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

TG TOR F 160

1. Generic Name

Atorvastatin Calcium & Fenofibrate Tablets I.P

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film coated tablet contains:

Atorvastatin Calcium I.P

Equivalent to Atorvastatin ……..…10 mg

Fenofibrate I.P (Micronized) ……. 160 mg

Colour : Titanium Dioxide I.P.

The excipients used are Calcium Carbonate, Lactose, Croscarmellose Sodium, Sodium Lauryl Sulphate, Polyvinyl Pyrrolidone, Colloidal Silicon Dioxide, Crospovidone, Magnesium Stearate, Hydroxy propyl methylcellulose, Colloidal Silicon Dioxide, Talc, Titanium Dioxide, and PEG 6000.

3. Dosage Form and Strength

Dosage Film coated tablet

Strength: Atorvastatin 10 mg and Fenofibrate 160 mg.

4. CLINICAL PARTICULARS

4.1 Therapeutic Indication

For the treatment of combined hyperlipidemia in patients with normal hepatic and renal function

4.2 Posology and Method of Administration

Dose: As directed by physician.

Method of administration:

Tablet should be swallowed whole during a meal.

4.3 Contraindications

It is contraindicated in patients:

- With hypersensitivity to the active substance or to any of the excipients
- With active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal.
- During pregnancy, while breastfeeding and in women of childbearing potential not using appropriate contraceptive measures

- Hepatic insufficiency (including biliary cirrhosis and unexplained persistent liver function abnormality
- Known gallbladder disease
- Severe renal insufficiency (estimated glomerular filtration rate < 30 mL/min/1.73 m^2)
- Chronic or acute pancreatitis with the exception of acute pancreatitis due to severe hypertriglyceridemia.
- Known photoallergy or phototoxic reaction during treatment with fibrates or ketoprofen.
- Treated with the hepatitis C antivirals glecaprevir/pibrentasvir

4.4 Special Warnings and Precautions for Use

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 haemorrhagic stroke in patients initiated on atorvastatin 80 mg compared to placebo. The increased risk was particularly noted in patients with prior haemorrhagic stroke or lacunar infarct at study entry. For patients with prior haemorrhagic stroke or lacunar infarct, the balance of risks and benefits of atorvastatin 80 mg is uncertain, and the potential risk of haemorrhagic 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.

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.

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 ≤ 5 x 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.

<u>Concomitant treatment with other medicinal products</u>

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. ciclosporin, telithromycin, clarithromycin, delavirdine, stiripentol, ketoconazole, voriconazole, itraconazole, posaconazole and HIV protease inhibitors including ritonavir, lopinavir, atazanavir, indinavir, darunavir, Tipranavir/ritonavir, etc.). The risk of myopathy may also be increased with the concomitant use of gemfibrozil and other fibric acid derivates, antivirals for the treatment of

hepatitis C (HCV) (boceprevir, telaprevir, and elbasvir/grazoprevir), erythromycin, niacin, or ezetimibe. If possible, alternative (non-interacting) therapies should be considered instead of these medicinal products.

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.

Atorvastatin must not be co-administered with systemic formulations of fusidic acid or within 7 days of stopping fusidic acid treatment. In patients where the use of systemic fusidic acid is considered essential, statin treatment should be discontinued throughout the duration of fusidic acid treatment. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving fusidic acid and statins in combination. The patient should be advised to seek medical advice immediately if they experience any symptoms of muscle weakness, pain or tenderness.

Statin therapy may be re-introduced seven days after the last dose of fusidic acid.

In exceptional circumstances, where prolonged systemic fusidic acid is needed, e.g., for the treatment of severe infections, the need for co-administration of Atorvastatin and fusidic acid should only be considered on a case by case basis and under close medical supervision.

Paediatric population

No clinically significant effect on growth and sexual maturation was observed in a 3-year study based on the assessment of overall maturation and development, assessment of Tanner Stage, and measurement of height and weight.

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>30kg/m^2, raised triglycerides, hypertension) should be monitored both clinically and biochemically according to national guidelines.

Excipients

Atorvastatin contains lactose. Patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Fenofibrate

Secondary causes of hyperlipidemia:

Secondary cause of hypercholesterolemia, such as uncontrolled type 2 diabetes mellitus, hypothyroidism, nephrotic syndrome, dysproteinemia, obstructive liver disease or alcoholism

should be adequately treated before fenofibrate therapy is considered. Secondary cause of hypercholesterolemia related to pharmacological treatment can be seen with diuretics, βblocking agents, estrogens, progestogens, combined oral contraceptives, immunosuppressive agents and protease inhibitors.

In these cases, it should be ascertained whether the hyperlipidaemia is of primary or secondary nature (possible elevation of lipid values caused by these therapeutic agents).

Liver function:

As with other lipid lowering agents, increases have been reported in transaminase levels in some patients. In the majority of cases these elevations were transient, minor and asymptomatic. It is recommended that transaminase levels are monitored every 3 months during the first 12 months of treatment and thereafter periodically.

Attention should be paid to patients who develop increase in transaminase levels and therapy should be discontinued if AST (SGOT) and ALT (SGPT) levels increase to more than 3 times the upper limit of the normal range. When symptoms indicative of hepatitis occurs (e.g. jaundice, pruritus), and diagnosis is confirmed by laboratory testing, fenofibrate therapy should be discontinued.

Pancreas:

Pancreatitis has been reported in patients taking fenofibrate. This occurrence may represent a failure of efficacy in patients with severe hypertriglyceridemia, a direct drug effect, or a secondary phenomenon mediated through biliary tract stone or sludge formation with obstruction of the common bile duct.

Muscle:

Muscle toxicity, including rare cases of rhabdomyolysis, with or without renal failure, has been reported with administration of fibrates and other lipid lowering agents. The incidence of this disorder increases in case of hypoalbuminaemia and previous renal insufficiency. Patients with predisposing factors for myopathy and/or rhabdomyolysis, including age above 70 years, personal or familial history of hereditary muscular disorders, renal impairment, hypothyroidism and high alcohol intake, may be at an increased risk of developing rhabdomyolysis. For these patients, the putative benefits and risks of fenofibrate therapy should be carefully weighed up.

Muscle toxicity should be suspected in patients presenting diffuse myalgia, myositis, muscular cramps and weakness and/or marked increases in CPK (levels exceeding 5 times the upper normal range). In such cases treatment with fenofibrate should be stopped.

The risk of muscle toxicity may be increased if the drug is administered with another fibrate or an HMGCoA reductase inhibitor, especially in case of pre-existing muscular disease. Consequently, the coprescription of fenofibrate with HMGCoA reductase inhibitor or another fibrate should be reserved to patients with severe combined dyslipidaemia and high cardiovascular risk without any history of muscular disease and with a close monitoring of potential muscle toxicity.

Renal function:

Fenofibrate 160 mg is contraindicated in severe renal impairment Fenofibrate 160 mg should be used with caution in patients with mild to moderate renal insufficiency. Dose should be adjusted in patients whose estimated glomerular filtration rate is 30 to 59 mL/min/1.73 m^2 Reversible elevations in serum creatinine have been reported in patients receiving fenofibrate monotherapy or Coadministered with statins.

Elevations in serum creatinine were generally stable over time with no evidence for continued increases in serum creatinine with long term therapy and tended to return to baseline following discontinuation of treatment.

