SUMMARY OF PRODUCT CHARACTERISTICS

FORMONIDE INHALER (Formoterol Fumarate 6 mcg / Budesonide 200 mcg and 400 mcg Pressurised Metered-Dose Inhaler)

1. NAME OF THE MEDICINAL PRODUCT

FORMONIDE 200 INHALER (Formoterol Fumarate 6 mcg / Budesonide 200 mcg per actuation, pressurised metered-dose inhaler)

FORMONIDE 400 INHALER (Formoterol Fumarate 6 mcg / Budesonide 400 mcg per actuation, pressurised metered-dose inhaler)

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

FORMONIDE 200 INHALER

Each actuation delivers:

Formoterol fumarate dihydrate BP equivalent to formoterol fumarate 6 mcg

Budesonide BP 200 mcg

Suspended in propellant HFA 134a (1,1,1,2-tetrafluoroethane), q.s.

FORMONIDE 400 INHALER

Each actuation delivers:

Formoterol fumarate dihydrate BP equivalent to formoterol fumarate 6 mcg

Budesonide BP 400 mcg

Suspended in propellant HFA 134a (1,1,1,2-tetrafluoroethane), q.s.

Excipients with known effect:

Contains lactose monohydrate (<1 mg per inhalation). The excipient lactose contains small amounts of milk proteins, which may cause allergic reactions. For warnings, see section 4.4.

For a full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Pressurised metered-dose inhaler (pMDI).

Microcrystalline suspension in a pressurised aluminium canister fitted with a suitable metered valve, actuator and dust cap. 120 metered actuations per inhaler.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Asthma

FORMONIDE INHALER is indicated for the regular maintenance treatment of asthma where use of a combination (inhaled corticosteroid and long-acting β2-adrenoceptor agonist) is appropriate:

- Patients not adequately controlled with inhaled corticosteroids and 'as-needed' inhaled short-acting β2-adrenoceptor agonists, or
- Patients already adequately controlled on both inhaled corticosteroids and long-acting β2-adrenoceptor agonists.

Chronic Obstructive Pulmonary Disease (COPD)

Symptomatic treatment of patients with severe COPD (FEV1 <50% predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular therapy with long-acting bronchodilators.

4.2 Posology and method of administration

General

FORMONIDE INHALER is not intended for the initial management of asthma. The dosage of the components is individual and should be adjusted to the severity of the disease. This should be considered not only when

treatment with combination products is initiated but also when the dose is adjusted. If an individual patient requires a combination of doses other than those available in this inhaler, appropriate doses of β2-adrenoceptor agonist and/or corticosteroid by individual inhalers should be prescribed.

Asthma

Adults (18 years and older): 1 inhalation twice daily. Some patients may require up to a maximum of 2 inhalations twice daily.

Adolescents (12–17 years): 1 inhalation twice daily.

Children (6–11 years): A lower strength is available for children aged 6–11 years. FORMONIDE 400 should not be used in children.

Children under 6 years: Limited data are available; FORMONIDE INHALER is not recommended for children younger than 6 years.

Patients should be regularly reassessed so that the dosage remains optimal and the dose is titrated to the lowest dose at which effective symptom control is maintained. FORMONIDE 400 should be used for maintenance therapy only, not for maintenance and reliever therapy.

Increasing use of a separate rapid-acting bronchodilator indicates worsening of the underlying condition and warrants reassessment of asthma therapy.

COPD

Adults: 1 inhalation twice daily.

Special populations

There are no special dosing requirements for elderly patients. There are no data available for use in patients with hepatic or renal impairment; as budesonide and formoterol are primarily eliminated via hepatic metabolism, increased exposure can be expected in patients with severe liver cirrhosis.

Method of administration

For inhalation use. Patients should be instructed in the correct use of the inhaler and their inhaler technique checked regularly. After inhaling the maintenance dose, patients should rinse their mouth with water and spit it out to minimise the risk of oropharyngeal candida infection.

4.3 Contraindications

- Hypersensitivity to budesonide, formoterol or to any of the excipients listed in section 6.1, including lactose (which contains small amounts of milk protein).

