SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Irbesartan comp HEXAL 300/12,5 mg, filmomhulde tabletten.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 300 mg of irbesartan and 12.5 mg of hydrochlorothiazide.

Excipient with known effect
Each film-coated tablet contains 19.5 mg of lactose (as monohydrate).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet.
Apricot, oval biconvex film-coated tablet, debossed with 300H on one side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Treatment of essential hypertension.
This fixed dose combination is indicated in adult patients whose blood pressure is not adequately controlled on irbesartan or hydrochlorothiazide alone (see section 5.1).

4.2 Posology and method of administration

Posology
[Nationally completed name] can be taken once daily, with or without food.
Dose titration with the individual components (i.e. irbesartan and hydrochlorothiazide) may be recommended.

When clinically appropriate direct change from monotherapy to the fixed combinations may be considered:

- [Nationally completed name 150 mg/12.5 mg] may be administered in patients whose blood pressure is not adequately controlled with hydrochlorothiazide or irbesartan 150 mg alone.
- [Nationally completed name 300 mg/12.5 mg] may be administered in patients insufficiently controlled by irbesartan 300 mg or by [Nationally completed name 150 mg/12.5 mg].
- [Nationally completed name 300 mg/25 mg] may be administered in patients insufficiently controlled by [Nationally completed name 300 mg/12.5 mg].

Doses higher than 300 mg irbesartan/25 mg hydrochlorothiazide once daily are not recommended. When necessary, [Nationally completed name] may be administered with another antihypertensive medicinal product (see sections 4.3, 4.4, 4.5 and 5.1).

Special populations

Renal impairment

Due to the hydrochlorothiazide component, [Nationally completed name] is not recommended for patients with severe renal dysfunction (creatinine clearance < 30 ml/min). Loop diuretics are preferred to thiazides in this population.

No dose adjustment is necessary in patients with renal impairment whose renal creatinine clearance is ≥ 30 ml/min (see sections 4.3 and 4.4).

Hepatic impairment

[Nationally completed name] is not indicated in patients with severe hepatic impairment. Thiazides should be used with caution in patients with impaired hepatic function. No dose adjustment of [Nationally completed name] is necessary in patients with mild to moderate hepatic impairment (see section 4.3).

Elderly

No dose adjustment of [Nationally completed name] is necessary in the elderly.

Paediatric population

[Nationally completed name] is not recommended for use in children and adolescents because the safety and efficacy have not been established. No data are available.

Method of administration

For oral use.

4.3 Contraindications

- Hypersensitivity to the active substances, or to any of the excipients listed in section 6.1, or to other sulphonamide-derived substances (hydrochlorothiazide is a sulphonamide-derived substance)
- Second and third trimesters of pregnancy (see sections 4.4 and 4.6)
- Severe renal impairment (creatinine clearance < 30 ml/min)
- Refractory hypokalaemia, hypercalcaemia
- Severe hepatic impairment, biliary cirrhosis and cholestasis
- The concomitant use of [Nationally completed name] with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60 ml/min/1.73 m²) (see sections 4.5 and 5.1).

4.4 Special warnings and precautions for use

Hypotension - Volume-depleted patients

[Nationally completed name] has been rarely associated with symptomatic hypotension in hypertensive patients without other risk factors for hypotension. Symptomatic hypotension may be

expected to occur in patients who are volume and/or sodium depleted by vigorous diuretic therapy, dietary salt restriction, diarrhoea or vomiting. Such conditions should be corrected before initiating therapy with [Nationally completed name].

Renal artery stenosis - Renovascular hypertension
There is an increased risk of severe hypotension and renal insufficiency when patients with bilateral renal artery stenosis or stenosis of the artery to a single functioning kidney are treated with angiotensin converting enzyme inhibitors or angiotensin-II receptor antagonists. While this is not documented with [Nationally completed name], a similar effect should be anticipated.

Renal impairment and kidney transplantation
When [Nationally completed name] is used in patients with impaired renal function, a periodic monitoring of potassium, creatinine and uric acid serum levels is recommended. There is no experience regarding the administration of [Nationally completed name] in patients with a recent kidney transplantation. [Nationally completed name] should not be used in patients with severe renal impairment (creatinine clearance < 30 ml/min) (see section 4.3).
Thiazide diuretic-associated azotaemia may occur in patients with impaired renal function. No dose adjustment is necessary in patients with renal impairment whose creatinine clearance is ≥ 30 ml/min. However, in patients with mild to moderate renal impairment (creatinine clearance ≥ 30 ml/min but < 60 ml/min) this fixed dose combination should be administered with caution.

Dual blockade of the renin-angiotensin-aldosterone system (RAAS)
There is evidence that the concomitant use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren increases the risk of hypotension, hyperkalaemia and decreased renal function (including acute renal failure). Dual blockade of RAAS through the combined use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren is therefore not recommended (see sections 4.5 and 5.1).
If dual blockade therapy is considered absolutely necessary, this should only occur under specialist supervision and subject to frequent close monitoring of renal function, electrolytes and blood pressure.
ACE-inhibitors and angiotensin II receptor blockers should not be used concomitantly in patients with diabetic nephropathy.

Hepatic impairment
Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. There is no clinical experience with [Nationally completed name] in patients with hepatic impairment.

Aortic and mitral valve stenosis, obstructive hypertrophic cardiomyopathy
As with other vasodilators, special caution is indicated in patients suffering from aortic or mitral stenosis, or obstructive hypertrophic cardiomyopathy.

Primary aldosteronism
Patients with primary aldosteronism generally will not respond to antihypertensive medicinal products acting through inhibition of the renin-angiotensin-aldosterone system. Therefore, the use of [Nationally completed name] is not recommended.

