

Summary of Product Characteristics

1. Name of the Medicinal Product

Lipecos film coated tablets 5mg

2. Qualitative and Quantitative Composition

Each film coated tablet contains 5.2 mg of Rosuvastatin Calcium calculated as 5 mg of Rosuvastatin.

3. Pharmaceutical Form

Film coated Tablets

4. Clinical Particulars

4.1 Therapeutic Indications

Primary hypercholesterolaemia (type IIa including heterozygous familial hypercholesterolaemia) or mixed dyslipidaemia (type IIb) as an adjunct to diet when response to diet and other non-pharmacological treatments (e.g. exercise, weight reduction) is inadequate. Homozygous familial hypercholesterolaemia as an adjunct to diet and other lipid lowering treatments (e.g. LDL apheresis) or if such treatments are not appropriate.

4.2 Posology and Method of administration

Before treatment initiation the patient should be placed on a standard cholesterol-lowering diet that should continue during treatment. The dose should be individualised according to the goal of therapy and patient response, using current consensus guidelines. The recommended start dose is 5 or 10 mg orally once daily in both statin naïve or patients switched from another HMG CoA reductase inhibitor. The choice of start dose should take into account the individual patient's cholesterol level and future cardiovascular risk as well as the potential risk for adverse reactions. A dose adjustment to the next dose level can be made after 4 weeks, if necessary. In light of the increased reporting rate of adverse reactions with the 40 mg dose compared to lower doses, a final titration to the maximum dose of 40 mg should only be considered in patients with severe hypercholesterolaemia at high cardiovascular risk (in particular those with familial hypercholesterolaemia), who do not achieve their treatment goal on 20 mg, and in whom routine follow-up will be performed. Specialist supervision is recommended when the 40 mg dose is initiated. Rosuvastatin may be given at any time of day, with or without food.

4.3 Contraindication

Rosuvastatin is contraindicated:

In patients with hypersensitivity to rosuvastatin or to any of the excipients.

In patients with active liver disease including unexplained, persistent elevations of serum transaminases and any serum transaminase elevation exceeding 3 x the upper limit of normal (ULN).

- In patients with severe renal impairment (creatinine clearance <30 ml/min).
- In patients with myopathy.
- In patients receiving concomitant cyclosporin.
- During pregnancy and lactation and in women of childbearing potential not using appropriate contraceptive measures. The 40 mg dose is contraindicated in patients with pre-disposing factors for myopathy/rhabdomyolysis.

Such factors include:

- Moderate renal impairment (creatinine clearance < 60 ml/min)
- Hypothyroidism
- Personal or family history of hereditary muscular disorders
- Previous history of muscular toxicity with another HMG-CoA reductase inhibitor or fibrate
- Alcohol abuse
- Situations where an increase in plasma levels may occur
- Japanese and Chinese patients
- Concomitant use of fibrates.

4.4 Special warnings and precautions for use

Renal Effects

Proteinuria, detected by dipstick testing and mostly tubular in origin, has been observed in patients treated with higher doses of Rosuvastatin, in particular 40 mg, where it was transient or intermittent in most cases. Proteinuria has not been shown to be predictive of acute or progressive renal disease. An assessment of renal function should be considered during routine follow-up of patients treated with a dose of 40 mg.

Skeletal Muscle Effects

Effects on skeletal muscle e.g. myalgia, myopathy and, rarely, rhabdomyolysis have been reported in Rosuvastatin-treated patients with all doses and in particular with doses > 20 mg.

Creatine Kinase Measurement

Creatine Kinase (CK) should not be measured following strenuous exercise or in the presence of a plausible alternative cause of CK increase which may confound interpretation of the result. If CK levels are significantly elevated at baseline (>5xULN) a confirmatory test should be carried out within 5 – 7 days.

If the repeat test confirms a baseline CK >5xULN, treatment should not be started.

Before Treatment

Rosuvastatin, as with other HMG-CoA reductase inhibitors, should be prescribed with caution in patients

with pre-disposing factors for myopathy/rhabdomyolysis. Such factors include:

- renal impairment
- hypothyroidism
- personal or family history of hereditary muscular disorders
- previous history of muscular toxicity with another HMG-CoA reductase inhibitor or fibrate
- alcohol abuse
- age >70 years
- situations where an increase in plasma levels may occur
- concomitant use of fibrates.

In such patients the risk of treatment should be considered in relation to possible benefit and clinical monitoring is recommended. If CK levels are significantly elevated at baseline (>5xULN) treatment should not be started.

