirin for use in pregnancy, caution should be exercised when considering use in pregnant patients. Aspirin has the ability to alter platelet function and there may be a risk of haemorrhage in infants whose mothers have consumed aspirin during pregnancy. Prolonged pregnancy and labour, with increased bleeding before and after delivery, decreased birth weight and increased rate of stillbirth have been reported with high blood salicylate levels. With high doses there may be premature closure of the ductus arteriosus and possible persistent pulmonary hypertension in the newborn. Analgesic doses of aspirin should be avoided during the last trimester of pregnancy.

Lactation: As aspirin is excreted in breast milk, aspirin should not be taken by patients who are breast-feeding, as there is a risk of Reye's syndrome in the infant. High maternal doses may impair platelet function in the infant.

CONTRAINDICATIONS

Atorvastatin is contraindicated in patients:

- with hypersensitivity to the active substance or to any of the excipients of this medicinal product.

- with active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal.

- during pregnancy, while breast-feeding and in women of child-bearing potential not using appropriate contraceptive measures.

Aspirin

- Hypersensitivity to aspirin. Hypoprothrombinaemia, haemophilia and active peptic ulceration or a history of peptic ulceration.

WARNINGS AND PRECAUTIONS

Atorvastatin

Liver effects

Liver function tests should be performed before the initiation of treatment and periodically thereafter. Patients who develop any signs or symptoms suggestive of liver injury should have liver function tests performed. Patients who develop increased transaminase levels should be monitored until the abnormality(ies) resolve. Should an increase in transaminases of greater than 3 times the upper limit of normal (ULN) persist, reduction of dose or withdrawal of atorvastatin is recommended.

Atorvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease.

Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL)

In a post-hoc analysis of stroke subtypes in patients without coronary heart disease (CHD) who had a recent stroke or transient ischemic attack (TIA) there was a higher incidence of hemorrhagic stroke in patients initiated on atorvastatin 80 mg compared to placebo. The increased risk was particularly noted in patients with prior hemorrhagic stroke or lacunar infarct at study entry. For patients with prior hemorrhagic stroke or lacunar infarct, the balance of risks and benefits of atorvastatin 80 mg is uncertain, and the potential risk of hemorrhagic stroke should be carefully considered before initiating treatment.

Skeletal muscle effects

Atorvastatin, like other HMG-CoA reductase inhibitors, may in rare occasions affect the skeletal muscle and cause myalgia, myositis, and myopathy that may progress to rhabdomyolysis, a potentially life-threatening condition characterised by markedly elevated creatine kinase (CK) levels (> 10 times ULN), myoglobinaemia and myoglobinuria which may lead to renal failure.

Before the treatment

Atorvastatin should be prescribed with caution in patients with pre-disposing factors for rhabdomyolysis. A CK level should be measured before starting statin treatment in the following situations:

- Renal impairment
- Hypothyroidism
- Personal or familial history of hereditary muscular disorders
- Previous history of muscular toxicity with a statin or fibrate
- Previous history of liver disease and/or where substantial quantities of alcohol are consumed
- In elderly (age > 70 years), the necessity of such measurement should be considered, according to the presence of other predisposing factors for rhabdomyolysis
- Situations where an increase in plasma levels may occur, such as interactions and special populations including genetic subpopulations

In such situations, the risk of treatment should be considered in relation to possible benefit, and clinical monitoring is recommended.

If CK levels are significantly elevated (> 5 times ULN) at baseline, treatment should not be started.

Creatine kinase measurement

Creatine kinase (CK) should not be measured following strenuous exercise or in the presence of any plausible alternative cause of CK increase as this makes value interpretation difficult. If CK levels are significantly elevated at baseline (> 5 times ULN), levels should be remeasured within 5 to 7 days later to confirm the results.

Whilst on treatment

– Patients must be asked to promptly report muscle pain, cramps, or weakness especially if accompanied by malaise or fever.

– If such symptoms occur whilst a patient is receiving treatment with atorvastatin, their CK levels should be measured. If these levels are found to be significantly elevated (> 5 times ULN), treatment should be stopped.

– If muscular symptoms are severe and cause daily discomfort, even if the CK levels are elevated to $\leq 5 \times$ ULN, treatment discontinuation should be considered.

– If symptoms resolve and CK levels return to normal, then re-introduction of atorvastatin or introduction of an alternative statin may be considered at the lowest dose and with close monitoring.

– Atorvastatin must be discontinued if clinically significant elevation of CK levels (> 10 x ULN) occur, or if rhabdomyolysis is diagnosed or suspected.