Metabolic and endocrine effects

Thiazide therapy may impair glucose tolerance. Latent diabetes mellitus may become manifest during thiazide therapy.
Irbesartan may induce hypoglycaemia, particularly in diabetic patients. In patients treated with insulin or antidiabetics an appropriate blood glucose monitoring should be considered; a dose adjustment of insulin or antidiabetics may be required when indicated (see section 4.5).
Increases in cholesterol and triglyceride levels have been associated with thiazide diuretic therapy, however, at the 12.5 mg dose of hydrochlorothiazide, minimal or no effects were reported.
Hyperuricaemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Electrolyte imbalance
As for any patient receiving diuretic therapy, periodic determination of serum electrolytes should be performed at appropriate intervals.
Thiazides, including hydrochlorothiazide, can cause fluid or electrolyte imbalance (hypokalaemia, hyponatraemia, and hypochloraemic alkalosis). Warning signs of fluid or electrolyte imbalance are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pain or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea or vomiting.
Although hypokalaemia may develop with the use of thiazide diuretics, concurrent therapy with irbesartan may reduce diuretic-induced hypokalaemia. The risk of hypokalaemia is greatest in patients with cirrhosis of the liver, in patients experiencing brisk diuresis, in patients who are receiving inadequate oral intake of electrolytes and in patients receiving concomitant therapy with corticosteroids or ACTH.
Conversely, due to the irbesartan component of [Nationally completed name] hyperkalaemia might occur, especially in the presence of renal impairment and/or heart failure, and diabetes mellitus. Adequate monitoring of serum potassium in patients at risk is recommended. Potassium-sparing diuretics, potassium supplements or potassium-containing salts substitutes should be co-administered cautiously with [Nationally completed name] (see section 4.5).
There is no evidence that irbesartan would reduce or prevent diuretic-induced hyponatraemia. Chloride deficit is generally mild and usually does not require treatment.
Thiazides may decrease urinary calcium excretion and cause an intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcaemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.
Thiazides have been shown to increase the urinary excretion of magnesium, which may result in hypomagnesaemia.

Non-melanoma skin cancer
An increased risk of non-melanoma skin cancer (NMSC) [basal cell carcinoma (BCC) and squamous cell carcinoma (SCC)] with increasing cumulative dose of hydrochlorothiazide (HCTZ) exposure has been observed in two epidemiological studies based on the Danish National Cancer Registry. Photosensitizing actions of HCTZ could act as a possible mechanism for NMSC.

Patients taking HCTZ should be informed of the risk of NMSC and advised to regularly check their skin for any new lesions and promptly report any suspicious skin lesions. Possible preventive measures such as limited exposure to sunlight and UV rays and, in case of exposure, adequate

protection should be advised to the patients in order to minimize the risk of skin cancer. Suspicious skin lesions should be promptly examined potentially including histological examinations of biopsies. The use of HCTZ may also need to be reconsidered in patients who have experienced previous NMSC (see also section 4.8).

Lithium
The combination of lithium and [Nationally completed name] is not recommended (see section 4.5).

Anti-doping test
Hydrochlorothiazide contained in this medicinal product could produce a positive analytic result in an anti-doping test.

General
In patients whose vascular tone and renal function depend predominantly on the activity of the renin-angiotensin-aldosterone system (e.g. patients with severe congestive heart failure or underlying renal disease, including renal artery stenosis), treatment with angiotensin converting enzyme inhibitors or angiotensin - II receptor antagonists that affect this system has been associated with acute hypotension, azotaemia, oliguria, or rarely acute renal failure (see section 4.5). As with any antihypertensive agent, excessive blood pressure decrease in patients with ischemic cardiopathy or ischemic cardiovascular disease could result in a myocardial infarction or stroke.
Hypersensitivity reactions to hydrochlorothiazide may occur in patients with or without a history of allergy or bronchial asthma, but are more likely in patients with such a history.
Exacerbation or activation of systemic lupus erythematosus has been reported with the use of thiazide diuretics.
Cases of photosensitivity reactions have been reported with thiazides diuretics (see section 4.8). If photosensitivity reaction occurs during treatment, it is recommended to stop the treatment. If a re-administration of the diuretic is deemed necessary, it is recommended to protect exposed areas to the sun or to artificial UVA.

Pregnancy
Angiotensin II Receptor Antagonists (AIIRAs) should not be initiated during pregnancy. Unless continued AIIRA therapy is considered essential, patients planning pregnancy should be changed to alternative antihypertensive treatments which have an established safety profile for use in pregnancy. When pregnancy is diagnosed, treatment with AIIRAs should be stopped immediately, and, if appropriate, alternative therapy should be started (see sections 4.3 and 4.6).

Special warnings regarding excipients
[Nationally completed name] contains lactose and sodium.
Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

This medicinal product contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially “sodium-free”.

Choroidal effusion, acute myopia and secondary acute angle-closure glaucoma

Sulphonamide medicinal products or sulphonamide derivative medicinal products can cause an idiosyncratic reaction, resulting in choroidal effusion with visual field defect, transient myopia and acute angle-closure glaucoma. While hydrochlorothiazide is a sulphonamide, only isolated cases of acute angle-closure glaucoma have been reported so far with hydrochlorothiazide. Symptoms include acute onset of decreased visual acuity or ocular pain and typically occur within hours to weeks of medicinal product initiation. Untreated acute angle-closure glaucoma can lead to permanent vision loss. The primary treatment is to discontinue medicinal product intake as rapidly as possible. Prompt medical or surgical treatments may need to be considered if the intraocular pressure remains uncontrolled. Risk factors for developing acute angle-closure glaucoma may include a history of sulphonamide or penicillin allergy (see section 4.8).

Acute respiratory toxicity
Very rare severe cases of acute respiratory toxicity, including acute respiratory distress syndrome (ARDS) have been reported after taking hydrochlorothiazide. Pulmonary oedema typically develops within minutes to hours after hydrochlorothiazide intake. At the onset, symptoms include dyspnoea, fever, pulmonary deterioration and hypotension. If diagnosis of ARDS is suspected, [Nationally completed name] should be withdrawn and appropriate treatment given. Hydrochlorothiazide should not be administered to patients who previously experienced ARDS following hydrochlorothiazide intake.

4.5 Interaction with other medicinal products and other forms of interaction

Other antihypertensive agents
The antihypertensive effect of [Nationally completed name] may be increased with the concomitant use of other antihypertensive agents. Irbesartan and hydrochlorothiazide (at doses up to 300 mg irbesartan/25 mg hydrochlorothiazide) have been safely administered with other antihypertensive agents including calcium channel blockers and beta adrenergic blockers. Prior treatment with high dose diuretics may result in volume depletion and a risk of hypotension when initiating therapy with irbesartan with or without thiazide diuretics unless the volume depletion is corrected first (see section 4.4).

