SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF MEDICINAL PRODUCT

Roswin(Rosuvastatin 5 mg) film coated tablets

2. QUANTITATIVE AND QUANTITATIVE COMPOSITION

Each film coated tablet contains; Rosuvastatin Calcium(USP0eq. to Rosuvastatin.....5mg

For the full list of excipients, see section 6.1

3. PHARMACEUTICAL FORM

Blue colored, oval shaped, biconvex film coated tablet, engraved M | D on one side and plain from other side.

4. CLINICAL PARTICULARS

4.1 Therapeutic Indications

Treatment of hypercholesterolemia

Adults, adolescents, and children aged 6 years or older with primary hypercholesterolemia (type IIa including heterozygous familial hypercholesterolemia) or mixed dyslipidemia (type IIb) as an adjunct to diet when response to diet and other non-pharmacological treatments (e.g., exercise, weight reduction) is inadequate.

Adults, adolescents, and children aged 6 years or older with homozygous familial hypercholesterolemia as an adjunct to diet and other lipid lowering treatments (e.g., LDL apheresis) or if such treatments are not appropriate.

Prevention of Cardiovascular Events

Prevention of major cardiovascular events in patients who are estimated to have a high risk for a first cardiovascular event, as an adjunct to correction of other risk factors.

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 individualized according to the goal of therapy and patient response, using current consensus guidelines. Roswin may be given at any time of day, with or without food.

Treatment of hypercholesterolemia

The recommended start dose is 5 or 10 mg orally once daily in both statin naive or patients switched from another HMG CoA reductase inhibitor. The choice of start dose should consider 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.

Prevention of cardiovascular events

In the cardiovascular events risk reduction study, the dose used was 20 mg daily.

Pediatric population

Pediatric use should only be carried out by specialists.

Children and adolescents 6 to 17 years of age (Tanner Stage <II-V) Heterozygous familial hypercholesterolemia

- In children and adolescents with heterozygous familial hypercholesterolemia the usual start dose is 5 mg daily.
- In children 6 to 9 years of age with heterozygous familial hypercholesterolemia, the usual dose range is 5-10 mg orally once daily. Safety and efficacy of doses greater than 10 mg have not been studied in this population.
- In children 10 to 17 years of age with heterozygous familial hypercholesterolemia, the usual dose range is 5-20 mg orally once daily. Safety and efficacy of doses greater than 20 mg have not been studied in this population.

Titration should be conducted according to the individual response and tolerability in pediatric patients, as recommended by the pediatric treatment recommendations. Children and adolescents should be placed on standard cholesterol-lowering diet before rosuvastatin treatment initiation; this diet should be continued during rosuvastatin treatment.

Homozygous familial hypercholesterolemia

In children 6 to 17 years of age with homozygous familial hypercholesterolemia, the recommended maximum dose is 20 mg once daily.
A starting dose of 5 to 10 mg once daily depending on age, weight and prior statin use is advised. Titration to the maximum dose of 20 mg once daily should be conducted according to the individual response and tolerability in pediatric patients, as recommended by the pediatric treatment recommendations. Children and adolescents should be

placed on standard cholesterol-lowering diet before rosuvastatin treatment initiation; this diet should be continued during rosuvastatin treatment. There is limited experience with doses other than 20 mg in this population.

Children younger than 6 years

The safety and efficacy of use in children younger than 6 years has not been studied. Therefore, Roswin is not recommended for use in children younger than 6 years.

Use in the elderly

A start dose of 5 mg is recommended in patients >70 years. No other dose adjustment is necessary in relation to age.

Dosage in patients with renal insufficiency

No dose adjustment is necessary in patients with mild to moderate renal impairment. The recommended start dose is 5 mg in patients with moderate renal impairment (creatinine clearance <60 ml/min). The use of Roswin in patients with severe renal impairment is contraindicated for all doses.