4.4 Special warnings and precautions for use

Asthma management

FORMONIDE INHALER should not be initiated during an exacerbation or if the patient has significantly worsening or acutely deteriorating asthma. Treatment should not be stopped abruptly; the dose should be tapered. Patients should always have a rescue inhaler available. They should be reminded to take FORMONIDE INHALER as prescribed even when asymptomatic.

Sudden and progressive deterioration in control of asthma or COPD is potentially life-threatening and the patient should undergo urgent medical assessment. Consideration should be given to the need for increased corticosteroid therapy, e.g. a course of oral corticosteroids, or antibiotic treatment if an infection is present.

If patients find the treatment ineffective or exceed the highest recommended dose of FORMONIDE INHALER, medical attention must be sought.

Paradoxical bronchospasm

As with other inhalation therapy, paradoxical bronchospasm may occur, with an immediate increase in wheezing and shortness of breath after dosing. If this occurs, FORMONIDE INHALER should be discontinued immediately, the patient assessed and alternative therapy instituted. Paradoxical bronchospasm responds to a rapid-acting inhaled bronchodilator.

Systemic corticosteroid effects

Systemic effects may occur with any inhaled corticosteroid, particularly at high doses prescribed for long periods. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, decrease in bone mineral density, cataract and glaucoma. These effects are much less likely than with oral corticosteroids.

Children receiving prolonged inhaled corticosteroid treatment should have their height monitored regularly. If growth is slowed, therapy should be re-evaluated. The benefits of corticosteroid therapy and the possible risks of growth suppression must be carefully weighed. Limited data from long-term studies suggest that most children treated with inhaled budesonide ultimately achieve their adult target height, though an initial small but transient reduction (approximately 1 cm) has been observed, generally in the first year of treatment.

Potential effects on bone density should be considered in patients on high doses for prolonged periods with coexisting risk factors for osteoporosis.

Adrenal suppression and stress dosing

If there is reason to suppose adrenal function is impaired from previous systemic steroid therapy, care should be taken when transferring patients to FORMONIDE INHALER. Prolonged treatment with high doses of inhaled corticosteroids, particularly higher than recommended doses, may result in clinically significant adrenal suppression. Supplementary systemic corticosteroid cover should be considered during periods of stress such as severe infections or elective surgery. Abrupt dose reduction may induce acute adrenal crisis — symptoms may include anorexia, abdominal pain, weight loss, tiredness, headache, nausea, vomiting, decreased level of consciousness, seizures, hypotension and hypoglycaemia.

During transfer from oral corticosteroid therapy to FORMONIDE INHALER, a lower systemic steroid action may result in the appearance of allergic or arthritic symptoms such as rhinitis, eczema and muscle and joint pain. Specific treatment should be initiated for these conditions. A temporary increase in the dose of oral glucocorticosteroids may sometimes be necessary if general symptoms of glucocorticoid insufficiency occur.

Oropharyngeal candidiasis

Patients should be instructed to rinse their mouth with water after each dose to minimise the risk of oropharyngeal candida infection.

CYP3A4 inhibitors

Concomitant treatment with itraconazole, ritonavir or other potent CYP3A4 inhibitors should be avoided. If this is not possible, the time interval between administration should be as long as possible (see section 4.5).

Cardiovascular and metabolic precautions

FORMONIDE INHALER should be administered with caution in patients with thyrotoxicosis, phaeochromocytoma, diabetes mellitus, untreated hypokalaemia, hypertrophic obstructive cardiomyopathy, idiopathic subvalvular aortic stenosis, severe hypertension, aneurysm or other severe cardiovascular disorders such as ischaemic heart disease, tachyarrhythmias or severe heart failure.

Caution should be observed when treating patients with prolongation of the QTc interval. Formoterol itself may induce prolongation of the QTc interval.