Concomitant treatment with other medicinal products

Risk of rhabdomyolysis is increased when atorvastatin is administered concomitantly with certain medicinal products that may increase the plasma concentration of atorvastatin such as potent inhibitors of CYP3A4 or transport proteins (e.g. ciclosporine, telithromycin, clarithromycin, delavirdine, stiripentol, ketoconazole, voriconazole, itraconazole, posaconazole and HIV protease inhibitors including ritonavir, lopinavir, atazanavir, indinavir, darunavir, etc). The risk of myopathy may also be increased with the concomitant use of gemfibrozil and other fibric acid derivatives, boceprevir, erythromycin, niacin, ezetimibe, telaprevir, or the combination of tipranavir/ritonavir. If possible, alternative (non-interacting) therapies should be considered instead of these medicinal products.

There have been very rare reports of an immune-mediated necrotizing myopathy (IMNM) during or after treatment with some statins. IMNM is clinically characterised by persistent proximal muscle weakness and elevated serum creatine kinase, which persist despite discontinuation of statin treatment.

In cases where co-administration of these medicinal products with atorvastatin is necessary, the benefit and the risk of concurrent treatment should be carefully considered. When patients are receiving medicinal products that increase the plasma concentration of atorvastatin, a lower maximum dose of atorvastatin is recommended. In addition, in the case of potent CYP3A4 inhibitors, a lower starting dose of atorvastatin should be considered and appropriate clinical monitoring of these patients is recommended.

The concurrent use of atorvastatin and fusidic acid is not recommended, therefore, temporary suspension of atorvastatin may be considered during fusidic acid therapy.

Paediatric use

Developmental safety in the paediatric population has not been established.

Interstitial lung disease

Exceptional cases of interstitial lung disease have been reported with some statins, especially with long term therapy. Presenting features can include dyspnoea, non-productive cough and deterioration in general health (fatigue, weight loss and fever). If it is suspected a patient has developed interstitial lung disease, statin therapy should be discontinued.

Diabetes Mellitus

Some evidence suggests that statins as a class raise blood glucose and in some patients, at high risk of future diabetes, may produce a level of hyperglycaemia where formal diabetes care is appropriate. This risk, however, is outweighed by the reduction in vascular risk with statins and therefore should not be a reason for stopping statin treatment. Patients at risk (fasting glucose 5.6 to 6.9 mmol/L, BMI > 30 kg/m², raised triglycerides, hypertension) should be monitored both clinically and biochemically according to national guidelines.

Aspirin

There is a possible association between aspirin and Reye's syndrome when given to children. Reye's syndrome is a very rare disease, which affects the brain and liver, and can be fatal. For this reason aspirin should not be given to children aged under 16 years unless specifically indicated (e.g. for Kawasaki's disease).

Before commencing long-term aspirin therapy for the management of cerebrovascular or cardiovascular disease patients should consult their doctor who can advise on the relative benefits versus the risks for the individual patient.

Aspirin decreases platelet adhesiveness and increases bleeding time. Haematological and haemorrhagic effects can occur, and may be severe. Patients should report any unusual bleeding symptoms to their physician.

Salicylates should be used with caution in patients with a history of peptic ulceration or coagulation abnormalities. They may also induce gastro-intestinal haemorrhage, occasionally major.

They may also precipitate bronchospasm or induce attacks of asthma in susceptible subjects.

Aspirin should be used with caution in patients with impaired renal or hepatic function (avoid if severe), or in patients who are dehydrated.

Patients with hypertension should be carefully monitored.

DRUG INTERACTIONS

Atorvastatin

Effect of co-administered medicinal products on atorvastatin

Atorvastatin is metabolized by cytochrome P450 3A4 (CYP3A4) and is a substrate to transport proteins e.g. the hepatic uptake transporter OATP1B1. Concomitant administration of medicinal products that are inhibitors of CYP3A4 or transport proteins may lead to increased plasma concentrations of atorvastatin and an increased risk of myopathy. The risk might also be increased at concomitant administration of atorvastatin with other medicinal products that have a potential to induce myopathy, such as fibric acid derivatives and ezetimibe.

CYP3A4 inhibitors

Potent CYP3A4 inhibitors have been shown to lead to markedly increased concentrations of atorvastatin. Co-administration of potent CYP3A4 inhibitors (e.g. ciclosporin, telithromycin, clarithromycin, delavirdine, stiripentol, ketoconazole, voriconazole, itraconazole, posaconazole and HIV protease inhibitors including ritonavir, lopinavir, atazanavir, indinavir, darunavir, etc.) should be avoided if possible. In cases where co-administration of these medicinal products with atorvastatin cannot be avoided lower starting and maximum doses of atorvastatin should be considered and appropriate clinical monitoring of the patient is recommended.