Clinical trial data has shown that dual blockade of the renin-angiotensin-aldosterone-system (RAAS) through the combined use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren is associated with a higher frequency of adverse events such as hypotension, hyperkalaemia and decreased renal function (including acute renal failure) compared to the use of a single RAAS-acting agent (see sections 4.3, 4.4 and 5.1).

Lithium
Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with angiotensin converting enzyme inhibitors. Similar effects have been very rarely reported with irbesartan so far. Furthermore, renal clearance of lithium is reduced by thiazides so the risk of lithium toxicity could be increased with [Nationally completed name]. Therefore, the combination of lithium and [Nationally completed name] is not recommended (see section 4.4). If the combination proves necessary, careful monitoring of serum lithium levels is recommended.

Medicinal products affecting potassium
The potassium-depleting effect of hydrochlorothiazide is attenuated by the potassium-sparing effect of irbesartan. However, this effect of hydrochlorothiazide on serum potassium would be expected to be potentiated by other medicinal products associated with potassium loss and hypokalaemia (e.g. other kaliuretic diuretics, laxatives, amphotericin, carbenoxolone, penicillin G sodium). Conversely, based on the experience with the use of other medicinal products that blunt the renin-angiotensin system, concomitant use of potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium or other medicinal products that may increase serum potassium levels (e.g. heparin sodium) may lead to increases in serum potassium. Adequate monitoring of serum potassium in patients at risk is recommended (see section 4.4).

Medicinal products affected by serum potassium disturbances
Periodic monitoring of serum potassium is recommended when [Nationally completed name] is administered with medicinal products affected by serum potassium disturbances (e.g. digitalis glycosides, antiarrhythmics).

Non-steroidal anti-inflammatory drugs
When angiotensin II antagonists are administered simultaneously with non-steroidal anti-inflammatory drugs (i.e. selective COX 2 inhibitors, acetylsalicylic acid (> 3 g/day) and non-selective NSAIDs), attenuation of the antihypertensive effect may occur.

As with ACE-inhibitors, concomitant use of angiotensin II antagonists and NSAIDs may lead to an increased risk of worsening of renal function, including possible acute renal failure, and an increase in serum potassium, especially in patients with poor pre-existing renal function. The combination should be administered with caution, especially in the elderly. Patients should be adequately hydrated and consideration should be given to monitoring renal function after initiation of concomitant therapy, and periodically thereafter.

Repaglinide
Irbesartan has the potential to inhibit OATP1B1. In a clinical study, it was reported that irbesartan increased the Cmax and AUC of repaglinide (substrate of OATP1B1) by 1.8-fold and 1.3-fold, respectively, when administered 1 hour before repaglinide. In another study, no relevant pharmacokinetic interaction was reported, when the two drugs were co-administered. Therefore, dose adjustment of antidiabetic treatment such as repaglinide may be required (see section 4.4).

Additional information on irbesartan interactions
In clinical studies, the pharmacokinetic of irbesartan is not affected by hydrochlorothiazide. Irbesartan is mainly metabolised by CYP2C9 and to a lesser extent by glucuronidation. No significant pharmacokinetic or pharmacodynamic interactions were observed when irbesartan was coadministered with warfarin, a medicinal product metabolised by CYP2C9. The effects of CYP2C9 inducers such as rifampicin on the pharmacokinetic of irbesartan have not been evaluated. The pharmacokinetic of digoxin was not altered by co-administration of irbesartan.

Additional information on hydrochlorothiazide interactions
When administered concurrently, the following medicinal products may interact with thiazide diuretics:

Alcohol
Potentiation of orthostatic hypotension may occur.

Antidiabetic medicinal products (oral agents and insulins)
Dose adjustment of the antidiabetic medicinal product may be required (see section 4.4).

Colestyramine and Colestipol resins
Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. [Nationally completed name] should be taken at least one hour before or four hours after these medicinal products.

Corticosteroids, ACTH
Electrolyte depletion, particularly hypokalaemia, may be increased.

Digitalis glycosides
Thiazide induced hypokalaemia or hypomagnesaemia favour the onset of digitalis-induced cardiac arrhythmias (see section 4.4).

Non-steroidal anti-inflammatory drugs
The administration of a non-steroidal anti-inflammatory drug may reduce the diuretic, natriuretic and antihypertensive effects of thiazide diuretics in some patients.

Pressor amines (e.g. noradrenaline)
The effect of pressor amines may be decreased, but not sufficiently to preclude their use.

Nondepolarizing skeletal muscle relaxants (e.g. tubocurarine)
The effect of nondepolarizing skeletal muscle relaxants may be potentiated by hydrochlorothiazide.

Antigout medicinal products
Dose adjustments of antigout medicinal products may be necessary as hydrochlorothiazide may raise the level of serum uric acid. Increase in dose of probenecid or sulphinpyrazone may be necessary. Co-administration of thiazide diuretics may increase the incidence of hypersensitivity reactions to allopurinol.

Calcium salts
Thiazide diuretics may increase serum calcium levels due to decreased excretion. If calcium supplements or calcium sparing medicinal products (e.g. vitamin D therapy) must be prescribed, serum calcium levels should be monitored and calcium dose adjusted accordingly.

Carbamazepine
Concomitant use of carbamazepine and hydrochlorothiazide has been associated with the risk of symptomatic hyponatraemia. Electrolytes should be monitored during concomitant use. If possible, another class of diuretics should be used.

Other interactions

The hyperglycaemic effect of beta-blockers and diazoxide may be enhanced by thiazides. Anticholinergic agents (e.g. atropine, biperiden) may increase the bioavailability of thiazide-type diuretics by decreasing gastrointestinal motility and stomach emptying rate. Thiazides may increase the risk of adverse events caused by amantadine. Thiazides may reduce the renal excretion of cytotoxic medicinal products (e.g. cyclophosphamide, methotrexate) and potentiate their myelosuppressive effects.