Hypokalaemia

Potentially serious hypokalaemia may result from high doses of β2-adrenoceptor agonists. Concomitant treatment with xanthine derivatives, steroids and diuretics may add to the hypokalaemic effect. Particular caution is recommended in unstable asthma with variable use of rescue bronchodilators, in acute severe asthma where hypoxia may augment the risk, and in other conditions where the likelihood for hypokalaemia is increased. Serum potassium levels should be monitored in these circumstances.

Pulmonary tuberculosis and infections

The need for, and dose of, inhaled corticosteroids should be re-evaluated in patients with active or quiescent pulmonary tuberculosis, fungal and viral infections in the airways.

Lactose content

This product contains lactose monohydrate (<1 mg per inhalation). This amount does not normally cause problems in lactose-intolerant people. The excipient lactose contains small amounts of milk proteins which may cause allergic reactions in patients with severe milk protein allergy.

4.5 Interaction with other medicinal products and other forms of interaction

Pharmacokinetic interactions

Potent inhibitors of CYP3A4 (e.g. ketoconazole, itraconazole, voriconazole, posaconazole, clarithromycin, telithromycin, nefazodone and HIV protease inhibitors) are likely to markedly increase plasma levels of budesonide and concomitant use should be avoided. If this is not possible, the time interval between administration of the inhibitor and budesonide should be as long as possible. Ketoconazole 200 mg once daily increased plasma levels of concomitantly orally administered budesonide (single dose of 3 mg) on average six-fold. When administered 12 hours after budesonide, the increase was on average three-fold.

Pharmacodynamic interactions

Beta-adrenergic blockers (including ophthalmic) can weaken or inhibit the effect of formoterol; FORMONIDE INHALER should therefore not be given together with beta-adrenergic blockers unless there are compelling reasons.

Concomitant treatment with quinidine, disopyramide, procainamide, phenothiazines, antihistamines (terfenadine), MAOIs and tricyclic antidepressants can prolong the QTc interval and increase the risk of ventricular arrhythmias.

L-Dopa, L-thyroxine, oxytocin and alcohol can impair cardiac tolerance towards β2-sympathomimetics. Concomitant treatment with MAOIs including agents with similar properties such as furazolidone and

procarbazine may precipitate hypertensive reactions. There is an elevated risk of arrhythmias in patients receiving concomitant anaesthesia with halogenated hydrocarbons. Concomitant use of other beta-adrenergic or anticholinergic drugs can have a potentially additive bronchodilating effect. Hypokalaemia may increase the disposition towards arrhythmias in patients treated with digitalis glycosides.

4.6 Fertility, pregnancy and lactation

Pregnancy

For FORMONIDE INHALER or the concomitant treatment with formoterol and budesonide, no clinical data on exposed pregnancies are available. Data from an embryo-foetal development study in the rat showed no evidence of any additional effect from the combination. During pregnancy, FORMONIDE INHALER should only be used when the benefits outweigh the potential risks. The lowest effective dose of budesonide needed to maintain adequate asthma control should be used.

There are no adequate data from the use of formoterol in pregnant women. In animal studies, formoterol has caused adverse effects in reproduction studies at very high systemic exposure levels. Data on approximately 2,000 exposed pregnancies indicate no increased teratogenic risk associated with the use of inhaled budesonide. In animal studies, glucocorticosteroids have been shown to induce malformations; however, these are not considered relevant to humans at recommended doses.

Breast-feeding

Budesonide is excreted in breast milk; at therapeutic doses no effects on the suckling child are anticipated. It is not known whether formoterol passes into human breast milk; in rats, small amounts have been detected in maternal milk. Administration of FORMONIDE INHALER to women who are breast-feeding should only be considered if the expected benefit to the mother is greater than any possible risk to the child.

Fertility

No specific fertility data available. Animal reproduction studies with formoterol have shown a somewhat reduced fertility in male rats at high systemic exposure.

4.7 Effects on ability to drive and use machines

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

4.8 Undesirable effects

Summary of the safety profile

Since FORMONIDE INHALER contains both budesonide and formoterol, the same pattern of undesirable effects as reported for these substances may occur. No increased incidence of adverse reactions has been seen following concurrent administration of the two compounds. The most common drug-related adverse reactions are pharmacologically predictable side-effects of β2-adrenoceptor agonist therapy, such as tremor and palpitations. These tend to be mild and usually disappear within a few days of treatment.