Moderate CYP3A4 inhibitors (e.g. erythromycin, diltiazem, verapamil and fluconazole) may increase plasma concentrations of atorvastatin. An increased risk of myopathy has been observed with the use of erythromycin in combination with statins. Interaction studies evaluating the effects of amiodarone or verapamil on atorvastatin have not been conducted. Both amiodarone and verapamil are known to inhibit CYP3A4 activity and co-administration with atorvastatin may result in increased exposure to atorvastatin. Therefore, a lower maximum dose of atorvastatin should be considered and appropriate clinical monitoring of the patient is recommended when concomitantly used with moderate CYP3A4 inhibitors. Appropriate clinical monitoring is recommended after initiation or following dose adjustments of the inhibitor.

CYP3A4 inducers

Concomitant administration of atorvastatin with inducers of cytochrome P450 3A (e.g. efavirenz, rifampin, St. John's Wort) can lead to variable reductions in plasma concentrations of atorvastatin. Due to the dual interaction mechanism of rifampin, (cytochrome P450 3A induction and inhibition of hepatocyte uptake transporter OATP1B1), simultaneous co-administration of atorvastatin with rifampin is recommended, as delayed administration of atorvastatin after administration of rifampin has been associated with a significant reduction in atorvastatin plasma concentrations. The effect of rifampin on atorvastatin concentrations in hepatocytes is, however, unknown and if concomitant administration cannot be avoided, patients should be carefully monitored for efficacy.

Transport protein inhibitors

Inhibitors of transport proteins (e.g. ciclosporin) can increase the systemic exposure of atorvastatin. The effect of inhibition of hepatic uptake transporters on atorvastatin concentrations in hepatocytes is unknown. If concomitant administration cannot be avoided, a dose reduction and clinical monitoring for efficacy is recommended.

Gemfibrozil / fibric acid derivatives

The use of fibrates alone is occasionally associated with muscle related events, including rhabdomyolysis. The risk of these events may be increased with the concomitant use of fibric acid derivatives and atorvastatin. If concomitant administration cannot be avoided, the lowest dose of atorvastatin to achieve the therapeutic objective should be used and the patients should be appropriately monitored.

Ezetimibe

The use of ezetimibe alone is associated with muscle related events, including rhabdomyolysis. The risk of these events may therefore be increased with concomitant use of ezetimibe and atorvastatin. Appropriate clinical monitoring of these patients is recommended.

Colestipol

Plasma concentrations of atorvastatin and its active metabolites were lower (by approx. 25%) when colestipol was co-administered with atorvastatin. However, lipid effects were greater when atorvastatin and colestipol were co-administered than when either medicinal product was given alone.

Fusidic acid

Interaction studies with atorvastatin and fusidic acid have not been conducted. As with other statins, muscle related events, including rhabdomyolysis, have been reported in post-marketing experience with atorvastatin and fusidic acid given concurrently. The mechanism of this interaction is not known. Patients should be closely monitored and temporary suspension of atorvastatin treatment may be appropriate.

Colchicine

Although interaction studies with atorvastatin and colchicine have not been conducted, cases of myopathy have been reported with atorvastatin co-administered with colchicine, and caution should be exercised when prescribing atorvastatin with colchicine.

Effect of atorvastatin on co-administered medicinal products

Digoxin

When multiple doses of digoxin and 10 mg atorvastatin were co-administered, steady-state digoxin concentrations increased slightly. Patients taking digoxin should be monitored appropriately.

Oral contraceptives

Co-administration of atorvastatin with an oral contraceptive produced increases in plasma concentrations of norethindrone and ethinyl oestradiol.

Warfarin

In a clinical study in patients receiving chronic warfarin therapy, coadministration of atorvastatin 80 mg daily with warfarin caused a small decrease of about 1.7 seconds in prothrombin time during the first 4 days of dosing which returned to normal within 15 days of atorvastatin treatment. Although only very rare cases of clinically significant anticoagulant interactions have been reported, prothrombin time should be determined before starting atorvastatin in patients taking coumarin anticoagulants and frequently enough during early therapy to ensure that no significant alteration of prothrombin time occurs. Once a stable prothrombin time has been documented, prothrombin times can be monitored at the intervals usually recommended for patients on coumarin anticoagulants. If the dose of atorvastatin is changed or discontinued, the same procedure should be repeated. Atorvastatin therapy has not been associated with bleeding or with changes in prothrombin time in patients not taking anticoagulants.

Paediatric population

Drug-drug interaction studies have only been performed in adults. The extent of interactions in the paediatric population is not known. The above mentioned interactions for adults and the warnings in should be taken into account for the paediatric population.