During clinical trials, 10% of patients had a creatinine increase from baseline greater than 30 µmol/L with Coadministered fenofibrate and simvastatin versus 4.4% with statin monotherapy. 0.3% of patients receiving coadministration had clinically relevant increases in creatinine to values > 200 µmol/Treatment should be interrupted when creatinine level is 50% above the upper limit of normal. It is recommended that creatinine is measured during the first 3 months after initiation of treatment and periodically thereafter excipients:

4.5 Drug-Interaction

Atorvastatin

Effect of co-administered medicinal products on atorvastatin

Atorvastatin is metabolised by cytochrome P450 3A4 (CYP3A4) and is a substrate of the hepatic transporters, organic anion-transporting polypeptide 1B1 (OATP1B1) and 1B3 (OATP1B3) transporter. Metabolites of atorvastatin are substrates of OATP1B1. Atorvastatin is also identified as a substrate of the multi-drug resistance protein 1 (MDR1) and breast cancer resistance protein (BCRP), which may limit the intestinal absorption and biliary clearance of atorvastatin. 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 derivates and ezetimibe.

CYP3A4 inhibitors

Potent CYP3A4 inhibitors have been shown to lead to markedly increased concentrations of atorvastatin (see Table 1 and specific information below). Co-administration of potent CYP3A4 inhibitors (e.g. ciclosporin, telithromycin, clarithromycin, delavirdine, stiripentol, ketoconazole, voriconazole, itraconazole, posaconazole, some antivirals used in the treatment of HCV (e.g., elbasvir/grazoprevir), 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 (see Table 1).

Moderate CYP3A4 inhibitors (e.g. erythromycin, diltiazem, verapamil and fluconazole) may increase plasma concentrations of atorvastatin (see Table 1). 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 inhibitors

Inhibitors of transport proteins (e.g. ciclosporin) can increase the systemic exposure of atorvastatin (see Table 1). 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 (see Table 1).

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 (ratio of atorvastatin concentration: 0.74) 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

The risk of myopathy including rhabdomyolysis may be increased by the concomitant administration of systemic fusidic acid with statins. The mechanism of this interaction (whether it is pharmacodynamic or pharmacokinetic, or both) is yet unknown. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving this combination.

If treatment with systemic fusidic acid is necessary, atorvastatin treatment should be discontinued throughout the duration of the fusidic acid treatment.

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.

<u>Effect of atorvastatin on co-administered medicinal products</u>

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, co-administration 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 Special warnings and precautions for use should be taken into account for the paediatric population.

Drug interactions

Table 1: Effect of co-administered medicinal products on the pharmacokinetics of atorvastatin

Co-administered medicinal product and dosing regimen	Dose (mg)	Ratio of AUC[&]	Clinical Recommendation[#]
Glecaprevir 400 mg OD/ Pibrentasvir 120 mg OD, 7 days	10 mg OD for 7 days	8.3	Co-administration with products containing glecaprevir or pibrentasvir is contraindicated.
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	In cases where co-administration 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	
Ciclosporin 5.2 mg/kg/day, stable dose	10 mg OD for 28 days	8.7	
Lopinavir 400 mg BID/ Ritonavir 100 mg BID, 14 days	20 mg OD for 4 days	5.9	In cases where co-administration with

Clarithromycin 500 mg BID, 9 days	80 mg OD for 8 days	4.5	atorvastatin is necessary, lower maintenance doses of atorvastatin are recommended. At atorvastatin doses exceeding 20 mg, clinical monitoring of these patients is recommended.
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	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 these patients is recommended.
Darunavir 300 mg BID/ Ritonavir 100 mg BID, 9 days	10 mg OD for 4 days	3.4	
Itraconazole 200 mg OD, 4 days	40 mg SD	3.3	
Fosamprenavir 700 mg BID/ Ritonavir 100 mg BID, 14 days	10 mg OD for 4 days	2.5	
Fosamprenavir 1400 mg BID, 14 days	10 mg OD for 4 days	2.3	
Elbasvir 50 mg OD/ Grazoprevir 200 mg OD, 13 days	10 mg SD	1.95	The dose of atorvastatin should not exceed a daily dose of 20 mg during co-administration with products containing elbasvir or grazoprevir.
Nelfinavir 1250 mg BID, 14 days	10 mg OD for 28 days	1.74	No specific recommendation.
Grapefruit Juice, 240 mL OD*	40 mg, SD	1.37	Concomitant intake of large quantities of grapefruit juice and atorvastatin is not recommended.
Diltiazem 240 mg OD, 28 days	40 mg, SD	1.51	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	1.33	Lower maximum dose and clinical monitoring of these patients is recommended.
Amlodipine 10 mg, single dose	80 mg, SD	1.18	No specific recommendation.
Cimetidine 300 mg QID, 2 weeks	10 mg OD for 2 weeks	1.00	No specific recommendation.
Colestipol 10 g BID, 24 weeks	40 mg OD for 8 weeks	0.74**	No specific recommendation
Antacid suspension of magnesium and aluminium hydroxides, 30 mL QID, 17 days	10 mg OD for 15 days	0.66	No specific recommendation.
Efavirenz 600 mg OD, 14 days	10 mg for 3 days	0.59	No specific recommendation.
Rifampin 600 mg OD, 7 days (co-administered)	40 mg SD	1.12	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	0.20	
Gemfibrozil 600 mg BID, 7 days	40 mg SD	1.35	Lower starting dose and clinical monitoring of these patients is recommended.
Fenofibrate 160 mg OD, 7 days	40 mg SD	1.03	Lower starting dose and clinical monitoring of these patients is recommended.
Boceprevir 800 mg TID, 7 days	40 mg SD	2.3	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.

[&] Represents ratio of treatments (co-administered drug plus atorvastatin versus atorvastatin alone).

[#] See Special warnings and precautions for use and Interaction with other medicinal products and other forms of interaction for clinical significance.

* Contains one or more components that inhibit CYP3A4 and can increase plasma concentrations of medicinal products metabolised 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) HMG-CoA reductase inhibitors 1.3 fold.

** Ratio based on a single sample taken 8-16 h post dose.

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

Table 2: Effect of atorvastatin on the pharmacokinetics of co-administered medicinal products

Atorvastatin and dosing regimen	Co-administered medicinal product		
	Medicinal product/Dose (mg)	Ratio of AUC[&]	Clinical Recommendation
80 mg OD for 10 days	Digoxin 0.25 mg OD, 20 days	1.15	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	1.28 1.19	No specific recommendation.
80 mg OD for 15 days	* Phenazone, 600 mg SD	1.03	No specific recommendation.
10 mg, SD	Tipranavir 500 mg BID/ritonavir 200 mg BID, 7 days	1.08	No specific recommendation.
10 mg, OD for 4 days	Fosamprenavir 1400 mg BID, 14 days	0.73	No specific recommendation.
10 mg OD for 4 days	Fosamprenavir 700 mg BID/ritonavir 100 mg BID, 14 days	0.99	No specific recommendation.

[&] Represents ratio of treatments (co-administered drug plus atorvastatin versus atorvastatin alone).

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

OD = once daily; SD = single dose; BID = twice daily.

Fenofibrate

Oral anticoagulants:

Fenofibrate enhances oral anticoagulant effect and may increase risk of bleeding. It is recommended that the dose of anticoagulants is reduced by about one third at the start of treatment and then gradually adjusted if necessary according to INR (International Normalised Ratio) monitoring.

Cyclosporin:

Some severe cases of reversible renal function impairment have been reported during concomitant administration of fenofibrate and cyclosporin. The renal function of these patients must therefore be closely monitored and the treatment with fenofibrate stopped in the case of severe alteration of laboratory parameters.

HMGCoA reductase inhibitors and other fibrates:

The risk of serious muscle toxicity is increased if a fibrate is used concomitantly with HMGCoA reductase inhibitors or other fibrates. Such combination therapy should be used with caution and patients monitored closely for signs of muscle toxicity.

Glitazones:

Some cases of reversible paradoxical reduction of HDL cholesterol have been reported during concomitant administration of fenofibrate and glitazones. Therefore, it is recommended to monitor HDL cholesterol if one of these components is added to the other and stopping of either therapy if HDL cholesterol is too low.