In a 3-year clinical trial with budesonide in COPD, skin bruises and pneumonia occurred at a frequency of 10% and 6%, respectively, compared with 4% and 3% in the placebo group.

System Organ Class	Frequency	Adverse Reaction
Infections and infestations	Common	Oral candidiasis (oropharyngeal fungal infection)
Infections and infestations	Common (COPD)	Pneumonia, bronchitis
Immune system disorders	Rare	Hypersensitivity reactions (anaphylaxis, angioedema, urticaria, rash, bronchospasm, hypotension)
Endocrine disorders	Very rare	Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation (children), decreased bone mineral density
Metabolism and nutrition disorders	Uncommon	Hypokalaemia
Metabolism and nutrition disorders	Rare	Hyperglycaemia
Psychiatric disorders	Uncommon	Psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes
Nervous system disorders	Common	Headache, tremor

System Organ Class	Frequency	Adverse Reaction
Nervous system disorders	Uncommon	Dizziness
Eye disorders	Very rare	Cataract, glaucoma
Cardiac disorders	Common	Palpitations
Cardiac disorders	Uncommon	Tachycardia
Cardiac disorders	Rare	Atrial fibrillation, supraventricular tachycardia, extrasystoles, QTc prolongation
Vascular disorders	Rare	Hypertension, hypotension
Respiratory, thoracic and mediastinal disorders	Uncommon	Paradoxical bronchospasm (immediate increase in wheezing after dosing)
Musculoskeletal disorders	Common (COPD)	Skin bruising
Musculoskeletal disorders	Uncommon	Muscle cramps
Skin and subcutaneous tissue disorders	Uncommon	Rash, pruritus, dermatitis, hives
Reproductive system	Very rare	Dysmenorrhoea

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the National Regulatory Authority.

4.9 Overdose

Formoterol overdose

An overdose of formoterol would likely lead to effects typical of β2-adrenoceptor agonists: tremor, headache, palpitations, tachycardia, hyperglycaemia, hypokalaemia, prolonged QTc interval, arrhythmia, nausea and vomiting. Supportive and symptomatic treatment may be indicated. A dose of 90 mcg administered during 3 hours in patients with acute bronchial obstruction raised no safety concerns.

Budesonide overdose

Acute overdosage with budesonide, even at excessive doses, is not expected to be a clinical problem. When used chronically in excessive doses, systemic glucocorticosteroid effects such as hypercorticism and adrenal suppression may appear.

If FORMONIDE INHALER therapy has to be withdrawn due to overdose of the formoterol component, appropriate inhaled corticosteroid therapy must be considered.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Adrenergics and other drugs for obstructive airway diseases. ATC code: R03AK07.

FORMONIDE INHALER contains formoterol and budesonide, which have different modes of action and show additive effects in terms of reduction of asthma exacerbations.

Budesonide:

A glucocorticosteroid that when inhaled has a dose-dependent anti-inflammatory action in the airways, resulting in reduced symptoms and fewer asthma exacerbations. The exact mechanism responsible for the anti-inflammatory effect of glucocorticosteroids is unknown.

Formoterol:

A selective β2-adrenoceptor agonist that when inhaled results in rapid and long-acting relaxation of bronchial smooth muscle in patients with reversible airways obstruction. The bronchodilating effect is dose-dependent, with onset within 1–3 minutes. Duration of effect is at least 12 hours after a single dose.

Clinical studies in adults showed that the addition of formoterol to budesonide improved asthma symptoms and lung function and reduced exacerbations. In two 12-week studies the effect on lung function of budesonide/formoterol was equal to that of the free combination and exceeded that of budesonide alone. In a 12-week paediatric study, 85 children aged 6–11 years treated with budesonide/formoterol showed improved lung function with good tolerability. In COPD, two 12-month studies showed significant reduction in

exacerbation rate with budesonide/formoterol compared with formoterol alone or placebo (mean rate 1.4 vs 1.8–1.9 per year).