Table : Effect of co-administered medicinal products on the pharmacokinetics of atorvastatin

Co-administered medicinal product and dosing regimen	Atorvastatin		
	Dose (mg)	Change in AUC ^{&}	Clinical Recommendation
Tipranavir 500 mg BID/ Ritonavir 200 mg BID, 8 days (days 14 to 21)	40 mg on day 1, 10 mg on day 20	↑ 9.4 fold	In cases where coadministration with atorvastatin is necessary, do not exceed 10 mg atorvastatin daily. Clinical monitoring of these patients is recommended
Telaprevir 750 mg q8h, 10 days	20 mg, SD	↑ 7.9 fold	
Ciclosporin 5.2 mg/kg/day, stable dose	10 mg OD for 28 days	↑ 8.7 fold	
Lopinavir 400 mg BID/ Ritonavir 100 mg BID, 14 days	20 mg OD for 4 days	↑ 5.9 fold	In cases where co-administration with atorvastatin is necessary, lower maintenance doses of atorvastatin are recommended. At atorvastatin doses exceeding 20 mg, clinical monitoring of these patients is recommended.
Clarithromycin 500 mg BID, 9 days	80 mg OD for 8 days	↑ 4.4 fold	
Saquinavir 400 mg BID/ Ritonavir (300 mg BID from days 5-7, increased to 400 mg BID on day 8), days 4-18, 30 min after atorvastatin dosing	40 mg OD for 4 days	↑ 3.9 fold	In cases where co-administration with atorvastatin is necessary, lower maintenance doses of atorvastatin are recommended. At atorvastatin doses exceeding 40 mg, clinical monitoring of

Darunavir 300 mg BID/ Ritonavir 100 mg BID, 9 days	10 mg OD for 4 days	↑ 3.3 fold	these patients is recommended.
Itraconazole 200 mg OD, 4 days	40 mg SD	↑ 3.3 fold	
Fosamprenavir 700 mg BID/ Ritonavir 100 mg BID, 14 days	10 mg OD for 4 days	↑ 2.5 fold	
Fosamprenavir 1400 mg BID, 14 days	10 mg OD for 4 days	↑ 2.3 fold	
Nelfinavir 1250 mg BID, 14 days	10 mg OD for 28 days	↑ 1.7 fold [^]	No specific recommendation
Grapefruit Juice, 240 mL OD *	40 mg, SD	↑ 37%	Concomitant intake of large quantities of grapefruit juice and atorvastatin is not recommended.
Diltiazem 240 mg OD, 28 days	40 mg, SD	↑ 51%	After initiation or following dose adjustments of diltiazem, appropriate clinical monitoring of these patients is recommended.
Erythromycin 500 mg QID, 7 days	10 mg, SD	↑ 33% [^]	Lower maximum dose and clinical monitoring of these patients is recommended.
Amlodipine 10 mg, single dose	80 mg, SD	↑ 18%	No specific recommendation.
Cimetidine 300 mg QID, 2 weeks	10 mg OD for 2 weeks	↓ less than 1% [^]	No specific recommendation.
Antacid suspension of magnesium and aluminium hydroxides, 30 mL QID, 2 weeks	10 mg OD for 4 weeks	↓ 35% [^]	No specific recommendation.
Efavirenz 600 mg OD, 14 days	10 mg for 3 days	↓ 41%	No specific recommendation.
Rifampin 600 mg OD, 7 days (co-administered)	40 mg SD	↑ 30%	If co-administration cannot be avoided, simultaneous co-administration of atorvastatin with rifampin is recommended, with clinical monitoring.
Rifampin 600 mg OD, 5 days (doses separated)	40 mg SD	↓ 80%	
Gemfibrozil 600 mg BID, 7 days	40mg SD	↑ 35%	Lower starting dose and clinical monitoring of these patients is recommended.
Fenofibrate 160 mg OD, 7 days	40mg SD	↑ 3%	Lower starting dose and clinical monitoring

			of these patients is recommended.
Boceprevir 800 mg TID, 7 days	40mg SD	↑ 2.3 fold	Lower starting dose and clinical monitoring of these patients is recommended. The dose of atorvastatin should not exceed a daily dose of 20 mg during co-administration with boceprevir.

&Data given as x-fold change represent a simple ratio between co-administration and atorvastatin alone (i.e., 1-fold = no change).

Data given as % change represent % difference relative to atorvastatin alone (i.e., 0% = no change).

*Contains one or more components that inhibit CYP3A4 and can increase plasma concentrations of medicinal products metabolized by CYP3A4. Intake of one 240 ml glass of grapefruit juice also resulted in a decreased AUC of 20.4% for the active orthohydroxy metabolite. Large quantities of grapefruit juice (over 1.2 l daily for 5 days) increased AUC of atorvastatin 2.5 fold and AUC of active (atorvastatin and metabolites).