Cytochrome P450 enzymes:

In vitro studies using human liver microsomes indicate that fenofibrate and fenofibric acid are not inhibitors of cytochrome (CYP) P450 isoforms CYP3A4, CYP2D6, CYP2E1, or CYP1A2. They are weak inhibitors of CYP2C19 and CYP2A6, and mild to moderate inhibitors of CYP2C9 at therapeutic concentrations.

Patients Coadministered

Fenofibrate and CYP2C19, CYP2A6, and especially CYP2C9 metabolised drugs with a narrow therapeutic index should be carefully monitored and, if necessary, dose adjustment of these drugs is recommended.

4.6 Use in special populations (such as pregnant women, lactating women, paediatric patients, geriatric patients etc.)

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. Studies in animals have shown toxicity to reproduction.

Maternal treatment with atorvastatin may reduce the foetal 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.

Breast-feeding

It is unknown 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 breast-feeding.

Fertility

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

Fenofibrate

Pregnancy: There are no adequate data from the use of fenofibrate in pregnant women. Animal studies have not demonstrated any teratogenic effects. Embryotoxic effects have been shown at doses in the range of maternal toxicity. The potential risk for humans is unknown. Therefore, Fenofibrate 160 mg film coated tablet should only be used during pregnancy after a careful benefit/risk assessment.

Lactation: It is unknown whether fenofibrate and/or its metabolites are excreted in human milk. A risk to the suckling child cannot be excluded. Therefore, fenofibrate should not be used during breastfeeding.

Fertility: Reversible effects on fertility have been observed in animals. There are no clinical data on fertility from the use of Fenofibrate 160 mg.

4.7 Effects On Ability To Drive And Use Machines

It has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable Effects

Atorvastatin

In the atorvastatin placebo-controlled clinical trial database of 16,066 (8755 Atorvastatin vs. 7311 placebo) patients treated for a mean period of 53 weeks, 5.2% of patients on atorvastatin discontinued due to adverse reactions compared to 4.0% of the patients on placebo.

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 (≥ 1/100, < 1/10); uncommon (≥ 1/1,000, < 1/100); rare (≥ 1/10,000, < 1/1,000); very rare (< 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

Paediatric patients aged from 10 to 17 years of age treated with atorvastatin had an adverse experience profile generally similar to that of patients treated with placebo, the most common adverse experiences observed in both groups, regardless of causality assessment, were infections. No clinically significant effect on growth and sexual maturation was observed in a 3-year study based on the assessment of overall maturation and development, assessment of Tanner Stage, and measurement of height and weight. The safety and tolerability profile in paediatric patients was similar to the known safety profile of atorvastatin in adult patients.

The clinical safety database includes safety data for 520 paediatric patients who received atorvastatin, among which 7 patients were < 6 years old, 121 patients were in the age range of 6 to 9, and 392 patients were in the age range of 10 to 17. Based on the data available, the frequency, type and severity of adverse reactions in children is similar to adults.

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>30kg/m^2, raised triglycerides, history of hypertension).

Fenofibrate

The most commonly reported ADRs during fenofibrate therapy are digestive, gastric or intestinal disorders. The following undesirable effects have been observed during placebo controlled clinical trials (n=2344) and post marketing with the below indicated frequencies:

* In the FIELD study, a randomized placebo controlled trial performed in 9,795 patients with type 2 diabetes mellitus, a statistically significant increase in pancreatitis cases was observed in patients receiving fenofibrate versus patients receiving placebo (0.8% versus 0.5%; p = 0.031). In the same study, a statistically significant increase was reported in the incidence of pulmonary embolism (0.7% in the placebo group versus 1.1% in the fenofibrate group; p = 0.022) and a statistically no significant increase in deep vein thromboses (placebo: 1.0% [48/4,900 patients] versus fenofibrate 1.4% [67/4,895 patients]; p = 0.074).

** In the FIELD study, the average increase in blood homocysteine level in patients treated with fenofibrate was 6.5 µmol/L, and was reversible on discontinuation of fenofibrate treatment. The increased risk of venous thrombotic events may be related to the increased homocysteine level. The clinical significance of this is not clear.

Reporting of side effects
If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via any point of contact of Torrent Pharma available at:
http://www.torrentpharma.com/index.php/site/info/adverse_event_reporting.

By reporting side effects, you can help provide more information on the safety of this medicine.

4.9 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.

Fenofibrate

Only anecdotal cases of fenofibrate overdosage have been received. In the majority of cases no overdose symptoms were reported.

No specific antidote is known. If an overdose is suspected, treat symptomatically and institute appropriate supportive measures as required. Fenofibrate cannot be eliminated by haemodialysis

5. Pharmacological properties

5.1 Mechanism of Action

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 catabolised 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.

Fenofibrate

Serum Lipid Reducing Agents / Cholesterol and Triglycerides Reducers / Fibrates.

ATC code: C10 AB 05

Fenofibrate is a fibric acid derivative whose lipid modifying effects reported in humans are mediated via activation of Peroxisome Proliferator Activated Receptor type alpha (PPARα).

Through activation of PPARα, fenofibrate increases the lipolysis and elimination of atherogenic triglyceride rich particles from plasma by activating lipoprotein lipase and reducing production of apoprotein CIII. Activation of PPARα also induces an increase in the synthesis of apoproteins AI and AII.

The above stated effects of fenofibrate on lipoproteins lead to a reduction in very low and low density fractions (VLDL and LDL) containing apoprotein B and an increase in the high density lipoprotein fraction (HDL) containing apoprotein AI and AII.

5.2 Pharmacodynamics Properties

Atorvastatin

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.

<u>Homozygous familial hypercholesterolaemia</u>

In a multicentre 8 week open-label compassionate-use study with an optional extension phase of variable length, 335 patients were enrolled, 89 of which were identified as homozygous familial hypercholesterolaemia patients. From these 89 patients, the mean percent reduction in LDL-C was approximately 20%. Atorvastatin was administered at doses up to 80 mg/day.

<u>Atherosclerosis</u>

In the Reversing Atherosclerosis with Aggressive Lipid- Lowering Study (REVERSAL), the effect of intensive lipid lowering with atorvastatin 80 mg and standard degree of lipid lowering with pravastatin 40 mg on coronary atherosclerosis was assessed by intravascular ultrasound (IVUS), during angiography, in patients with coronary heart disease. In this randomised, double- blind, multicentre, controlled clinical trial, IVUS was performed at baseline and at 18

months in 502 patients. In the atorvastatin group (n=253), there was no progression of atherosclerosis.

The median percent change, from baseline, in total atheroma volume (the primary study criteria) was -0.4% (p=0.98) in the atorvastatin group and +2.7% (p=0.001) in the pravastatin group (n=249). When compared to pravastatin the effects of atorvastatin were statistically significant (p=0.02). The effect of intensive lipid lowering on cardiovascular endpoints (e. g. need for revascularisation, non-fatal myocardial infarction, and coronary death) was not investigated in this study.

In the atorvastatin group, LDL-C was reduced to a mean of 2.04 mmol/L ± 0.8 (78.9 mg/dl ± 30) from baseline 3.89 mmol/L ± 0.7 (150 mg/dl ± 28) and in the pravastatin group, LDL-C was reduced to a mean of 2.85 mmol/L ± 0.7 (110 mg/dl ± 26) from baseline 3.89 mmol/L ± 0.7 (150 mg/dl ± 26) (p<0.0001). Atorvastatin also significantly reduced mean TC by 34.1% (pravastatin: -18.4%, p<0.0001), mean TG levels by 20% (pravastatin: -6.8%, p<0.0009), and mean apolipoprotein B by 39.1% (pravastatin: -22.0%, p<0.0001). Atorvastatin increased mean HDL-C by 2.9% (pravastatin: +5.6%, p=NS). There was a 36.4% mean reduction in CRP in the atorvastatin group compared to a 5.2% reduction in the pravastatin group (p<0.0001).