4.6 Fertility, pregnancy and lactation

Pregnancy

Angiotensin II Receptor Antagonists (AIIRAs):

The use of AIIRAs is not recommended during the first trimester of pregnancy (see section 4.4). The use of AIIRAs is contra-indicated during the 2nd and 3rd trimester of pregnancy (see sections 4.3 and 4.4).

Epidemiological evidence regarding the risk of teratogenicity following exposure to ACE-inhibitors during the first trimester of pregnancy has not been conclusive; however a small increase in risk cannot be excluded. Whilst there is no controlled epidemiological data on the risk with Angiotensin II Receptor Antagonists (AIIRAs), similar risks may exist for this class of medicinal products. Unless continued AIIRA therapy is considered essential, patients planning pregnancy should be changed to alternative antihypertensive treatments which have an established safety profile for use in pregnancy. When pregnancy is diagnosed, treatment with AIIRAs should be stopped immediately and, if appropriate, alternative therapy should be started.

Exposure to AIIRA therapy during the second and third trimesters is known to induce human foetotoxicity (decreased renal function, oligohydramnios, skull ossification retardation) and neonatal toxicity (renal failure, hypotension, hyperkalaemia) (see section 5.3).
Should exposure to AIIRAs have occurred from the second trimester of pregnancy, ultrasound check of renal function and skull is recommended.
Infants whose mothers have taken AIIRAs should be closely observed for hypotension (see sections 4.3 and 4.4).

Hydrochlorothiazide:
There is limited experience with hydrochlorothiazide during pregnancy, especially during the first trimester. Animal studies are insufficient.
Hydrochlorothiazide crosses the placenta. Based on the pharmacological mechanism of action of hydrochlorothiazide its use during the second and third trimester may compromise foeto-placental perfusion and may cause foetal and neonatal effects like icterus, disturbance of electrolyte balance and thrombocytopenia.
Hydrochlorothiazide should not be used for gestational oedema, gestational hypertension or preeclampsia due to the risk of decreased plasma volume and placental hypoperfusion, without a beneficial effect on the course of the disease.
Hydrochlorothiazide should not be used for essential hypertension in pregnant women except in rare situations where no other treatment could be used.

Since [Nationally completed name] contains hydrochlorothiazide, it is not recommended during the first trimester of pregnancy. A switch to a suitable alternative treatment should be carried out in advance of a planned pregnancy.

Breast-feeding
Angiotensin II Receptor Antagonists (AIIRAs):
Because no information is available regarding the use of [Nationally completed name] during breast-feeding, [Nationally completed name] is not recommended and alternative treatments with better established safety profiles during breast-feeding are preferable, especially while nursing a newborn or preterm infant.

It is unknown whether irbesartan or its metabolites are excreted in human milk.
Available pharmacodynamic/toxicological data in rats have shown excretion of irbesartan or its metabolites in milk (see section 5.3).

Hydrochlorothiazide:
Hydrochlorothiazide is excreted in human milk in small amounts. Thiazides in high doses causing intense diuresis can inhibit the milk production. The use of [Nationally completed name] during breast-feeding is not recommended. If [Nationally completed name] is used during breast-feeding, doses should be kept as low as possible.

Fertility
Irbesartan had no effect upon fertility of treated rats and their offspring up to the dose levels inducing the first signs of parental toxicity (see section 5.3).

4.7 Effects on ability to drive and use machines

Based on its pharmacodynamic properties, [Nationally completed name] is unlikely to affect the ability to drive and use machines. When driving vehicles or operating machines, it should be taken into account that occasionally dizziness or weariness may occur during treatment of hypertension.

4.8 Undesirable effects

Irbesartan/hydrochlorothiazide combination:
Among 898 hypertensive patients who received various doses of irbesartan/hydrochlorothiazide (range: 37.5 mg/6.25 mg to 300 mg/25 mg) in placebo-controlled trials, 29.5% of the patients experienced adverse reactions. The most commonly reported ADRs were dizziness (5.6%), fatigue (4.9%), nausea/vomiting (1.8%), and abnormal urination (1.4%). In addition, increases in blood urea nitrogen (BUN) (2.3%), creatine kinase (1.7%) and creatinine (1.1%) were also commonly observed in the trials.

Table 1 gives the adverse reactions observed from spontaneous reporting and in placebo-controlled trials.
The frequency of adverse reactions listed below is defined using the following convention:

very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000), not known (cannot be estimated from the available data). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

Table 1: Adverse Reactions in Placebo-Controlled Trials and Spontaneous Reports		
System Organ Class	**Frequency**	**Undesirable effect**
Immune system disorders	Not known	cases of hypersensitivity reactions such as angioedema, rash, urticaria
Metabolism and nutrition disorders	Not known	hyperkalaemia
Nervous system disorders	Common	dizziness
	Uncommon	orthostatic dizziness
	Not known	headache
Ear and labyrinth disorders	Not known	tinnitus
Cardiac disorders	Uncommon	syncope, hypotension, tachycardia, oedema
Vascular disorders	Uncommon	flushing
Respiratory, thoracic and mediastinal disorders	Not known	cough
Gastrointestinal disorders	Common	nausea/vomiting
	Uncommon	diarrhoea
	Not known	dyspepsia, dysgeusia
Hepatobiliary disorders	Uncommon	jaundice
	Not known	hepatitis, abnormal liver function
Musculoskeletal and connective tissue disorders	Uncommon	swelling extremity
	Not known	arthralgia, myalgia
Renal and urinary disorders	Common	abnormal urination
	Not known	impaired renal function including isolated cases of renal failure in patients at risk (see section 4.4)
Reproductive system and breast disorders	Uncommon	sexual dysfunction, libido changes
General disorders and administration site conditions	Common	fatigue
Investigations	Common	increases in blood urea nitrogen (BUN), creatinine and creatine kinase
	Uncommon	decreases in serum potassium and sodium

Additional information on individual components:
In addition to the adverse reactions listed above for the combination product, other adverse reactions previously reported with one of the individual components may be potential adverse reactions with [Nationally completed name]. Tables 2 and 3 below detail the adverse reactions reported with the individual components of [Nationally completed name].