Dosage in patients with hepatic impairment

There was no increase in systemic exposure to rosuvastatin in subjects with Child-Pugh scores of 7 or below. However, increased systemic exposure has been observed in subjects with Child-Pugh scores of 8 and 9. In these patients an assessment of renal function should be considered. There is no experience in subjects with Child-Pugh scores above 9. Roswin is contraindicated in patients with active liver disease.

Race

Increased systemic exposure has been seen in Asian subjects. The recommended start dose is 5 mg for patients of Asian ancestry.

Genetic polymorphisms

Specific types of genetic polymorphisms are known that can lead to increased rosuvastatin exposure. For patients who are known to have such specific types of polymorphisms, a lower daily dose of Roswin is recommended.

Dosage in patients with pre-disposing factors to myopathy

The recommended start dose is 5 mg in patients with predisposing factors to myopathy.

Concomitant therapy

Rosuvastatin is a substrate of various transporter proteins (e.g., OATP1B1 and BCRP). The risk of myopathy (including rhabdomyolysis) is increased when Roswin is administered concomitantly with certain medicinal products that may increase the plasma concentration of rosuvastatin due to interactions with these transporter proteins (e.g. ciclosporin and certain protease inhibitors including combinations of ritonavir with atazanavir, lopinavir and/or tipranavir) Whenever possible, alternative medications should be considered, and, if necessary, consider temporarily discontinuing Roswin therapy. In situations where co-administration of these medicinal products with Roswin is unavoidable, the benefit and the risk of concurrent treatment and Roswin dosing adjustments should be carefully considered.

Method of administration:

Rosuvastatin may be given at any time of day, with or without food.

4.3 Contraindications

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 times 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 combination of sofosbuvir/velpatasvir/voxilaprevir
- in patients receiving concomitant ciclosporin.
- during pregnancy and lactation and in women of childbearing potential not using appropriate

contraceptive measures.

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, 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 higher dose.

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. Very rare cases of rhabdomyolysis have been reported with the use of ezetimibe in combination with HMG-CoA reductase inhibitors. A pharmacodynamic interaction cannot be excluded and caution should be exercised with their combined use. As with other HMG-CoA reductase inhibitors, the reporting rate for rhabdomyolysis associated with Rosuvastatin in known post-marketing use is higher at higher doses.

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:

- 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.
- Renal Impairment

Whilst on Treatment

Patients should be asked to report inexplicable muscle pain, weakness, or cramps immediately, particularly if associated with malaise or fever. CK levels should be measured in these patients. Therapy should be discontinued if CK levels are markedly elevated (>5xULN) or if muscular

symptoms are severe and cause daily discomfort (even if CK levels are ≤5xULN). If symptoms resolve and CK levels return to normal, then consideration should be given to re-introducing Rosuvastatin or an alternative HMG-CoA reductase inhibitor at the lowest dose with close monitoring. Routine monitoring of CK levels in asymptomatic patients is not warranted. There have been very rare reports of an immune-mediated necrotizing myopathy (IMNM) during or after treatment with statins, including rosuvastatin. IMNM is clinically characterized by proximal muscle weakness and elevated serum creatine kinase, which persist despite discontinuation of statin treatment.

No evidence known of increased skeletal muscle effects in the small number of patients dosed with Rosuvastatin and concomitant therapy. However, an increase in the incidence of myositis and myopathy has been seen in patients receiving other HMG-CoA reductase inhibitors together with fibric acid derivatives including gemfibrozil, ciclosporin, nicotinic acid, azole antifungals, protease inhibitors and macrolide antibiotics. Gemfibrozil increases the risk of myopathy when given concomitantly with some HMG-CoA reductase inhibitors. Therefore, the combination of Rosuvastatin and gemfibrozil is not recommended. The benefit of further alterations in lipid levels by the combined use of Rosuvastatin with fibrates or niacin should be carefully weighed against the potential risks of such combinations.

Rosuvastatin 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. Patients 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 Rosuvastatin and Fusidic acid should only be considered on a case-by-case basis and under close medical supervision.