Study results were obtained with the 80 mg dose strength. Therefore, they cannot be extrapolated to the lower dose strengths.

The safety and tolerability profiles of the two treatment groups were comparable.

The effect of intensive lipid lowering on major cardiovascular endpoints was not investigated in this study. Therefore, the clinical significance of these imaging results with regard to the primary and secondary prevention of cardiovascular events is unknown.

Acute coronary syndrome

In the MIRACL study, atorvastatin 80 mg has been evaluated in 3,086 patients (atorvastatin n=1,538; placebo n=1,548) with an acute coronary syndrome (non Q-wave MI or unstable angina). Treatment was initiated during the acute phase after hospital admission and lasted for a period of 16 weeks. Treatment with atorvastatin 80 mg/day increased the time to occurrence of the combined primary endpoint, defined as death from any cause, nonfatal MI, resuscitated cardiac arrest, or angina pectoris with evidence of myocardial ischaemia requiring hospitalization, indicating a risk reduction by 16% (p=0.048). This was mainly due to a 26% reduction in re-hospitalisation for angina pectoris with evidence of myocardial ischaemia (p=0.018). The other secondary endpoints did not reach statistical significance on their own (overall: Placebo: 22.2%, Atorvastatin: 22.4%).

The safety profile of atorvastatin in the MIRACL study was consistent with what is described in Undesirable effects.

Prevention of cardiovascular disease

The effect of atorvastatin on fatal and non-fatal coronary heart disease was assessed in a randomised, double-blind, placebo-controlled study, the Anglo-Scandinavian Cardiac Outcomes Trial Lipid Lowering Arm (ASCOT-LLA). Patients were hypertensive, 40-79 years of age, with no previous myocardial infarction or treatment for angina, and with TC levels ≤6.5 mmol/L (251 mg/dl). All patients had at least 3 of the pre-defined cardiovascular risk factors: male gender, age ≥55 years, smoking, diabetes, history of CHD in a first-degree relative, TC:HDL-C >6, peripheral vascular disease, left ventricular hypertrophy, prior cerebrovascular event, specific ECG abnormality, proteinuria/albuminuria. Not all included patients were estimated to have a high risk for a first cardiovascular event.

Patients were treated with anti-hypertensive therapy (either amlodipine or atenolol-based regimen) and either atorvastatin 10 mg daily (n=5,168) or placebo (n=5,137).

The absolute and relative risk reduction effect of atorvastatin was as follows:

Event	Relative Risk Reduction (%)	No. of Events (Atorvastatin vs Placebo)	Absolute Risk Reduction[1] (%)	p-value
Fatal CHD plus non-fatal MI	36%	100 vs. 154	1.1%	0.0005
Total cardiovascular events and revascularization procedures	20%	389 vs. 483	1.9%	0.0008
Total coronary events	29%	178 vs 247	1.4%	0.0006

[1]Based on difference in crude events rates occurring over a median follow-up of 3.3 years.

CHD = coronary heart disease; MI = myocardial infarction.

Total mortality and cardiovascular mortality were not significantly reduced (185 vs. 212 events, p=0.17 and 74 vs. 82 events, p=0.51). In the subgroup analyses by gender (81% males, 19% females), a beneficial effect of atorvastatin was seen in males but could not be established in females possibly due to the low event rate in the female subgroup. Overall and cardiovascular mortality were numerically higher in the female patients (38 vs. 30 and 17 vs. 12), but this was not statistically significant. There was significant treatment interaction by antihypertensive baseline therapy. The primary endpoint (fatal CHD plus non-fatal MI) was significantly reduced by atorvastatin in patients treated with amlodipine (HR 0.47 (0.32-0.69), p=0.00008), but not in those treated with atenolol (HR 0.83 (0.59-1.17), p=0.287).

The effect of atorvastatin on fatal and non-fatal cardiovascular disease was also assessed in a randomised, double-blind, multicentre, placebo-controlled trial, the Collaborative Atorvastatin Diabetes Study (CARDS) in patients with type 2 diabetes, 40-75 years of age, without prior history of cardiovascular disease, and with LDL-C ≤4.14 mmol/L (160 mg/dl) and TG ≤6.78 mmol/L (600 mg/dl). All patients had at least 1 of the following risk factors: hypertension, current smoking, retinopathy, microalbuminuria or macroalbuminuria.

Patients were treated with either atorvastatin 10 mg daily (n=1,428) or placebo (n=1,410) for a median follow-up of 3.9 years.

The absolute and relative risk reduction effect of atorvastatin was as follows:

Event	Relative Risk Reduction (%)	No. of Events (Atorvastatin vs Placebo)	Absolute Risk Reduction[1] (%)	p-value
Major cardiovascular events (fatal and non-fatal AMI, silent MI, acute CHD death, unstable angina, CABG, PTCA, revascularization, stroke)	37%	83 vs. 127	3.2%	0.0010
	42%	38 vs 64	1.9%	0.0070
	48%	21 vs. 39	1.3%	0.0163

MI (fatal and non-fatal AMI, silent MI) Strokes (Fatal and non-fatal)				

[1]Based on difference in crude events rates occurring over a median follow-up of 3.9 years.

AMI = acute myocardial infarction; CABG = coronary artery bypass graft; CHD = coronary heart disease; MI = myocardial infarction; PTCA = percutaneous transluminal coronary angioplasty.

There was no evidence of a difference in the treatment effect by patient's gender, age, or baseline LDL-C level. A favourable trend was observed regarding the mortality rate (82 deaths in the placebo group vs. 61 deaths in the atorvastatin group, p=0.0592).

Recurrent stroke

In the Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) study, the effect of atorvastatin 80 mg daily or placebo on stroke was evaluated in 4731 patients who had a stroke or transient ischemic attack (TIA) within the preceding 6 months and no history of coronary heart disease (CHD). Patients were 60% male, 21-92 years of age (average age 63 years), and had an average baseline LDL of 133 mg/dL (3.4 mmol/L). The mean LDL-C was 73 mg/dL (1.9 mmol/L) during treatment with atorvastatin and 129 mg/dL (3.3 mmol/L) during treatment with placebo. Median follow-up was 4.9 years.

Atorvastatin 80 mg reduced the risk of the primary endpoint of fatal or non-fatal stroke by 15% (HR 0.85; 95% CI, 0.72-1.00; p=0.05 or 0.84; 95% CI, 0.71-0.99; p=0.03 after adjustment for baseline factors) compared to placebo. All-cause mortality was 9.1% (216/2365) for atorvastatin versus 8.9% (211/2366) for placebo.

In a post-hoc analysis, atorvastatin 80 mg reduced the incidence of ischemic stroke (218/2365, 9.2% vs. 274/2366, 11.6%, p=0.01) and increased the incidence of haemorrhagic stroke (55/2365, 2.3% vs. 33/2366, 1.4%, p=0.02) compared to placebo.

• The risk of haemorrhagic stroke was increased in patients who entered the study with prior haemorrhagic stroke (7/45 for atorvastatin versus 2/48 for placebo; HR 4.06; 95% CI, 0.84-19.57), and the risk of ischemic stroke was similar between groups (3/45 for atorvastatin versus 2/48 for placebo; HR 1.64; 95% CI, 0.27-9.82).

• The risk of haemorrhagic stroke was increased in patients who entered the study with prior lacunar infarct (20/708 for atorvastatin versus 4/701 for placebo; HR 4.99; 95% CI, 1.71-14.61), but the risk of ischemic stroke was also decreased in these patients (79/708 for atorvastatin versus 102/701 for placebo; HR 0.76; 95% CI, 0.57-1.02). It is possible that the net risk of stroke is increased in patients with prior lacunar infarct who receive atorvastatin 80 mg/day.