Table 2: Adverse Reactions reported with the use of irbesartan alone		
System Organ Class	**Frequency**	**Undesirable effect**
General disorders and	Uncommon	chest pain

administration site conditions		
Immune system disorders	Not known	anaphylactic reaction including anaphylactic shock
Blood and lymphatic system disorders	Not known	thrombocytopenia, anaemia
Metabolism and nutrition disorders	Not known	hypoglycaemia

Table 3: Adverse Reactions reported with the use of hydrochlorothiazide alone		
System Organ Class	**Frequency**	**Undesirable effect**
Blood and lymphatic system disorders	Not known	aplastic anaemia, bone marrow depression, neutropenia/agranulocytosis, haemolytic anaemia, leucopenia, thrombocytopenia
Psychiatric disorders	Not known	depression, sleep disturbances
Nervous system disorders	Not known	vertigo, paraesthesia, light-headedness, restlessness
Eye disorders	Not known	transient blurred vision, xanthopsia, choroidal effusion, acute myopia and secondary acute angle-closure glaucoma
Cardiac disorders	Not known	cardiac arrhythmias
Vascular disorders	Not known	postural hypotension
Respiratory, thoracic and mediastinal disorders	Not known	respiratory distress (including pneumonitis and pulmonary oedema)
	Very rare	acute respiratory distress syndrome (ARDS) (see section 4.4)
Gastrointestinal disorders	Not known	pancreatitis, anorexia, diarrhoea, constipation, gastric irritation, sialadenitis, loss of appetite
Hepatobiliary disorders	Not known	jaundice (intrahepatic cholestatic jaundice)
Skin and subcutaneous tissue disorders	Not known	anaphylactic reactions, toxic epidermal necrolysis, necrotizing angiitis (vasculitis, cutaneous vasculitis), cutaneous lupus erythematosus-like reactions, reactivation of cutaneous lupus erythematosus, photosensitivity reactions, rash, urticaria
Musculoskeletal, connective tissue and bone disorders	Not known	weakness, muscle spasm
Renal and urinary disorders	Not known	interstitial nephritis, renal dysfunction
Neoplasms benign, malignant and unspecified (incl. cysts and polyps)	Not known	non-melanoma skin cancer (basal cell carcinoma and squamous cell carcinoma)*
General disorders and administration site conditions	Not known	fever
Investigations	Not known	electrolyte imbalance (including hypokalaemia and hyponatraemia, see section 4.4), hyperuricaemia, glycosuria,

		hyperglycaemia, increases in cholesterol and triglycerides

*Non-melanoma skin cancer: Based on available data from epidemiological studies, cumulative dose-dependent association between HCTZ and NMSC has been observed (see also sections 4.4 and 5.1).

The dose dependent adverse events of hydrochlorothiazide (particularly electrolyte disturbances) may increase when titrating hydrochlorothiazide.

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 reporting system listed in Appendix V*.

[*For the printed material, please refer to the guidance of the annotated QRD template.]

4.9 Overdose

No specific information is available on the treatment of overdose with [Nationally completed name]. The patient should be closely monitored, and the treatment should be symptomatic and supportive. Management depends on the time since ingestion and the severity of the symptoms. Suggested measures include induction of emesis and/or gastric lavage. Activated charcoal may be useful in the treatment of overdose. Serum electrolytes and creatinine should be monitored frequently. If hypotension occurs, the patient should be placed in a supine position, with salt and volume replacements given quickly.

The most likely manifestations of irbesartan overdose are expected to be hypotension and tachycardia; bradycardia might also occur.

Overdose with hydrochlorothiazide is associated with electrolyte depletion (hypokalaemia, hypochloraemia, hyponatraemia) and dehydration resulting from excessive diuresis. The most common signs and symptoms of overdose are nausea and somnolence. Hypokalaemia may result in muscle spasms and/or accentuate cardiac arrhythmias associated with the concomitant use of digitalis glycosides or certain anti-arrhythmic medicinal products.

Irbesartan is not removed by haemodialysis. The degree to which hydrochlorothiazide is removed by haemodialysis has not been established.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Angiotensin II antagonists and diuretics
ATC code: C09DA04

[Nationally completed name] is a combination of an angiotensin II receptor antagonist, irbesartan, and a thiazide diuretic, hydrochlorothiazide. The combination of these ingredients has an additive antihypertensive effect, reducing blood pressure to a greater degree than either component alone.

Irbesartan is a potent, orally active, selective angiotensin II receptor (AT_1 subtype) antagonist. It is expected to block all actions of angiotensin II mediated by the AT_1 receptor, regardless of the source or route of synthesis of angiotensin II. The selective antagonism of the angiotensin II (AT_1) receptors results in increases in plasma renin levels and angiotensin II levels, and a decrease in plasma aldosterone concentration. Serum potassium levels are not significantly affected by irbesartan alone at the recommended doses in patients without risk of electrolyte imbalance (see sections 4.4 and 4.5). Irbesartan does not inhibit ACE (kininase II), an enzyme which generates angiotensin II and also degrades bradykinin into inactive metabolites. Irbesartan does not require metabolic activation for its activity.

Hydrochlorothiazide is a thiazide diuretic. The mechanism of antihypertensive effect of thiazide diuretics is not fully known. Thiazides affect the renal tubular mechanisms of electrolyte reabsorption, directly increasing excretion of sodium and chloride in approximately equivalent amounts. The diuretic action of hydrochlorothiazide reduces plasma volume, increases plasma renin activity, increases aldosterone secretion, with consequent increases in urinary potassium and bicarbonate loss, and decreases in serum potassium. Presumably through blockade of the renin-angiotensin-aldosterone system, co-administration of irbesartan tends to reverse the potassium loss associated with these diuretics. With hydrochlorothiazide, onset of diuresis occurs in 2 hours, and peak effect occurs at about 4 hours, while the action persists for approximately 6-12 hours.

The combination of hydrochlorothiazide and irbesartan produces dose-related additive reductions in blood pressure across their therapeutic dose ranges. The addition of 12.5 mg hydrochlorothiazide to 300 mg irbesartan once daily in patients not adequately controlled on 300 mg irbesartan alone resulted in further placebo-corrected diastolic blood pressure reductions at trough (24 hours post-dosing) of 6.1 mm Hg. The combination of 300 mg irbesartan and 12.5 mg hydrochlorothiazide resulted in an overall placebo-subtracted systolic/diastolic reductions of up to 13.6/11.5 mm Hg.