^ Total atorvastatin equivalent activity

Increase is indicated as “↑”, decrease as “↓”

OD = once daily; SD = single dose; BID = twice daily; TID = three times daily; QID = four times daily

Table : Effect of atorvastatin on the pharmacokinetics of co-administered medicinal products

Atorvastatin and dosing regimen	Co-administered medicinal product		
	Medicinal product/Dose (mg)	Change in AUC ^{&}	Clinical Recommendation
80 mg OD for 10 days	Digoxin 0.25 mg OD, 20 days	↑ 15%	Patients taking digoxin should be monitored appropriately.
40 mg OD for 22 days	Oral contraceptive OD, 2 months - norethindrone 1 mg -ethinyl estradiol 35 µg	↑ 28% ↑ 19%	No specific recommendation.
80 mg OD for 15 days	* Phenazone, 600 mg SD	↑ 3%	No specific recommendation
10 mg, SD	Tipranavir 500 mg BID/ritonavir 200 mg BID, 7 days	No change	No specific recommendation
10 mg, OD for 4 days	Fosamprenavir 1400 mg BID, 14 days	↓ 27%	No specific recommendation

10 mg OD for 4 days	Fosamprenavir 700 mg BID/ritonavir 100 mg BID, 14 days	No change	No specific recommendation
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&Data given as % change represent % difference relative to medicinal product alone (i.e., 0% = no change)

*Co-administration of multiple doses of atorvastatin and phenazone showed little or no detectable effect in the clearance of phenazone.

Increase is indicated as “↑”, decrease as “↓”

OD = once daily; SD = single dose

Aspirin

Salicylates may enhance the effect of oral hypoglycaemic agents, phenytoin and sodium valproate. They inhibit the uricosuric effect of probenecid and may increase the toxicity of sulphonamides.

Aspirin may potentiate the effect of heparin and increases the risk of bleeding with oral anticoagulants, antiplatelet agents and fibrinolytics.

Plasma salicylate concentrations may be reduced by concurrent use of corticosteroids, and salicylate toxicity may occur following withdrawal of the corticosteroids. The risk of gastrointestinal ulceration and bleeding may be increased when aspirin and corticosteroids are co-administered.

Concurrent use of aspirin and other NSAIDs should be avoided. Use of two or more NSAID preparations increases the risk of serious gastrointestinal haemorrhage.

Concurrent administration of carbonic anhydrase inhibitors such as acetazolamide and salicylates may result in severe acidosis and increased central nervous system toxicity.

In large doses, salicylates may also decrease insulin requirements.

Patients using gastro-resistant aspirin should be advised against ingesting antacids simultaneously to avoid premature drug release.

Experimental data suggest that ibuprofen may inhibit the effect of low dose aspirin on platelet aggregation when they are dosed concomitantly. However, the limitations of these data and the uncertainties regarding extrapolation of ex-vivo data to the clinical situation imply that no firm conclusions can be made for regular ibuprofen use, and no clinically relevant effect is considered to be likely for occasional ibuprofen use.

UNDESIRABLE EFFECTS

Atorvastatin

Based on data from clinical studies and extensive post-marketing experience, the following table presents the adverse reaction profile for atorvastatin.

Estimated frequencies of reactions are ranked according to the following convention: common ($\geq 1/100$, $< 1/10$); uncommon ($\geq 1/1,000$, $< 1/100$); rare ($\geq 1/10,000$, $< 1/1,000$); very rare ($\leq 1/10,000$), not known (cannot be estimated from the available data).

Infections and infestations

Common: nasopharyngitis.

Blood and lymphatic system disorders

Rare: thrombocytopenia.

Immune system disorders

Common: allergic reactions.

Very rare: anaphylaxis.

Metabolism and nutrition disorders

Common: hyperglycaemia.

Uncommon: hypoglycaemia, weight gain, anorexia

Psychiatric disorders

Uncommon: nightmare, insomnia.

Nervous system disorders

Common: headache.

Uncommon: dizziness, paraesthesia, hypoesthesia, dysgeusia, amnesia.

Rare: peripheral neuropathy.

Eye disorders

Uncommon: vision blurred.

Rare: visual disturbance.

Ear and labyrinth disorders

Uncommon: tinnitus

Very rare: hearing loss.

Respiratory, thoracic and mediastinal disorders

Common: pharyngolaryngeal pain, epistaxis.

Gastrointestinal disorders

Common: constipation, flatulence, dyspepsia, nausea, diarrhoea.

Uncommon: vomiting, abdominal pain upper and lower, eructation, pancreatitis.

Hepatobiliary disorders

Uncommon: hepatitis.

Rare: cholestasis.
Very rare: hepatic failure.

Skin and subcutaneous tissue disorders

Uncommon: urticaria, skin rash, pruritus, alopecia.
Rare: angioneurotic oedema, dermatitis bullous including erythema multiforme, Stevens-Johnson syndrome and toxic epidermal necrolysis.