All-cause mortality was 15.6% (7/45) for atorvastatin versus 10.4% (5/48) in the subgroup of patients with prior haemorrhagic stroke. All-cause mortality was 10.9% (77/708) for atorvastatin versus 9.1% (64/701) for placebo in the subgroup of patients with prior lacunar infarct.

Paediatric population

Heterozygous Familial Hypercholesterolaemia in Paediatric Patients aged 6-17 years old

An 8-week, open-label study to evaluate pharmacokinetics, pharmacodynamics, and safety and tolerability of atorvastatin was conducted in children and adolescents with genetically

confirmed heterozygous familial hypercholesterolemia and baseline LDL-C ≥ 4 mmol/L. A total of 39 children and adolescents, 6 to 17 years of age, were enrolled. Cohort A included 15 children, 6 to 12 years of age and at Tanner Stage 1. Cohort B included 24 children, 10 to 17 years of age and at Tanner Stage ≥ 2.

The initial dose of atorvastatin was 5 mg daily of a chewable tablet in Cohort A and 10 mg daily of a tablet formulation in Cohort B. The atorvastatin dose was permitted to be doubled if a subject had not attained target LDL-C of < 3.35 mmol/L at Week 4 and if atorvastatin was well tolerated.

Mean values for LDL-C, TC, VLDL-C, and Apo B decreased by Week 2 among all subjects. For subjects whose dose was doubled, additional decreases were observed as early as 2 weeks, at the first assessment, after dose escalation. The mean percent decreases in lipid parameters were similar for both cohorts, regardless of whether subjects remained at their initial dose or doubled their initial dose. At Week 8, on average, the percent change from baseline in LDL-C and TC was approximately 40% and 30%, respectively, over the range of exposures.

In a second open label, single arm study, 271 male and female HeFH children 6-15 years of age were enrolled and treated with atorvastatin for up to three years. Inclusion in the study required confirmed HeFH and a baseline LDL-C level ≥ 4 mmol/L (approximately 152 mg/dL). The study included 139 children at Tanner 1 developmental stage (generally ranging from 6-10 years of age). The dosage of atorvastatin (once daily) was initiated at 5 mg (chewable tablet) in children less than 10 years of age. Children age 10 and above were initiated at 10 mg atorvastatin (once daily). All children could titrate to higher doses to achieve a target of < 3.35 mmol/L LDL-C. The mean weighted dose for children aged 6 to 9 years was 19.6 mg and the mean weighted dose for children aged 10 years and above was 23.9 mg.

The mean (+/- SD) baseline LDL-C value was 6.12 (1.26) mmol/L which was approximately 233 (48) mg/dL. See table 3 below for final results.

The data were consistent with no drug effect on any of the parameters of growth and development (i.e., height, weight, BMI, Tanner stage, Investigator assessment of Overall Maturation and Development) in paediatric and adolescent subjects with HeFH receiving atorvastatin treatment over the 3-year study. There was no Investigator-assessed drug effect noted in height, weight, BMI by age or by gender by visit.

TABLE 3. Lipid-lowering Effects of Atorvastatin in Adolescent Boys and Girls with Heterozygous Familial Hypercholesterolemia (mmol/L)

Time point	N	TC (S.D.)	LDL-C (S.D.)	HDL-C (S.D.)	TG (S.D.)	Apo B (S.D.)#
Baseline	271	7.86(1.30)	6.12(1.26)	1.314(0.2663)	0.93(0.47)	1.42(0.28)**
Month 30	206	4.95(0.77)*	3.25(0.67)	1.327(0.2796)	0.79(0.38)*	0.90(0.17)*
Month 36/ET	240	5.12(0.86)	3.45(0.81)	1.308(0.2739)	0.78(0.41)	0.93(0.20)***

TC= total cholesterol; LDL-C = low density lipoprotein cholesterol-C; HDL-C = high density lipoprotein cholesterol-C; TG = triglycerides; Apo B = apolipoprotein B; "Month 36/ET" included final visit data for subjects who ended participation prior to the scheduled 36 month time point as well as full 36 month data for subjects completing the 36 month participation;

"*"= Month 30 N for this parameter was 207; "**"= Baseline N for this parameter was 270; "***" = Month 36/ET N for this parameter was 243; "#"=g/L for Apo B.

Heterozygous Familial Hypercholesterolaemia in Paediatric Patients aged 10-17 years' old

In a double-blind, placebo controlled study followed by an open-label phase, 187 boys and postmenarchal girls 10-17 years of age (mean age 14.1 years) with heterozygous familial hypercholesterolaemia (FH) or severe hypercholesterolaemia were randomised to atorvastatin (n=140) or placebo (n=47) for 26 weeks and then all received atorvastatin for 26 weeks. The dosage of atorvastatin (once daily) was 10 mg for the first 4 weeks and up-titrated to 20 mg if the LDL-C level was >3.36 mmol/L. Atorvastatin significantly decreased plasma levels of Total-C, LDL-C, triglycerides, and apolipoprotein B during the 26 week double-blind phase. The mean achieved LDL-C value was 3.38 mmol/L (range: 1.81-6.26 mmol/L) in the atorvastatin group compared to 5.91 mmol/L (range: 3.93-9.96 mmol/L) in the placebo group during the 26-week double-blind phase.

An additional paediatric study of atorvastatin versus colestipol in patients with hypercholesterolaemia aged 10-18 years demonstrated that atorvastatin (N=25) caused a significant reduction in LDL-C at week 26 ($p<0.05$) compared with colestipol (N=31).

A compassionate use study in patients with severe hypercholesterolaemia (including homozygous hypercholesterolaemia) included 46 paediatric patients treated with atorvastatin titrated according to response (some subjects received 80 mg atorvastatin per day). The study lasted 3 years: LDL-cholesterol was lowered by 36%.

The long-term efficacy of atorvastatin therapy in childhood to reduce morbidity and mortality in adulthood has not been established.

The European Medicines Agency has waived the obligation to submit the results of studies with atorvastatin in children aged 0 to less than 6 years in the treatment of heterozygous hypercholesterolaemia and in children aged 0 to less than 18 years in the treatment of homozygous familial hypercholesterolaemia, combined (mixed) hypercholesterolaemia, primary hypercholesterolaemia and in the prevention of cardiovascular events (see Posology and method of administration for information on paediatric use).

Fenofibrate

In addition, through modulation of the synthesis and the catabolism of VLDL fractions fenofibrate increases the LDL clearance and reduces small dense LDL, the levels of which are elevated in the atherogenic lipoprotein phenotype, a common disorder in patients at risk for coronary heart disease. During clinical trials with fenofibrate, total cholesterol was reduced by 20 to 25%, triglycerides by 40 to 55% and HDL cholesterol was increased by 10 to 30%. In hypercholesterolaemic patients, where LDL cholesterol levels are reduced by 20 to 35%, the overall effect on cholesterol results in a decrease in the ratios of total cholesterol to HDL cholesterol, LDL cholesterol to HDL cholesterol, or Apo B to Apo AI, all of which are markers of atherogenic risk.

There is evidence that treatment with fibrates may reduce coronary heart disease events but they have not been shown to decrease all-cause mortality in the primary or secondary prevention of cardiovascular disease.

The Action to Control Cardiovascular Risk in Diabetes (ACCORD) lipid trial was a randomized placebo-controlled study of 5518 patients with type 2 diabetes mellitus treated with fenofibrate in addition to simvastatin. Fenofibrate plus simvastatin therapy did not show any significant differences compared to simvastatin monotherapy in the composite primary outcome of

nonfatal myocardial infarction, nonfatal stroke, and cardiovascular death (hazard ratio [HR] 0.92, 95% CI 0.791.08, p = 0.32; absolute risk reduction: 0.74%). In the prespecified subgroup of dyslipidaemic patients, defined as those in the lowest tertile of HDLC (≤34 mg/dl or 0.88 mmol/L) and highest tertile of TG (≥204 mg/dl or 2.3 mmol/L) at baseline, fenofibrate plus simvastatin therapy demonstrated a 31% relative reduction compared to simvastatin monotherapy for the composite primary outcome (hazard ratio [HR] 0.69, 95% CI 0.490.97, p = 0.03; absolute risk reduction: 4.95%).