Limited clinical data (7 out of 22 patients) suggest that patients not controlled with the 300 mg/12.5 mg combination may respond when uptitrated to 300 mg/25 mg. In these patients, an incremental blood pressure lowering effect was observed for both systolic blood pressure (SBP) and diastolic blood pressure (DBP) (13.3 and 8.3 mm Hg, respectively).

Once daily dosing with 150 mg irbesartan and 12.5 mg hydrochlorothiazide gave systolic/diastolic mean placebo-adjusted blood pressure reductions at trough (24 hours post-dosing) of 12.9/6.9 mm Hg in patients with mild-to-moderate hypertension. Peak effects occurred at 3-6 hours. When assessed by ambulatory blood pressure monitoring, the combination 150 mg irbesartan and 12.5 mg hydrochlorothiazide once daily produced consistent reduction in blood pressure over the 24 hours period with mean 24 hour placebo-subtracted systolic/diastolic reductions of 15.8/10.0 mm Hg. When measured by ambulatory blood pressure monitoring, the trough to peak effects of irbesartan/hydrochlorothiazide combination 150 mg/12.5 mg were 100%. The trough to peak effects measured by cuff during office visits were 68% and 76% for irbesartan/hydrochlorothiazide

combination 150 mg/12.5 mg and irbesartan/hydrochlorothiazide combination 300 mg/12.5 mg, respectively. These 24 hour effects were observed without excessive blood pressure lowering at peak and are consistent with safe and effective blood-pressure lowering over the once-daily dosing interval.

In patients not adequately controlled on 25 mg hydrochlorothiazide alone, the addition of irbesartan gave an added placebo-subtracted systolic/diastolic mean reduction of 11.1/7.2 mm/Hg.

The blood pressure lowering effect of irbesartan in combination with hydrochlorothiazide is apparent after the first dose and substantially present within 1-2 weeks, with the maximal effect occurring by 6-8 weeks. In long-term follow-up studies, the effect of irbesartan/hydrochlorothiazide was maintained for over one year. Although not specifically studied with the irbesartan/hydrochlorothiazide combination, rebound hypertension has not been seen with either irbesartan or hydrochlorothiazide.

The effect of the combination of irbesartan and hydrochlorothiazide on morbidity and mortality has not been studied. Epidemiological studies have shown that long term treatment with hydrochlorothiazide reduces the risk of cardiovascular mortality and morbidity.

There is no difference in response to irbesartan/hydrochlorothiazide combination, regardless of age or gender. As is the case with other medicinal products that affect the renin-angiotensin system, black hypertensive patients have notably less response to irbesartan monotherapy. When irbesartan is administered concomitantly with a low dose of hydrochlorothiazide (e.g. 12.5 mg daily), the antihypertensive response in black patients approaches that of non-black patients.

Efficacy and safety of irbesartan/hydrochlorothiazide combination as initial therapy for severe hypertension (defined as SeDBP ≥ 110 mmHg) was evaluated in a multicenter, randomized, double-blind, active-controlled, 8-week, parallel-arm study. A total of 697 patients were randomized in a 2:1 ratio to either irbesartan/hydrochlorothiazide 150 mg/12.5 mg or to irbesartan 150 mg and systematically force-titrated (before assessing the response to the lower dose) after one week to irbesartan/hydrochlorothiazide 300 mg/25 mg or irbesartan 300 mg, respectively.

The study recruited 58% males. The mean age of patients was 52.5 years, 13% were 65 years of age, and just 2% were ≥ 75 years of age. Twelve percent (12%) of patients were diabetic, 34% were hyperlipidemic and the most frequent cardiovascular condition was stable angina pectoris in 3.5% of the participants.

The primary objective of this study was to compare the proportion of patients whose SeDBP was controlled (SeDBP < 90 mmHg) at Week 5 of treatment. Forty-seven percent (47.2%) of patients on the combination achieved through SeDBP < 90 mmHg compared to 33.2% of patients on irbesartan ($p = 0.0005$). The mean baseline blood pressure was approximately 172/113 mm Hg in each treatment group and decreases of SeSBP/SeDBP at five weeks were 30.8/24.0 mm Hg and 21.1/19.3 mm Hg for irbesartan/hydrochlorothiazide and irbesartan, respectively ($p < 0.0001$).

The types and incidences of adverse events reported for patients treated with the combination were similar to the adverse event profile for patients on monotherapy. During the 8 week treatment period, there were no reported cases of syncope in either treatment group. There were 0.6% and 0% of

patients with hypotension and 2.8% and 3.1% of patients with dizziness as adverse reactions reported in the combination and monotherapy groups, respectively.

Dual blockade of the renin-angiotensin-aldosterone system (RAAS)
Two large randomised, controlled trials (ONTARGET (ONgoing Telmisartan Alone and in combination with Ramipril Global Endpoint Trial) and VA NEPHRON-D (The Veterans Affairs Nephropathy in Diabetes)) have examined the use of the combination of an ACE-inhibitor with an angiotensin II receptor blocker.
ONTARGET was a study conducted in patients with a history of cardiovascular or cerebrovascular disease, or type 2 diabetes mellitus accompanied by evidence of end-organ damage. VA NEPHRON-D was a study in patients with type 2 diabetes mellitus and diabetic nephropathy.
These studies have shown no significant beneficial effect on renal and/or cardiovascular outcomes and mortality, while an increased risk of hyperkalaemia, acute kidney injury and/or hypotension as compared to monotherapy was observed. Given their similar pharmacodynamic properties, these results are also relevant for other ACE-inhibitors and angiotensin II receptor blockers.
ACE-inhibitors and angiotensin II receptor blockers should therefore not be used concomitantly in patients with diabetic nephropathy.
ALTITUDE (Aliskiren Trial in Type 2 Diabetes Using Cardiovascular and Renal Disease Endpoints) was a study designed to test the benefit of adding aliskiren to a standard therapy of an ACE-inhibitor or an angiotensin II receptor blocker in patients with type 2 diabetes mellitus and chronic kidney disease, cardiovascular disease, or both. The study was terminated early because of an increased risk of adverse outcomes. Cardiovascular death and stroke were both numerically more frequent in the aliskiren group than in the placebo group and adverse events and serious adverse events of interest (hyperkalaemia, hypotension and renal dysfunction) were more frequently reported in the aliskiren group than in the placebo group.