Rosuvastatin should not be used in any patient with an acute, serious condition suggestive of myopathy or predisposing to the development of renal failure secondary to rhabdomyolysis (e.g. sepsis, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders; or uncontrolled seizures).

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. The reporting rate for serious hepatic events (consisting mainly of increased hepatic transaminases) in known post-marketing use is higher at higher doses.

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

Race

Pharmacokinetic studies show an increase in exposure in Asian subjects compared with Caucasians.

Protease Inhibitors

Increased systemic exposure to rosuvastatin has been observed in subjects receiving rosuvastatin concomitantly with various protease inhibitors in combination with ritonavir. Consideration should be given both to the benefit of lipid lowering by use of Rosuvastatin in HIV patients receiving protease inhibitors and the potential for increased rosuvastatin plasma concentrations when initiating and up titrating Rosuvastatin doses in patients treated with protease inhibitors. The concomitant use with certain protease inhibitors is not recommended unless the dose of Rosuvastatin is adjusted.

Lactose Intolerance

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

Interstitial Lung Disease

Exceptional cases of interstitial lung disease have been reported with some statins, especially with long- term therapy. Presenting features can include dyspnea, 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 hyperglycemia where formal diabetes care is appropriate. This risk,

however, is outweighed by the reduction in vascular risk with statins and therefore should not be a reason for stopping statin treatment. Patients at risk (fasting glucose 5.6 to 6.9 mmol/l, BMI>30 kg/m^2, raised triglycerides, hypertension) should be monitored both clinically and biochemically according to national guidelines.
In the known JUPITER study, the reported overall frequency of diabetes mellitus was 2.8% in rosuvastatin and 2.3% in placebo, mostly in patients with fasting glucose 5.6 to 6.9 mmol/l.

4.5 Interaction with other medicinal products and other forms of interaction

Effect of co-administered medicinal products on rosuvastatin

Transporter protein inhibitors: Rosuvastatin is a substrate for certain transporter proteins including the hepatic uptake transporter OATP1B1 and efflux transporter BCRP. Concomitant administration of Rosuvastatin with medicinal products that are inhibitors of these transporter proteins may result in increased rosuvastatin plasma concentrations and an increased risk of myopathy.

Ciclosporin: During concomitant treatment with Rosuvastatin and ciclosporin, rosuvastatin AUC values were on average 7 times higher than those observed in healthy volunteers (see Table 1). Rosuvastatin is contraindicated in patients receiving concomitant ciclosporin. Concomitant administration did not affect plasma concentrations of ciclosporin.

Protease inhibitors: Although the exact mechanism of interaction is unknown, concomitant protease inhibitor use may strongly increase rosuvastatin exposure (see Table 1). For instance, in a pharmacokinetic study, co-administration of 10 mg rosuvastatin and a combination product of two protease inhibitors (300 mg atazanavir/100 mg ritonavir) in healthy volunteers was associated with an approximately three-fold and seven-fold increase in rosuvastatin AUC and Cmax respectively. The concomitant use of Rosuvastatin and some protease inhibitor combinations may be considered after careful consideration of Rosuvastatin dose adjustments based on the expected increase in rosuvastatin exposure.

Gemfibrozil and other lipid-lowering products: Concomitant use of Rosuvastatin and gemfibrozil resulted in a 2-fold increase in rosuvastatin Cmax 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 1 g/day) of niacin (nicotinic acid) increase the risk of myopathy when given concomitantly with HMG-CoA reductase inhibitors, probably because they can produce

myopathy when given alone. These patients should also start with the 5 mg dose.

Ezetimibe: Concomitant use of 10 mg Rosuvastatin and 10 mg ezetimibe resulted in a 1.2-fold increase in AUC of rosuvastatin in hypercholesterolemia subjects. A pharmacodynamic interaction, in terms of adverse effects, between Rosuvastatin and ezetimibe cannot be ruled out.

Antacid: The simultaneous dosing of Rosuvastatin with an antacid suspension containing aluminum 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.