Another prespecified subgroup analysis identified a statistically significant treatment by gender interaction (p = 0.01) indicating a possible treatment benefit of combination therapy in men (p=0.037) but a potentially higher risk for the primary outcome in women treated with combination therapy compared to simvastatin monotherapy (p=0.069). This was not observed in the aforementioned subgroup of patients with dyslipidaemia but there was also no clear evidence of benefit in dyslipidaemic women treated with fenofibrate plus simvastatin, and a possible harmful effect in this subgroup could not be excluded.

Extravascular deposits of cholesterol (tendinous and tuberous xanthoma) may be markedly reduced or even entirely eliminated during fenofibrate therapy.

Patients with raised levels of fibrinogen treated with fenofibrate have shown significant reductions in this parameter, as have those with raised levels of Lp(a). Other inflammatory markers such as C Reactive Protein are reduced with fenofibrate treatment.

The uricosuric effect of fenofibrate leading to reduction in uric acid levels of approximately 25% should be of additional benefit in those dyslipidaemic patients with hyperuricaemia. Fenofibrate has been shown to possess an antiaggregatory effect on platelets in animals and in a clinical study, which showed a reduction in platelet aggregation induced by ADP, arachidonic acid and epinephrine.

5.3 Pharmacokinetic Properties

Atorvastatin

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 ≥ 98% bound to plasma proteins.

Biotransformation

Atorvastatin is metabolised by cytochrome P450 3A4 to ortho- and parahydroxylated derivatives and various beta-oxidation products. Apart from other pathways these products are further metabolised 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.

Atorvastatin is a substrate of the hepatic transporters, organic anion-transporting polypeptide 1B1 (OATP1B1) and 1B3 (OATP1B3) transporter. Metabolites of atorvastatin are substrates of OATP1B1. Atorvastatin is also identified as a substrate of the efflux transporters multi-drug resistance protein 1 (MDR1) and breast cancer resistance protein (BCRP), which may limit the intestinal absorption and biliary clearance of atorvastatin.

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 population

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.

Renal impairment

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

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).

SLOC1B1 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. 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.

Fenofibrate

Absorption**:**

Maximum plasma concentrations (Cmax) occur within 4 to 5 hours after oral administration. Plasma concentrations are stable during continuous treatment in any given individual. The absorption of fenofibrate is increased when administered with food.

Distribution:

Fenofibric acid is strongly bound to plasma albumin (more than 99%).

Metabolism and excretion:

After oral administration, fenofibrate is rapidly hydrolysed by esterases to the active metabolite fenofibric acid. No unchanged fenofibrate can be detected in the plasma. Fenofibrate is not a substrate for CYP 3A4. No hepatic microsomal metabolism is involved.

The drug is excreted mainly in the urine. Practically all the drug is eliminated within 6 days. Fenofibrate is mainly excreted in the form of fenofibric acid and its glucuronide conjugate. In elderly patients, the fenofibric acid apparent total plasma clearance is not modified. Kinetic studies following the administration of a single dose and continuous treatment have demonstrated that the drug does not accumulate. Fenofibric acid is not eliminated by haemodialysis. The plasma elimination half-life of fenofibric acid is approximately 20 hours.

6. Nonclinical properties

6.1 Animal Toxicology or Pharmacology

Atorvastatin

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 AUC0-24h 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 foetuses. In rats, rabbits and dogs atorvastatin had no effect on fertility and was not teratogenic, however, at maternally toxic doses foetal 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.

Fenofibrate

In a three-month oral nonclinical study in the rat species with fenofibric acid, the active metabolite of fenofibrate, toxicity for the skeletal muscles (particularly those rich in type I slow Oxidative myofibres) and cardiac degeneration, anemia and decreased body weight were seen. No skeletal toxicity was noted at doses up to 30 mg/kg (approximately 17time the exposure at the human maximum recommended dose (MRHD). No sign of cardio myotoxicity were noted at an exposure about 3 times the exposure at MRHD. Reversible ulcers and erosions in the gastrointestinal tract occurred in dogs treated for 3 months. No gastrointestinal lesions were noted in that study at an exposure approximately 5 times the exposure at the MRHD.

Studies on mutagenicity of fenofibrate have been negative.

In rats and mice, liver tumours have been found at high dosages, which are attributable to peroxisome proliferation.

These changes are specific to small rodents and have not been observed in other animal species. This is of no relevance to therapeutic use in man.

Studies in mice, rats and rabbits did not reveal any teratogenic effect. Embryotoxic effects were observed at doses in the range of maternal toxicity. Prolongation of the gestation period and difficulties during delivery were observed at high doses.

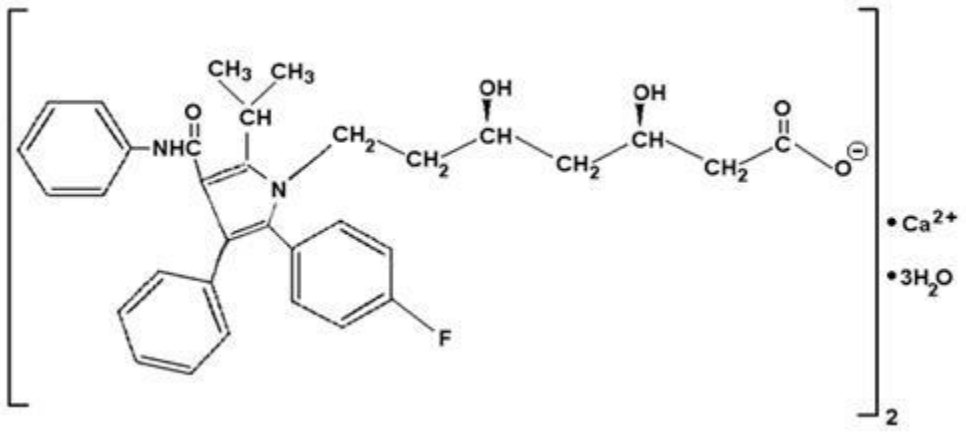
Reversible hypospermia and testicular vacuolation and immaturity of the ovaries were observed in a repeat dose toxicity study with fenofibric acid in young dogs. However, no effects on fertility were detected in nonclinical reproductive toxicity studies conducted with fenofibrate.

7. DESCRIPTION

Atorvastatin and Fenofibrate Tablets is used for the treatment of combined hyperlipidemia in patients with normal hepatic and renal function.

Atorvastatin Calcium

Atorvastatin Calcium is calcium salt of (βR,8R)-2-(4-fluorophenyl)-α,δ-dihydroxy-5-(1-methylethyl)-3-phenyl-4-[(phenylamino)carbonyl]-1H-pyrrole-1-heptanoic acid trihydrate. The empirical formula of atorvastatin calcium is $(C_{33}H_{34}FN_2O_5)_2Ca\cdot 3H_2O$ and its molecular weight is 1209.42. Its structural formula is:



Atorvastatin calcium is a white to off-white crystalline powder. It is freely soluble in methanol; slightly soluble in ethanol (95%) and very slightly soluble in water.

Fenofibrate

The chemical name for fenofibrate is 2-[4-(4-chlorobenzoyl) phenoxy]-2-methyl-propanoic acid, 1-methylethyl ester. The empirical formula is $C_{20}H_{21}O_4Cl$ and the molecular weight is 360.83. Its structural formula is:

Fenofibrate is white or almost white crystalline powder. It is very soluble in dichloromethane, slightly soluble in ethanol (95%); practically insoluble in water.