5.2 Pharmacokinetic properties

Absorption

The fixed-dose combination of budesonide and formoterol has been shown to be bioequivalent in terms of systemic exposure to the corresponding monoproducts. Inhaled budesonide is rapidly absorbed; maximum plasma concentration is reached within 30 minutes. Mean lung deposition is 32–44% of the delivered dose; systemic bioavailability is approximately 49% of the delivered dose. In children aged 6–16 years, lung deposition falls within the same range as adults. Inhaled formoterol is rapidly absorbed; maximum plasma concentration is reached within 10 minutes. Mean lung deposition is 28–49% of the delivered dose; systemic bioavailability is approximately 61% of the delivered dose.

Distribution and metabolism

Plasma protein binding is approximately 50% for formoterol and 90% for budesonide. Volume of distribution is approximately 4 L/kg for formoterol and 3 L/kg for budesonide. Formoterol is inactivated via conjugation reactions. Budesonide undergoes extensive (approximately 90%) first-pass hepatic biotransformation to metabolites of low glucocorticosteroid activity. The glucocorticosteroid activity of the major metabolites (6-beta-hydroxy-budesonide and 16-alpha-hydroxy-prednisolone) is less than 1% of that of budesonide.

Elimination

The major part of formoterol is transformed by liver metabolism followed by renal elimination; 8–13% of the delivered dose is excreted unmetabolised in the urine. Systemic clearance of formoterol is approximately 1.4 L/min; terminal elimination half-life averages 17 hours. Budesonide is eliminated via CYP3A4-catalysed metabolism; metabolites are eliminated in urine as such or in conjugated form. Systemic clearance of budesonide is approximately 1.2 L/min; plasma elimination half-life after IV dosing averages 4 hours. Exposure to budesonide and formoterol may be increased in patients with liver disease.

5.3 Preclinical safety data

The toxicity observed in animal studies with budesonide and formoterol, given in combination or separately, were effects associated with exaggerated pharmacological activity. In animal reproduction studies, corticosteroids such as budesonide have been shown to induce malformations (cleft palate, skeletal malformations); however, these experimental results do not appear relevant in humans at recommended doses. Animal reproduction studies with formoterol have shown a somewhat reduced fertility in male rats and implantation losses and decreased early postnatal survival at considerably higher systemic exposures than those reached during clinical use.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

FORMONIDE 200 INHALER: HFA 134a (1,1,1,2-tetrafluoroethane; Dymel-134a pharma, DuPont), lactose monohydrate.

FORMONIDE 400 INHALER: HFA 134a (1,1,1,2-tetrafluoroethane; Dymel-134a pharma, DuPont), lactose monohydrate.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months.

6.4 Special precautions for storage

Store below 30°C. Do not freeze. Keep the canister away from heat sources including the sun. Pressurised container — do not pierce or burn, even when apparently empty.

6.5 Nature and contents of container

Pressurised aluminium canister fitted with a suitable metered valve, actuator and dust cap, assembled into a pMDI device. Each inhaler contains 120 metered actuations. Pack size: 1 × 120MD inhaler.

6.6 Special precautions for disposal and other handling

No special handling requirements. Patients should be instructed to read the package leaflet for instructions on correct use of the inhaler.

7. MARKETING AUTHORISATION HOLDER

ZYDUS LIFESCIENCES LIMITED

Zydus Corporate Park, Scheme No. 63, Survey No. 536,

Khoraj (Gandhinagar), Nr. Vaishnodevi Circle,

Ahmedabad, Gujarat 382481, India.

8. MARKETING AUTHORISATION NUMBER (PPB REGISTRATION NUMBER)

Formonide 200 Inhaler: 19803 Formonide 400 Inhaler: 19796

9. DATE OF FIRST AUTHORISATION / RENEWAL OF AUTHORISATION

07.02. 2026

10. DATE OF REVISION OF THE TEXT

07.02. 2026