Liver Effects

As with other HMG-CoA reductase inhibitors, Rosuvastatin should be used with caution in patients who consume excessive quantities of alcohol and/or have a history of liver disease.

It is recommended that liver function tests be carried out prior to, and 3 months following, the initiation of treatment. Rosuvastatin should be discontinued or the dose reduced if the level of serum transaminases is greater than 3 times the upper limit of normal.

In patients with secondary hypercholesterolaemia caused by hypothyroidism or nephrotic syndrome, the underlying disease should be treated prior to initiating therapy with Rosuvastatin.

4.5 Interaction with other medicinal products and other forms of interaction

Ciclosporin:

During concomitant treatment with rosuvastatin and ciclosporin, Rosuvastatin AUC values were on average 7 times higher than those observed in healthy volunteers. Concomitant administration did not affect plasma concentrations of ciclosporin.

Vitamin K antagonists:

As with other HMG-CoA reductase inhibitors, the initiation of

treatment or dosage up-titration of Rosuvastatin in patients treated concomitantly with vitamin K antagonists (e.g. warfarin or another coumarin anticoagulant) may result in an increase in International Normalised Ratio (INR). Discontinuation or down-titration of Rosuvastatin may result in a decrease in INR. In such situations, appropriate monitoring of INR is desirable.

Gemfibrozil and other lipid-lowering products:

Concomitant use of Rosuvastatin and Gemfibrozil resulted in a 2-fold increase in Rosuvastatin C_{max} and AUC.

Based on data from specific interaction studies no pharmacokinetic relevant interaction with fenofibrate is expected, however a pharmacodynamic interaction may occur. Gemfibrozil, fenofibrate, other fibrates and lipid lowering doses (> or equal to 1g/day) of niacin (nicotinic acid) increase the risk of myopathy when give concomitantly with HMG-CoA reductase inhibitors, probably because they can produce myopathy when given alone. The 40 mg dose is contraindicated with concomitant use of a fibrate. These patients should also start with the 5 mg dose.

Ezetimibe:

Concomitant use of rosuvastatin and ezetimibe resulted in no change to AUC or C_{max} for either drug. However, a pharmacodynamic interaction, in terms of adverse effects, between Rosuvastatin and Ezetimibe cannot be ruled out.

Protease inhibitors:

Although the exact mechanism of interaction is unknown, concomitant protease inhibitor use may strongly increase rosuvastatin exposure. In a pharmacokinetic study, co-administration of 20 mg rosuvastatin and a combination product of two protease inhibitors (400 mg lopinavir/100 mg ritonavir) in healthy volunteers was associated with an approximately two-fold and five-fold increase in rosuvastatin steady-state AUC(0-24) and C_{max}, respectively. Therefore, concomitant use of rosuvastatin in HIV patients receiving protease inhibitors is not recommended.

Antacids:

The simultaneous dosing of rosuvastatin with an antacid suspension containing Aluminium and magnesium hydroxide resulted in a decrease in Rosuvastatin plasma concentration of approximately 50%. This effect was mitigated when the antacid was dosed 2 hours after rosuvastatin. The clinical relevance of this interaction has not been studied.

Erythromycin:

Concomitant use of rosuvastatin and erythromycin resulted in a 20% decrease in AUC(0-t) and a 30% decrease in C_{max} of Rosuvastatin. This interaction may be caused by the increase in gut motility caused by erythromycin.

4.6 Pregnancy and lactation

Rosuvastatin is contraindicated in pregnancy and lactation. Women of child bearing potential should use appropriate contraceptive measures. Since cholesterol and other products of cholesterol biosynthesis are essential for the development of the foetus, the potential risk from inhibition of HMG-CoA reductase outweighs the advantage of treatment during pregnancy. Animal studies provide limited evidence of reproductive toxicity. If a patient becomes pregnant during use of this product, treatment should be discontinued immediately.

Rosuvastatin is excreted in the milk of rats. There are no data with respect to excretion in milk in humans.

4.7 Effects on ability to drive and use machines

Studies to determine the effect of Rosuvastatin on the ability to drive and use machines have not been conducted. However, based on its pharmacodynamic properties, Rosuvastatin is unlikely to affect this ability. When driving vehicles or operating machines, it should be taken into account that dizziness may occur during treatment.

4.8 Undesirable effects

Renal Effects

Proteinuria, detected by dipstick testing and mostly tubular in origin, has been observed in patients treated with higher doses of Rosuvastatin, in particular 40 mg.

Skeletal Muscle Effects

Effects on skeletal muscle e.g. myalgia, myopathy and, rarely, rhabdomyolysis have been reported in Rosuvastatin-treated patients with all doses and in particular with doses > 20 mg.