Atorvastatin and Fenofibrate Tablets is white to off-white, round, biconvex, film coated tablets, plain on both sides. The excipients used are Calcium Carbonate, Lactose, Croscarmellose Sodium, Sodium Lauryl Sulphate, Polyvinyl Pyrrolidone, Colloidal Silicon Dioxide, Crospovidone, Magnesium Stearate, Hydroxy propyl methylcellulose, Colloidal Silicon Dioxide, Talc, Titanium Dioxide, and PEG 6000.

8. PHARMACEUTICAL PARTICULARS

8.1 Incompatibilities

Not Available

8.2 Shelf-life

Do not use later than the date of expiry.

8.3 Packaging Information

TGTOR F 160 is available in 10 BLISTER STRIPS OF 10 TABLETS EACH.

8.4 Storage and Handing Instructions

STORE AT A TEMPERATURE NOT EXCEEDING 30°C, PROTECTED FROM LIGHT AND MOISTURE.

9. PATIENT COUNSELLING INFORMATION

TG TOR F 160

Atorvastatin Calcium & Fenofibrate Tablets I.P

Read all of this leaflet carefully before you start taking this medicine because it contains important information for you.

- Keep this leaflet. You may need to read it again.
- if you have any further questions, ask your doctor, pharmacist or nurse.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- if you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet.

What is in this leaflet?

9.1 What TG TOR F 160is and what it is used for

Atorvastatin Calcium belongs to a group of medicines known as statins, which are lipid (fat) regulating medicines. Atorvastatin Calcium is used to lower lipids known as cholesterol and triglycerides in the blood when a low fat diet and life style changes on their own have failed. If you are at an increased risk of heart disease,

Fenofibrate 160 mg belongs to a group of medicines, commonly known as fibrates. These medicines are used to lower the level of fats (lipids) in the blood. For example, the fats known as triglycerides.

TG TOR F is used for the treatment of combined hyperlipidaemia in patients with normal hepatic and renal function

9.2 What you need to know before you take TG TOR F 160

Do not take TG TOR F 160 Calcium:

- If you are allergic to TG TOR F 160 or any of the other ingredients of this medicine
- If you have or have ever had a disease which affects the liver
- If you have had any unexplained abnormal blood tests for liver function
- If you are a woman able to have children and not using reliable contraception
- If you are pregnant or trying to become pregnant
- If you are breast-feeding
- If you use the combination of glecaprevir/pibrentasvir in the treatment of hepatitis C
- you are allergic to peanut or arachis oil or soya lecithin or related products
- while taking other medicines (such as other fibrates or an anti-inflammatory medicine called 'ketoprofen'), you have had an allergic reaction or skin damage from sunlight or UV light
- you have severe, kidney or gallbladder problems
- you have pancreatitis (an inflamed pancreas which causes abdominal pain) which is not caused by high levels of fat in the blood

Warnings and precautions

Talk to your doctor, pharmacist or nurse before taking TG TOR F 160 Calcium:

- If you have severe respiratory failure
- If you are taking or have taken in the last 7 days a medicine called fusidic acid, (a medicine for bacterial infection) orally or by injection. The combination of fusidic acid and TG TOR F 160can lead to serious muscle problems (rhabdomyolysis)
- If you have had a previous stroke with bleeding into the brain, or have small pockets of fluid in the brain from previous strokes
- If you have kidney problems
- If you have an under-active thyroid gland (hypothyroidism)
- If you have had repeated or unexplained muscle aches or pains, a personal history or family history of muscle problems
- If you have had previous muscular problems during treatment with other lipid-lowering medicines (e.g. other '-statin' or '-fibrate' medicines)
- If you regularly drink a large amount of alcohol
- If you have a history of liver disease
- If you are older than 70 years

If any of these apply to you, your doctor will need to carry out a blood test before and possibly during your TG TOR F 160treatment to predict your risk of muscle related side effects. The risk of muscle related side effects e.g. rhabdomyolysis is known to increase when certain medicines are taken at the same time.

Also tell your doctor or pharmacist if you have a muscle weakness that is constant. Additional tests and medicines may be needed to diagnose and treat this.

While you are on this medicine your doctor will monitor you closely if you have diabetes or are at risk of developing diabetes. You are likely to be at risk of developing diabetes if you have high levels of sugars and fats in your blood, are overweight and have high blood pressure.

Stop taking Fenofibrate 160 mg and see a doctor straight away if you get

- unexplained cramps
- Painful, tender or weak muscles.

This is because this medicine may cause muscle problems, which may be serious. These problems are rare but include muscle inflammation and breakdown. This can cause kidney damage or even death. Your doctor may do a blood test to check your muscles before and after starting treatment.

The risk of muscle breakdown is higher in some patients. In particular, tell your doctor if:

- you or a close family member has muscle problem which runs in the family
- you drink large amounts of alcohol
- you are taking medicines called statins to lower cholesterol (such as simvastatin, atorvastatin, pravastatin, rosuvastatin or fluvastatin)
- You have ever had muscle problems during treatment with statins or fibrates (such as fenofibrate, bezafibrate or gemfibrozil).

If any of the above apply to you (or you are not sure), talk to your doctor before taking Fenofibrate 160 mg.

Other medicines and TG TOR F 160

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines. There are some medicines that may change the effect of TG TOR F 160or their effect may be changed by TG TOR F 160. This type of interaction could make one or both of the medicines less effective. Alternatively, it could increase the risk or severity of side-effects, including the important muscle wasting condition known as rhabdomyolysis

Medicines used to alter the way your immune system works, e.g. ciclosporin

- Certain antibiotics or antifungal medicines, e.g. erythromycin, clarithromycin, telithromycin, ketoconazole, itraconazole, voriconazole, fluconazole, posaconazole, rifampin, fusidic acid
- Other medicines to regulate lipid levels, e.g. gemfibrozil, other fibrates, colestipol
- Some calcium channel blockers used for angina or high blood pressure, e.g. amlodipine, diltiazem; medicines to regulate your heart rhythm e.g. digoxin, verapamil, amiodarone
- Medicines used in the treatment of HIV e.g. ritonavir, lopinavir, atazanavir, indinavir, darunavir, the combination of Tipranavir/ritonavir etc.
- Some medicines used in the treatment of hepatitis C e.g. telaprevir, boceprevir and the combination of elbasvir/grazoprevir

- Other medicines known to interact with TG TOR F 160include ezetimibe (which lowers cholesterol), warfarin (which reduces blood clotting), oral contraceptives, stiripentol (an anti-convulsant for epilepsy), cimetidine (used for heartburn and peptic ulcers), phenazone (a painkiller), colchicine (used to treat gout), and antacids (indigestion products containing aluminium or magnesium)
- Medicines obtained without a prescription: St John's Wort
- If you need to take oral fusidic acid to treat a bacterial infection you will need to temporarily stop using this medicine. Your doctor will tell you when it is safe to restart TG TOR F 160 Calcium. Taking TG TOR F 160with fusidic acid may rarely lead to muscle weakness, tenderness or pain (rhabdomyolysis).
- anti-coagulants to thin your blood (such as warfarin)
- may increase the risk of muscle problems
- a particular class of medicines to treat diabetes (such as rosiglitazone or pioglitazone)
- cyclosporin (an immunosuppressant)

TG TOR F 160with food and drink

how to take TG TOR F 160. Please note the following:

Take the tablet with food — it will not work as well if your stomach is empty.

- Swallow the tablet with a glass of water.
- Do not crush or chew the tablet.

Remember that as well as taking Fenofibrate 160 mg, it is also important that you:

- have a low fat diet
- Take regular exercise.

Grapefruit juice

Do not take more than one or two small glasses of grapefruit juice per day because large quantities of grapefruit juice can change the effects of TG TOR F 160 Calcium.