Musculoskeletal and connective tissue disorders

Common: myalgia, arthralgia, pain in extremity, muscle spasms, joint swelling, back pain.
Uncommon: neck pain, muscle fatigue.
Rare: myopathy, myositis, rhabdomyolysis, tendonopathy, sometimes complicated by rupture.
Not known: immune-mediated necrotizing myopathy.

Reproductive system and breast disorders

Very rare: gynecomastia.

General disorders and administration site conditions

Uncommon: malaise, asthenia, chest pain, peripheral oedema, fatigue, pyrexia.

Investigations

Common: liver function test abnormal, blood creatine kinase increased.
Uncommon: white blood cells urine positive.

As with other HMG-CoA reductase inhibitors elevated serum transaminases have been reported in patients receiving Atorvastatin. These changes were usually mild, transient, and did not require interruption of treatment. Clinically important (> 3 times upper normal limit) elevations in serum transaminases occurred in 0.8% patients on Atorvastatin. These elevations were dose related and were reversible in all patients.

Elevated serum creatine kinase (CK) levels greater than 3 times upper limit of normal occurred in 2.5% of patients on Atorvastatin, similar to other HMG-CoA reductase inhibitors in clinical trials. Levels above 10 times the normal upper range occurred in 0.4% Atorvastatin treated patients.

Paediatric Population

The clinical safety database includes safety data for 249 paediatric patients who received atorvastatin, among which 7 patients were < 6 years old, 14 patients were in the age range of 6 to 9, and 228 patients were in the age range of 10 to 17.

Nervous system disorders

Common: Headache

Gastrointestinal disorders

Common: Abdominal pain

Investigations

Common: Alanine aminotransferase increased, blood creatine phosphokinase increased

Based on the data available, frequency, type and severity of adverse reactions in children are expected to be the same as in adults. There is currently limited experience with respect to long-term safety in the paediatric population.

The following adverse events have been reported with some statins:

- Sexual dysfunction.
- Depression.
- Exceptional cases of interstitial lung disease, especially with long term therapy
- Diabetes Mellitus: Frequency will depend on the presence or absence of risk factors (fasting blood glucose ≥ 5.6 mmol/L, BMI >30 kg/m², raised triglycerides, history of hypertension).

Aspirin

Gastrointestinal irritation is common in patients taking aspirin preparations, and nausea, vomiting, dyspepsia, gastritis, gastrointestinal erosions and ulceration have been reported. Anaemia may occur following chronic gastrointestinal blood loss or acute haemorrhage.

Aspirin prolongs bleeding time, and bleeding disorders, such as epistaxis, haematuria, purpura, ecchymoses, haemoptysis, gastrointestinal bleeding, haematoma and cerebral haemorrhage have occasionally been reported. Fatalities have occurred.

Hypersensitivity reactions include skin rashes, urticaria, angioedema, asthma, bronchospasm and rarely, anaphylaxis.

Other side effects: urate kidney stones and tinnitus

OVERDOSE

Atorvastatin

Specific treatment is not available for atorvastatin overdose. Should an overdose occur, the patient should be treated symptomatically and supportive measures instituted, as required. Liver function tests should be performed and serum CK levels should be monitored. Due to extensive atorvastatin binding to plasma proteins, haemodialysis is not expected to significantly enhance atorvastatin clearance.

Aspirin

Salicylate poisoning is usually associated with plasma concentrations >350 mg/L (2.5 mmol/L). Most adult deaths occur in patients whose concentrations exceed 700 mg/L (5.1 mmol/L). Single doses less than 100 mg/kg are unlikely to cause serious poisoning.

Symptoms

Common features include vomiting, dehydration, tinnitus, vertigo, deafness, sweating, warm extremities with bounding pulses, increased respiratory rate and hyperventilation. Some degree of acid-base disturbance is present in most cases.

A mixed respiratory alkalosis and metabolic acidosis with normal or high arterial pH (normal or reduced hydrogen ion concentration) is usual in adults and children over the age of 4 years. In children aged 4 years or less, a dominant metabolic acidosis with low arterial pH (raised hydrogen ion concentration) is common. Acidosis may increase salicylate transfer across the blood brain barrier.

Uncommon features include haematemesis, hyperpyrexia, hypoglycaemia, hypokalaemia, thrombocytopenia, increased INR/PTR, intravascular coagulation, renal failure and non-cardiogenic pulmonary oedema.

Central nervous system features including confusion, disorientation, coma and convulsions are less common in adults than in children.

Management

Give activated charcoal if an adult presents within one hour of ingestion of more than 250 mg/kg. The plasma salicylate concentration should be measured, although the severity of poisoning cannot be determined from this alone and the clinical and biochemical features must be taken into account. Elimination is increased by urinary alkalinisation, which is achieved by the administration of 1.26% sodium bicarbonate. The urine pH should be monitored. Correct metabolic acidosis with intravenous 8.4% sodium bicarbonate (first check serum potassium). Forced diuresis should not be used since it does not enhance salicylate excretion and may cause pulmonary oedema.