Erythromycin: Concomitant use of Rosuvastatin and erythromycin resulted in a 20% decrease in AUC and a 30% decrease in Cmax of rosuvastatin. This interaction may be caused by the increase in gut motility caused by erythromycin.

Cytochrome P450 enzymes: Results from in vitro and in vivo studies show that rosuvastatin is neither an inhibitor nor an inducer of cytochrome P450 isoenzymes. In addition, rosuvastatin is a poor substrate for these isoenzymes. Therefore, drug interactions resulting from cytochrome P450- mediated metabolism are not expected. No clinically relevant interactions have been observed between rosuvastatin and either fluconazole (an inhibitor of CYP2C9 and CYP3A4) or ketoconazole (an inhibitor of CYP2A6 and CYP3A4).

Interactions requiring rosuvastatin dose adjustments: When it is necessary to co- administer Rosuvastatin with other medicinal products known to increase exposure to rosuvastatin, doses of Rosuvastatin should be adjusted. Start with a 5 mg once daily dose of Rosuvastatin if the expected increase in exposure (AUC) is approximately 2-fold or higher. The maximum daily dose of Rosuvastatin should be adjusted so that the expected rosuvastatin taken without interacting medicinal products, for example a 20 mg dose of Rosuvastatin with gemfibrozil (1.9-fold increase), and a 10 mg dose of Rosuvastatin with combination ritonavir/atazanavir (3.1-fold increase).

If medicinal product is observed to increase rosuvastatin AUC less than 2-fold, the starting dose need not be decreased but caution should be taken if increasing the Rosuvastatin dose above 20mg.

Effect of rosuvastatin on co-administered medicinal products

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 Normalized Ratio (INR). Discontinuation or down-titration of Rosuvastatin may result in a decrease in INR. In such situations, appropriate monitoring of INR is desirable.

Oral contraceptive/hormone replacement therapy (HRT): Concomitant use of Rosuvastatin and an oral contraceptive resulted in an increase in ethinyl estradiol and norgestrel AUC of 26% and 34%, respectively. These increased plasma levels should be considered when selecting oral contraceptive doses. There are no pharmacokinetic data available in subjects taking concomitant Rosuvastatin and HRT, therefore, a similar effect cannot be excluded. However, the combination has been extensively used in women in clinical trials and was well tolerated.

Other medicinal products:

Digoxin: Based on data from specific interaction studies no clinically relevant interaction with digoxin is expected.

Fusidic Acid: Interaction studies with rosuvastatin and Fusidic acid have not been conducted. 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, Rosuvastatin treatment should be discontinued throughout the duration of the Fusidic acid treatment.

Pediatric population: Interaction studies have only been performed in adults. The extent of interactions in the pediatric population is not known.

4.6 Fertility, Pregnancy & Lactation

Rosuvastatin is contraindicated in pregnancy and lactation.

Women of childbearing potential should use appropriate contraceptive measures.

Since cholesterol and other products of cholesterol biosynthesis are essential for the development of the fetus, 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 considered that dizziness may occur during treatment.

4.8 Undesirable effects

Reporting of suspected adverse reactions

Reporting of suspected adverse reactions: Healthcare professionals are asked to report any suspected adverse reactions via pharmacy and poisons board, Pharmacovigilance Electronic Reporting System (PvERS) https://pv.pharmacyboardkenya.org

Common: Diabetes mellitus, Headache, Dizziness, Constipation, Nausea, Abdominal pain, Myalgia, Asthenia.

Uncommon: Pruritus, Rash, Urticaria.

Rare: Thrombocytopenia, Hypersensitivity reactions including angioedema, Pancreatitis, increased hepatic transaminases, Myopathy (including myositis) Rhabdomyolysis Lupus-like syndrome, Muscle rupture.

Very Rare: Polyneuropathy, Memory loss, Jaundice, Hepatitis, Arthralgia, Hematuria, Gynecomastia.

4.9 Overdosage

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. Hemodialysis is unlikely to be of benefit.

5. PHARMACOLOGOCAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: HMG-CoA reductase inhibitors *ATC code:* C10AA07

Mechanism of action:

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.