Alcohol

Avoid drinking too much alcohol while taking this medicine.

Pregnancy and breast-feeding

Do not take TG TOR F 160 if you are pregnant, or if you are trying to become pregnant.

Do not take TG TOR F 160if you are able to become pregnant unless you use reliable contraceptive measures.

Do not take TG TOR F 160if you are breast-feeding.

The safety of TG TOR F 160during pregnancy and breast-feeding has not yet been proven. Ask your doctor or pharmacist for advice before taking any medicine.

Driving and using machines

Normally this medicine does not affect your ability to drive or operate machines. However, do not drive if this medicine affects your ability to drive. Do not use any tools or machines if your ability to use them is affected by this medicine.

TG TOR F 160contains lactose

If you have been told by your doctor that you have an intolerance to some sugars, contact your doctor before taking this medicinal product.

9.3 How to take TG TOR F 160

Before starting treatment, your doctor will place you on a low-cholesterol diet, which you should maintain also during therapy with TG TOR F 160.

Always take this medicine exactly as your doctor or pharmacist has told you. Check with your doctor or pharmacist if you are not sure.

Dose: As directed by physician

The duration of treatment with TG TOR F 160is determined by your doctor.

Please ask your doctor if you think that the effect of TG TOR F 160 is too strong or too weak.

If you take more TG TOR F 160than you should

If you accidently take too many TG TOR F 160tablets (more than your usual daily dose), contact your doctor or nearest hospital for advice.

If you forget to take TG TOR F 160

If you forget to take a dose, just take your next scheduled dose at the correct time. Do not take a double dose to make up for a forgotten dose.

If you stop taking TG TOR F 160

If you have any further questions on the use of this medicine or wish to stop your treatment, ask your doctor or pharmacist.

9.4 Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them.

If you experience any of the following serious side effects, stop taking your tablets and tell your doctor immediately or go to the nearest hospital accident and emergency department.

Rare: may affect up to 1 in 1,000 people

- Serious allergic reaction which causes swelling of the face, tongue and throat that can cause great difficulty in breathing.
- Serious illness with severe peeling and swelling of the skin, blistering of the skin, mouth, eyes, genitals and fever. Skin rash with pink-red blotches especially on palms of hands or soles of feet which may blister.
- Muscle weakness, tenderness or pain and particularly, if at the same time, you feel unwell or have a high temperature it may be caused by an abnormal muscle breakdown (rhabdomyolysis). The abnormal muscle breakdown does not always go away, even after you have stopped taking TG TOR F 160, and it can be life-threatening and lead to kidney problems.
- yellowing of the skin and whites of the eyes (jaundice), or an increase in liver enzymes - these may be signs of an inflamed liver (hepatitis)

Very rare: may affect up to 1 in 10,000 people

- If you experience problems with unexpected or unusual bleeding or bruising, this may be suggestive of a liver complaint. You should consult your doctor as soon as possible.

Uncommon: may affect up to 1 in 100 people

- pain, redness or swelling in the legs - these may be signs of a blood clot in the leg (deep vein thrombosis)

Not known: it is not known how often these happen

- severe skin rash which reddens, peels and swells and looks like a severe burn
- long-term lung problems

Other possible side effects with TG TOR F 160

Common: may affect up to 1 in 10 people

- inflammation of the nasal passages, pain in the throat, nose bleed
- allergic reactions
- increases in blood sugar levels (if you have diabetes continue careful monitoring of your blood sugar levels), increase in blood creatine kinase
- headache
- nausea, constipation, wind, indigestion, diarrhoea
- joint pain, muscle pain and back pain
- blood test results that show your liver function can become abnormal
- diarrhoea
- stomach pain
- wind (flatulence)
- feeling sick (nausea)
- being sick (vomiting)
- raised levels of liver enzymes in the blood - shown in tests
- increase in homocysteine (too much of this amino acid in the blood has been associated to a higher risk of coronary heart disease, stroke and peripheral vascular disease, although a causal link has not been established)

Uncommon: may affect up to 1 in 100 people

- anorexia (loss of appetite), weight gain, decreases in blood sugar levels (if you have diabetes you should continue careful monitoring of your blood sugar levels)
- having nightmares, insomnia
- dizziness, numbness or tingling in the fingers and toes, reductions of sensation to pain or touch, change in sense of taste, loss of memory
- blurred vision
- ringing in the ears and/or head
- vomiting, belching, abdominal pain upper and lower, pancreatitis (inflammation of the pancreas leading to stomach pain)
- hepatitis (liver inflammation)
- rash, skin rash and itching, hives, hair loss

- neck pain, muscle fatigue

- fatigue, feeling unwell, weakness, chest pain, swelling especially in the ankles (oedema), raised temperature

- urine tests that are positive for white blood cells

- headache

- gallstones

- reduced sex drive

- rash, itching or red patches on the skin

- increase in creatinine (produced by the kidneys) - shown in tests

Rare: may affect up to 1 in 1,000 people

- visual disturbance

- unexpected bleeding or bruising

- cholestasis (yellowing of the skin and whites of the eyes)

- hair loss

- increase in urea (produced by the kidneys) - shown in tests

- skin is more sensitive to sunlight, sun lamps and sunbeds

- drop in haemoglobin (that carries oxygen in blood) and white blood cells - shown in tests

- tendon injury

Very rare: may affect up to 1 in 10,000 people

An allergic reaction - symptoms may include sudden wheezing and chest pain or tightness, swelling of the eyelids, face, lips, mouth, tongue or throat, difficulty breathing, collapse

- hearing loss

- Gynecomastia (breast enlargement in men).

Not known: frequency cannot be estimated from the available data: Muscle weakness that is constant.

Possible side effects reported with some statins (medicines of the same type):

- Sexual difficulties

- Depression

- Breathing problems including persistent cough and/or shortness of breath or fever

- Diabetes. This is more likely if you have high levels of sugars and fats in your blood, are overweight and have high blood pressure. Your doctor will monitor you while you are taking this medicine.

- muscle breakdown

- complications of gallbladder stones

- Feeling exhausted (fatigue).

Reporting of side effects
If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via any point of contact of Torrent Pharma available at:
http://www.torrentpharma.com/index.php/site/info/adverse_event_reporting.

By reporting side effects, you can help provide more information on the safety of this medicine.

9.5 How to store TGTOR F 160

Store at a temperature not exceeding 30°C, protected from light and moisture.

9.6 Content of the pack and other information

What TGTOR F 160 contains

The active substance is Atorvastatin and Fenofibrate

The other ingredients are Calcium Carbonate, Lactose, Croscarmellose Sodium, Sodium Lauryl Sulphate, Polyvinyl Pyrrolidone, Colloidal Silicon Dioxide, Crospovidone, Magnesium Stearate, Hydroxy propyl methylcellulose, Colloidal Silicon Dioxide, Talc, Titanium Dioxide, and PEG 6000.

TGTOR F 160 is available in Blister strips of 10 tablets

10. DETAILS OF MANUFACTURER

Manufactured by:

TORRENT PHARMACEUTICALS LTD.

32 No. Middle Camp, NH-10,

East District, Gangtok. Sikkim-737 135.

OR

Innova Captab Limited

Kh No. 1281/1, Hilltop, Industrial Estate,

Nr. EPIP, Phase-1, Jharmajri,

Baddi, Distt. Solan (H.P.)-173205.

11. DETAILS OF PERMISSION OR LICENCE NUMBER WITH DATE

Mfg Licence No.: M/563/2010 issued on 06.12.2021

OR

License No.: MNB/16/970 issued on 02.11.2020

12. DATE OF REVISION

Sep-2022

MARKETED BY

TORRENT PHARMACEUTICALS LTD.

IN/ TG TOR F 10,160 mg/Sep-22/02/PI