Creatine Kinase Measurement

Creatine Kinase (CK) should not be measured following strenuous exercise or in the presence of a plausible alternative cause of CK increase which may confound interpretation of the result.

Liver Effects

As with other HMG-CoA reductase inhibitors, Rosuvastatin should be used with caution in patients who consume excessive quantities of alcohol and/or have a history of liver disease.

Lactose intolerance

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

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.

5 Overdose

There is no specific treatment in the event of overdose. In the event of overdose, the patient should be treated symptomatically and supportive measures instituted as required. Liver function and CK levels should be monitored. Haemodialysis is unlikely to be of benefit.

6 Pharmacological Properties

6.1 Pharmacodynamic Properties

Rosuvastatin is a selective and competitive inhibitor of HMG-CoA reductase, the rate-limiting enzyme that converts 3-hydroxy-3-methylglutaryl coenzyme A to mevalonate, a precursor for cholesterol. The primary site of action of rosuvastatin is the liver, the target organ for cholesterol lowering.

Rosuvastatin increases the number of hepatic LDL receptors on the cell-surface, enhancing uptake and catabolism of LDL and it inhibits the hepatic synthesis of VLDL, thereby reducing the total number of VLDL and LDL particles.

6.2 Pharmacokinetic Properties

Absorption: Maximum rosuvastatin plasma concentrations are achieved approximately 5 hours after oral administration. The absolute bioavailability is approximately 20%.

Distribution: Rosuvastatin is taken up extensively by the liver which is the primary site of cholesterol synthesis and LDL-C clearance. The volume of distribution of rosuvastatin is approximately 134 L. Approximately 90% of rosuvastatin is bound to plasma proteins, mainly to albumin.

Metabolism: Rosuvastatin undergoes limited metabolism (approximately 10%). *In vitro* metabolism studies using human hepatocytes indicate that rosuvastatin is a poor substrate for cytochrome P450-based metabolism. CYP2C9 was the principal isoenzyme involved, with 2C19, 3A4 and 2D6 involved to a lesser extent. The main metabolites identified are the N-desmethyl and lactone metabolites. The N-desmethyl metabolite is approximately 50% less active than

rosuvastatin whereas the lactone form is considered clinically inactive. Rosuvastatin accounts for greater than 90% of the circulating HMG-CoA reductase inhibitor activity.

Excretion: Approximately 90% of the rosuvastatin dose is excreted unchanged in the faeces (consisting of absorbed and non-absorbed active substance) and the remaining part is excreted in urine. Approximately 5% is excreted unchanged in urine. The plasma elimination half-life is approximately 19 hours. The elimination half-life does not increase at higher doses. The geometric mean plasma clearance is approximately 50 litres/hour (coefficient of variation 21.7%). As with other HMG-CoA reductase inhibitors, the hepatic uptake of rosuvastatin involves the membrane transporter OATP-C. This transporter is important in the hepatic elimination of rosuvastatin.

6.3 Preclinical safety data

Preclinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, genotoxicity and carcinogenicity potential. Specific tests for effects on hERG have not been evaluated. Adverse reactions not observed in clinical studies, but seen in animals at exposure levels similar to clinical exposure levels were as follows: In repeated-dose toxicity studies histopathologic liver changes likely due to the pharmacologic action of rosuvastatin were observed in mouse, rat, and to a lesser extent with effects in the gall bladder in dogs, but not in monkeys. In addition, testicular toxicity was observed in monkeys and dogs at higher dosages. Reproductive toxicity was evident in rats, with reduced litter sizes, litter weight and pup survival observed at maternally toxic doses, where systemic exposures were several times above the therapeutic exposure level.

7 Pharmaceutical Particulars

7.1 list of Excipients

Lactose BP
Microcrystalline cellulose dried BP
Calcium hydrogen phosphate BP
Crospovidone BP
Magnesium stearate BP
Opadry II yellow 85F32410

7.2 Incompatibilities

Not applicable.

7.3 Shelf life

2 years

7.4 Special precautions for storage

Store in a dry place below 30°C. Protect from light

7.5 Nature and contents of container

ALU/ALU Blister Packing

7.6 Instructions for use, handling and disposal

No special requirements for disposal.

8 Registrant

Cosmos Limited

9 Manufacturer

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10 Date of Revision of Text

19/11/2014

11 Dosimetry (if applicable)

New registration

12 Instructions for Preparation of radiopharmaceuticals (if applicable)

New Registration

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