5.2 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.

Special populations:

Age and sex:

There was no clinically relevant effect of age or sex on the pharmacokinetics of rosuvastatin in adults. The exposure in children and adolescents with heterozygous familial hypercholesterolemia appears to be similar to or lower than that in adult patients with dyslipidemia.

Race:

Asian-Indians show an approximate 1.3-fold elevation in median AUC and Cmax. A population pharmacokinetic analysis revealed no clinically relevant differences in pharmacokinetics between Caucasian and Black groups.

Renal insufficiency:

In a study in subjects with varying degrees of renal impairment, mild to moderate renal disease had no influence on plasma concentration of rosuvastatin or the N-desmethyl metabolite. Subjects with severe impairment (CrCl <30 ml/min) had a 3-fold increase in plasma concentration and a 9-fold increase in the N-desmethyl metabolite concentration compared to healthy volunteers. Steady- state plasma concentrations of rosuvastatin in subjects undergoing haemodialysis were approximately 50% greater compared to healthy volunteers.

Hepatic insufficiency:

In a study with subjects with varying degrees of hepatic impairment, there was no evidence of increased exposure to rosuvastatin in subjects with Child-Pugh scores of 7 or below. However, two subjects with Child-Pugh scores of 8 and 9 showed an increase in systemic exposure of at least 2- fold compared to subjects with lower Child-Pugh scores. There is no experience in subjects with Child-Pugh scores above 9.

Genetic polymorphisms:

Disposition of HMG-CoA reductase inhibitors, including rosuvastatin, involves OATP1B1 and BCRP transporter proteins. In patients with SLCO1B1 (OATP1B1) and/or ABCG2 (BCRP) genetic polymorphisms there is a risk of increased rosuvastatin exposure. Individual polymorphisms of SLCO1B1 c.521CC and ABCG2 c.421AA are associated with a higher rosuvastatin exposure (AUC) compared to the SLCO1B1 c.521TT or ABCG2 c.421CC genotypes. This specific genotyping is not established in clinical practice, but for patients who are known to have these types of polymorphisms, they should take a lower daily dose of Rosuvastatin.

Pediatric population: Two pharmacokinetic studies with rosuvastatin in pediatric patients with heterozygous familial hypercholesterolemia 10 to 17 or 6 to 17 years of age (total of 214 patients) demonstrated that exposure in pediatric patients appears comparable to or lower than that in adult patients. Rosuvastatin exposure was predictable with respect to dose and time over a 2-year period.

6. PHARMACEUTICAL EXCIPIENTS

6.1 List of Excipients:

- Microcrystalline Cellulose PH 102
- Lactose Anhydrous
- Corn Starch White
- Cross Povidone
- Di-calcium Phosphate Dihydrous DC grade
- Magnesium Stearate
- Opadry White II 85G68918
- Brilliant Blue Color (CAS No. 3844-45-9)
- Polyethylene Glycol 6000

6.2 Incompatibilities

Not applicable

6.3 Shelf life

2 years

6.4 Special precautions for storage

Protect from light,heat and moisture

Store below 30°C.

6.5 Nature and contents of container

Roswin Tablets 20mg is available in blister pack of 1 x 10 tablets in a unit carton along with a package insert.

6.6 Special precautions for disposal and other handling

No special requirements for disposal

7. Marketing authorization holder and manufacturing site addresses

Marketing authorization holder:
Martin Dow Limited.
Company name: Martin Dow Limited.

Address: Plot # 37, Sector 19, Korangi Industrial Area, Karachi-74900, Pakistan

Manufacturing site address:
Martin Dow Limited.
Company name: Martin Dow Limited.
Address: Plot # 37, Sector 19, Korangi Industrial Area, Karachi-74900, Pakistan.

8. Marketing authorization number
CTD9797

9. Date of first registration
10/02/2023

10 Date of revision of the text:
18/09/2023

11 Dosimetry:
Not Applicable

12 Instructions for Preparation of Radiopharmaceuticals:
Not Applicable