Haemodialysis is the treatment of choice for severe poisoning and should be considered in patients with plasma salicylate concentrations >700 mg/L (5.1 mmol/L), or lower concentrations associated with severe clinical or metabolic features. Patients under 10 years and over 70 have increased risk of salicylate toxicity, and may require dialysis at an earlier stage.

PHARMACODYNAMIC AND PHARMACOKINETIC PROPERTIES

Atorvastatin

Pharmacotherapeutic group: Lipid modifying agents, HMG-CoA-reductase inhibitors, ATC code: C10AA05

Atorvastatin is a selective, competitive inhibitor of HMG-CoA reductase, the rate-limiting enzyme responsible for the conversion of 3-hydroxy-3-methyl-glutaryl-coenzyme A to mevalonate, a precursor of sterols, including cholesterol. Triglycerides and cholesterol in the liver are incorporated into very low-density lipoproteins (VLDL) and released into the plasma for delivery to peripheral tissues. Low-density lipoprotein (LDL) is formed from VLDL and is catabolized primarily through the receptor with high affinity to LDL (LDL receptor).

Atorvastatin lowers plasma cholesterol and lipoprotein serum concentrations by inhibiting HMG-CoA reductase and subsequently cholesterol biosynthesis in the liver and increases the number of hepatic LDL receptors on the cell surface for enhanced uptake and catabolism of LDL.

Atorvastatin reduces LDL production and the number of LDL particles. Atorvastatin produces a profound and sustained increase in LDL receptor activity coupled with a beneficial change in the quality of circulating LDL particles. Atorvastatin is effective in reducing LDL-C in patients with homozygous familial hypercholesterolaemia, a population that has not usually responded to lipid-lowering medicinal products.

Atorvastatin has been shown to reduce concentrations of total-C (30% - 46%), LDL-C (41% - 61%), apolipoprotein B (34% - 50%), and triglycerides (14% - 33%) while producing variable increases in HDL-C and apolipoprotein A1 in a dose response study. These results are consistent in patients with heterozygous familial hypercholesterolaemia, nonfamilial forms of hypercholesterolaemia, and mixed hyperlipidaemia, including patients with noninsulin-dependent diabetes mellitus.

Reductions in total-C, LDL-C, and apolipoprotein B have been proven to reduce risk for cardiovascular events and cardiovascular mortality.

Pharmacokinetic properties

Absorption

Atorvastatin is rapidly absorbed after oral administration; maximum plasma concentrations (C_{max}) occur within 1 to 2 hours. Extent of absorption increases in proportion to atorvastatin dose. After oral administration, atorvastatin film-coated tablets are 95% to 99% bioavailable compared to the oral solution. The absolute bioavailability of atorvastatin is approximately 12% and the systemic availability of HMG-CoA reductase inhibitory activity is approximately 30%. The low systemic availability is attributed to presystemic clearance in gastrointestinal mucosa and/or hepatic first-pass metabolism

Distribution

Mean volume of distribution of atorvastatin is approximately 381 l. Atorvastatin is $\geq 98\%$ bound to plasma proteins.

Biotransformation

Atorvastatin is metabolized by cytochrome P450 3A4 to ortho- and parahydroxylated derivatives and various beta-oxidation products. Apart from other pathways these products are further metabolized via glucuronidation. In vitro, inhibition of HMG-CoA reductase by ortho- and parahydroxylated metabolites is equivalent to that of atorvastatin. Approximately 70% of circulating inhibitory activity for HMG-CoA reductase is attributed to active metabolites.

Elimination

Atorvastatin is eliminated primarily in bile following hepatic and/or extrahepatic metabolism. However, atorvastatin does not appear to undergo significant enterohepatic recirculation. Mean plasma elimination half-life of atorvastatin in humans is approximately 14 hours. The half-life of

inhibitory activity for HMG-CoA reductase is approximately 20 to 30 hours due to the contribution of active metabolites.

Special populations

Elderly

Plasma concentrations of atorvastatin and its active metabolites are higher in healthy elderly subjects than in young adults while the lipid effects were comparable to those seen in younger patient populations.

Paediatric

In an open-label, 8-week study, Tanner Stage 1 (N=15) and Tanner Stage ≥ 2 (N=24) paediatric patients (ages 6-17 years) with heterozygous familial hypercholesterolemia and baseline LDL-C ≥ 4 mmol/L were treated with 5 or 10 mg of chewable or 10 or 20 mg of film-coated atorvastatin tablets once daily, respectively. Body weight was the only significant covariate in atorvastatin population PK model. Apparent oral clearance of atorvastatin in paediatric subjects appeared similar to adults when scaled allometrically by body weight. Consistent decreases in LDL-C and TC were observed over the range of atorvastatin and o-hydroxyatorvastatin exposures.