Non-melanoma skin cancer
Based on available data from epidemiological studies, cumulative dose-dependent association between HCTZ and NMSC has been observed. One study included a population comprised of 71,533 cases of BCC and of 8,629 cases of SCC matched to 1,430,833 and 172,462 population controls, respectively. High HCTZ use (≥50,000 mg cumulative) was associated with an adjusted OR of 1.29 (95% CI: 1.23-1.35) for BCC and 3.98 (95% CI: 3.68-4.31) for SCC. A clear cumulative dose response relationship was observed for both BCC and SCC. Another study showed a possible association between lip cancer (SCC) and exposure to HCTZ: 633 cases of lip-cancer were matched with 63,067 population controls, using a risk-set sampling strategy. A cumulative dose-response relationship was demonstrated with an adjusted OR 2.1 (95% CI: 1.7-2.6) increasing to OR 3.9 (3.0-4.9) for high use (~25,000 mg) and OR 7.7 (5.7-10.5) for the highest cumulative dose (~100,000 mg) (see also section 4.4).

5.2 Pharmacokinetic properties

Concomitant administration of hydrochlorothiazide and irbesartan has no effect on the pharmacokinetics of either medicinal product.

Irbesartan and hydrochlorothiazide are orally active agents and do not require biotransformation for their activity. Following oral administration of irbesartan/hydrochlorothiazide combination, the absolute oral bioavailability is 60-80% and 50-80% for irbesartan and hydrochlorothiazide,

respectively. Food does not affect the bioavailability of irbesartan/hydrochlorothiazide combination. Peak plasma concentration occurs at 1.5-2 hours after oral administration for irbesartan and 1-2.5 hours for hydrochlorothiazide.

Plasma protein binding of irbesartan is approximately 96%, with negligible binding to cellular blood components. The volume of distribution for irbesartan is 53-93 litres. Hydrochlorothiazide is 68% protein-bound in the plasma, and its apparent volume of distribution is 0.83-1.14 l/kg.

Irbesartan exhibits linear and dose proportional pharmacokinetics over the dose range of 10 to 600 mg. A less than proportional increase in oral absorption at doses beyond 600 mg was observed; the mechanism for this is unknown. The total body and renal clearance are 157-176 and 3.0-.5 ml/min, respectively. The terminal elimination half-life of irbesartan is 11-15 hours. Steady-state plasma concentrations are attained within 3 days after initiation of a once-daily dosing regimen. Limited accumulation of irbesartan (< 20%) is observed in plasma upon repeated once-daily dosing. In a study, somewhat higher plasma concentrations of irbesartan were observed in female hypertensive patients. However, there was no difference in the half-life and accumulation of irbesartan. No dose adjustment is necessary in female patients. Irbesartan AUC and C_{max} values were also somewhat greater in elderly subjects (≥ 65 years) than those of young subjects (18-40 years). However the terminal half-life was not significantly altered. No dose adjustment is necessary in the elderly. The mean plasma half-life of hydrochlorothiazide reportedly ranges from 5-15 hours.

Following oral or intravenous administration of ^{14}C irbesartan, 80-85% of the circulating plasma radioactivity is attributable to unchanged irbesartan. Irbesartan is metabolised by the liver via glucuronide conjugation and oxidation. The major circulating metabolite is irbesartan glucuronide (approximately 6%). *In vitro* studies indicate that irbesartan is primarily oxidised by the cytochrome P450 enzyme CYP2C9; isoenzyme CYP3A4 has negligible effect. Irbesartan and its metabolites are eliminated by both biliary and renal pathways. After either oral or intravenous administration of ^{14}C irbesartan, about 20% of the radioactivity is recovered in the urine, and the remainder in the faeces. Less than 2% of the dose is excreted in the urine as unchanged irbesartan. Hydrochlorothiazide is not metabolized but is eliminated rapidly by the kidneys. At least 61% of the oral dose is eliminated unchanged within 24 hours. Hydrochlorothiazide crosses the placental but not the blood-brain barrier, and is excreted in breast milk.

Renal impairment
In patients with renal impairment or those undergoing haemodialysis, the pharmacokinetic parameters of irbesartan are not significantly altered. Irbesartan is not removed by haemodialysis. In patients with creatinine clearance < 20 ml/min, the elimination half-life of hydrochlorothiazide was reported to increase to 21 hours.

Hepatic impairment
In patients with mild to moderate cirrhosis, the pharmacokinetic parameters of irbesartan are not significantly altered. Studies have not been performed in patients with severe hepatic impairment.

5.3 Preclinical safety data

Irbesartan/hydrochlorothiazide

The potential toxicity of the irbesartan/hydrochlorothiazide combination after oral administration was evaluated in rats and macaques in studies lasting up to 6 months. There were no toxicological findings observed of relevance to human therapeutic use.

The following changes, observed in rats and macaques receiving the irbesartan/hydrochlorothiazide combination at 10/10 and 90/90 mg/kg/day, were also seen with one of the two medicinal products alone and/or were secondary to decreases in blood pressure (no significant toxicologic interactions were observed):

- kidney changes, characterized by slight increases in serum urea and creatinine, and hyperplasia/hypertrophy of the juxtaglomerular apparatus, which are a direct consequence of the interaction of irbesartan with the renin-angiotensin system;
- slight decreases in erythrocyte parameters (erythrocytes, haemoglobin, haematocrit);
- stomach discoloration, ulcers and focal necrosis of gastric mucosa were observed in few rats in a 6 months toxicity study at irbesartan 90 mg/kg/day, hydrochlorothiazide 90 mg/kg/day, and irbesartan/hydrochlorothiazide 10/10 mg/kg/day. These lesions were not observed in macaques;
- decreases in serum potassium due to hydrochlorothiazide and partly prevented when hydrochlorothiazide was given in combination with irbesartan.

Most of the above mentioned effects appear to be due to the pharmacological activity of irbesartan (blockade of angiotensin II-induced inhibition of renin release, with stimulation of the renin-producing cells) and occur also with angiotensin converting enzyme inhibitors. These findings appear to have no relevance to the use of therapeutic doses of irbesartan/hydrochlorothiazide in humans.

No teratogenic effects were seen in rats given irbesartan and hydrochlorothiazide in combination at doses that produced maternal toxicity. The effects of the irbesartan/hydrochlorothiazide combination on fertility have not been evaluated in animal studies, as there is no evidence of adverse event on fertility in animals or humans with either irbesartan or hydrochlorothiazide when administered alone. However, another angiotensin II antagonist affected fertility parameters in animal studies when given alone. These findings were also observed with lower doses of this other angiotensin II antagonist when given in combination with hydrochlorothiazide.

There was no evidence of mutagenicity or clastogenicity with the irbesartan/hydrochlorothiazide combination. The carcinogenic potential of irbesartan and hydrochlorothiazide in combination has not been evaluated in animal studies.

Irbesartan

There was no evidence of abnormal systemic or target organ toxicity at clinically relevant doses. In non-clinical safety studies, high doses of irbesartan (≥ 250 mg/kg/day in rats and ≥ 100 mg/kg/day in macaques) caused a reduction of red blood cell parameters (erythrocytes, haemoglobin, haematocrit). At very high doses (≥ 500 mg/kg/day) degenerative changes in the kidneys (such as interstitial nephritis, tubular distention, basophilic tubules, increased plasma concentrations of urea and creatinine) were induced by irbesartan in the rat and the macaque and are considered secondary to the hypotensive effects of the medicinal product which led to decreased renal perfusion. Furthermore, irbesartan induced hyperplasia/hypertrophy of the juxtaglomerular cells (in rats at ≥ 90 mg/kg/day, in macaques at ≥10 mg/kg/day). All of these changes were considered to be caused by the

pharmacological action of irbesartan. For therapeutic doses of irbesartan in humans, the hyperplasia/hypertrophy of the renal juxtaglomerular cells does not appear to have any relevance.

There was no evidence of mutagenicity, clastogenicity or carcinogenicity.

Fertility and reproductive performance were not affected in studies of male and female rats even at oral doses of irbesartan causing some parental toxicity (from 50 to 650 mg/kg/day), including mortality at the highest dose. No significant effects on the number of corpora lutea, implants, or live fetuses were observed. Irbesartan did not affect survival, development, or reproduction of offspring. Studies in animals indicate that the radiolabelled irbesartan is detected in rat and rabbit fetuses. Irbesartan is excreted in the milk of lactating rats.

Animal studies with irbesartan showed transient toxic effects (increased renal pelvic cavitation, hydroureter or subcutaneous oedema) in rat foetuses, which were resolved after birth. In rabbits, abortion or early resorption was noted at doses causing significant maternal toxicity, including mortality. No teratogenic effects were observed in the rat or rabbit.

Hydrochlorothiazide
Equivocal evidence for a genotoxic or carcinogenic effect was found in some experimental models.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core
Microcrystalline cellulose
Lactose monohydrate
Croscarmellose sodium
Colloidal anhydrous silica
Hypromellose 3 mPas
Silicified microcrystalline cellulose
Magnesium stearate

Film-coating:
Hypromellose 6 mPas
Hydroxypropylcellulose
Macrogol 6000
Lactose monohydrate
Titanium dioxide (E 171)
Iron oxide (yellow and red) (E 172)
Talc

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

PVC/PVDC/ALU blisters:
2 years.

ALU/ALU blisters:
3 years

NL/H/1579/002 only
HDPE bottles:
3 years

6.4 Special precautions for storage

PVC/PVDC/ALU blisters:
Do not store above 25 °C.
Store in the original package in order to protect from moisture.

ALU/ALU blisters:
Store in the original package, in order to protect from moisture.

NL/H/1579/002 only
HDPE bottles:
Store in the original package, in order to protect from moisture.

6.5 Nature and contents of container

NL/H/1579/002:

The film-coated tablets are packed in PVC/PDVC/ALU blisters or ALU/ALU blisters and inserted in a carton or are packed in a HDPE bottle with a PP screw cap and silica gel desiccant.

Pack sizes:
PVC/PVDC/ALU blister:
7, 10, 14, 20, 28, 30, 49, 50, 56, 60, 84, 90, 98, 100 film-coated tablets.

ALU/ALU blister:
7, 10, 14, 20, 28, 30, 49, 50, 56, 60, 84, 90, 98, 100 film-coated tablets.

HDPE bottle:
100 film-coated tablets.

NL/H/1581/002

The film-coated tablets are packed in PVC/PDVC/ALU blisters or ALU/ALU blisters and inserted in a carton.

PVC/PVDC/ALU blister:
7, 10, 14, 20, 28, 30, 49, 50, 56, 60, 90, 98, 100 film-coated tablets.

ALU/ALU blister:
7, 10, 14, 20, 28, 30, 49, 50, 56, 60, 90, 98, 100 film-coated tablets.

NL/H/1582/002

The film-coated tablets are packed in PVC/PDVC/ALU blisters or ALU/ALU blisters and inserted in a carton.

PVC/PVDC/ALU blister:
7, 10, 14, 20, 28, 30, 49, 50, 56, 60, 90, 98, 100 film-coated tablets.

ALU/ALU blister:
7, 10, 14, 20, 28, 30, 49, 50, 56, 60, 90, 98, 100 film-coated tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal <and other handling>

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. HOUDER VAN DE VERGUNNING VOOR HET IN DE HANDEL BRENGEN

Hexal AG
Industriestrasse 25
83607 Holzkirchen
Duitsland

8. NUMMERS VAN DE VERGUNNING VOOR HET IN DE HANDEL BRENGEN

RVG 107107

9. DATUM VAN EERSTE VERLENING VAN DE VERGUNNING/HERNIEUWING VAN DE VERGUNNING

Datum van eerste verlening van de vergunning: 22 maart 2011
Datum van laatste hernieuwing: 23 augustus 2013

10. DATUM VAN HERZIENING VAN DE TEKST

Laatste gedeeltelijke wijziging betreft de rubrieken 4.4 en 4.8: 13 februari 2024