Gender

Concentrations of atorvastatin and its active metabolites in women differ from those in men (Women: approx. 20% higher for C_{max} and approx. 10% lower for AUC). These differences were of no clinical significance, resulting in no clinically significant differences in lipid effects among men and women.

Patients with renal impairment

Renal disease has no influence on the plasma concentrations or lipid effects of atorvastatin and its active metabolites.

Patients with hepatic impairment

Plasma concentrations of atorvastatin and its active metabolites are markedly increased (approx. 16-fold in C_{max} and approx. 11-fold in AUC) in patients with chronic alcoholic liver disease (Child-Pugh B).

SLCO1B1 polymorphism

Hepatic uptake of all HMG-CoA reductase inhibitors including atorvastatin, involves the OATP1B1 transporter. In patients with SLCO1B1 polymorphism there is a risk of increased exposure of atorvastatin, which may lead to an increased risk of rhabdomyolysis (see section 4.4). Polymorphism in the gene encoding OATP1B1 (SLCO1B1 c.521CC) is associated with a 2.4-fold higher atorvastatin exposure (AUC) than in individuals without this genotype variant (c.521TT). A genetically impaired hepatic uptake of atorvastatin is also possible in these patients. Possible consequences for the efficacy are unknown.

Preclinical safety data

Atorvastatin was negative for mutagenic and clastogenic potential in a battery of 4 in vitro tests and 1 in vivo assay. Atorvastatin was not found to be carcinogenic in rats, but high doses in mice

(resulting in 6-11 fold the AUC_{0-24h} reached in humans at the highest recommended dose) showed hepatocellular adenomas in males and hepatocellular carcinomas in females.

There is evidence from animal experimental studies that HMG-CoA reductase inhibitors may affect the development of embryos or fetuses. In rats, rabbits and dogs atorvastatin had no effect on fertility and was not teratogenic, however, at maternally toxic doses fetal toxicity was observed in rats and rabbits. The development of the rat offspring was delayed and post-natal survival reduced during exposure of the dams to high doses of atorvastatin. In rats, there is evidence of placental transfer. In rats, plasma concentrations of atorvastatin are similar to those in milk. It is not known whether atorvastatin or its metabolites are excreted in human milk.

Aspirin

Pharmacodynamic properties

Aspirin has analgesic, antipyretic and anti-inflammatory actions.

It also has antithrombotic action which is mediated through inhibition of platelet activation.

Experimental data suggest that ibuprofen may inhibit the effect of low dose aspirin on platelet aggregation when they are dosed concomitantly. In one study, when a single dose of ibuprofen 400mg was taken within 8 hours before or within 30 minutes after immediate release aspirin (81mg), a decreased effect of aspirin on the formation of thromboxane or platelet aggregation occurred. However, the limitations of these data and the uncertainties regarding extrapolation of ex vivo data to the clinical situation imply that no firm conclusions can be made for regular ibuprofen use, and no clinically relevant effect is considered to be likely for occasional ibuprofen use.

Pharmacokinetic properties

In a bioequivalence study comparing the pharmacokinetics of the 300mg product with 4 x 75mg presentation in human volunteers, measures such as terminal phase half-life, area-under-the curve and peak plasma concentrations were recorded on days 1 and 4. On day 1 salicylate reached a peak plasma concentration of between 10.34 and 31.57 mcg/ml and between 11.76 and 27.47mcg/ml for the 300mg and 75mg tablets respectively. Time to peak concentration ranged from 4 to 8 hours and from 3 to 6 hours respectively. AUC ranged from 54.0 to 131.2 and from 64.3 to 137.6 h.mcg/ml respectively. The terminal phase half-life ranged from 1.33 to 2.63 hours and from 1.47 to 2.59 hours respectively. On day 4 C_{max} varied from 15.01 to 48.97 mcg/ml for the 300mg tablet and from 11.26 to 60.21 mcg/ml for 4 x 75mg tablets. T_{max} ranged from 4 to 8 hours and from 3 to 8 hours, whilst AUC ranged from 89.8 to 297.4 h.mcg/ml and from 61.5 to 293.4 h.mcg/ml respectively.

EXPIRY DATE

Do not use later than the date of expiry.

PACKAGING INFORMATION

NEW MODLIP-ASG 20 is available in strip of 10 capsules.

STORAGE AND HANDLING INSTRUCTIONS

Store below 25°C, protected from light and moisture. Keep out of reach of children.

MARKETED BY



TORRENT PHARMACEUTICALS LTD.

Torrent House, Off Ashram Road,

Ahmedabad-380 009, INDIA

IN/NEW MODLIP-ASG 10,75,150mg/May-15/01/PI