Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Valsartan Rowa 80 mg film-coated tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

One film-coated tablet contains 80 mg of valsartan.

Excipients:
Excipients with known effect:
sorbitol 9.25 mg
lactose monohydrate 1.1 mg
sodium 0.32 mg (0.01 mmol)

For a full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.
Valsartan Rowa 80 mg film-coated tablets: cylindrical, coated, scored on one side, pink film-coated tablets.
The tablet can be divided into equal doses.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Hypertension
Treatment of essential hypertension - in adult patients and hypertension in children and adolescents 6 to 18 years of age.
Recent myocardial infarction
Treatment of clinically stable adults patients with symptomatic heart failure or asymptomatic left ventricular systolic dysfunction after a recent (12 hours-10 days) myocardial infarction (see sections 4.4 and 5.1).
Heart failure
Treatment of adult patients with symptomatic heart failure when ACE-inhibitors are not tolerated or in beta-blocker intolerant patients as add-on therapy to ACE-inhibitors when mineralocorticoid receptor antagonists cannot be used (see sections 4.2, 4.4, 4.5 and 5.1).

4.2 Posology and method of administration

Posology

Hypertension
The recommended starting dose of Valsartan Rowa is 80 mg once daily. The antihypertensive effect is substantially present within 2 weeks, and maximal effects are attained within 4 weeks. In some patients whose blood pressure is not adequately controlled, the dose can be increased to 160 mg and to a maximum of 320 mg.

Valsartan Rowa may also be administered with other antihypertensive agents (see sections 4.3, 4.4, 4.5 and 5.1). The addition of a diuretic such as hydrochlorothiazide will decrease blood pressure even further in these patients.

Recent myocardial infarction
In clinically stable patients, therapy may be initiated as early as 12 hours after a myocardial infarction. After an initial dose of 20 mg twice daily, valsartan should be titrated to 40 mg, 80 mg, and 160 mg twice daily over the next few weeks. The starting dose is provided by the 40 mg divisible tablet.

The target maximum dose is 160 mg twice daily. In general, it is recommended that patients achieve a dose level of 80 mg twice daily by two weeks after treatment initiation and that the target maximum dose, 160 mg twice daily, be achieved by three

months, based on the patient's tolerability. If symptomatic hypotension or renal dysfunction occur, consideration should be given to a dosage reduction.

Valsartan may be used in patients treated with other post-myocardial infarction therapies, e.g. thrombolytics, acetylsalicylic acid, beta blockers, statins, and diuretics. The combination with ACE inhibitors is not recommended (see sections 4.4 and 5.1).

Evaluation of post-myocardial infarction patients should always include assessment of renal function.

Heart failure
The recommended starting dose of Valsartan Rowa is 40 mg twice daily. Uptitration to 80 mg and 160 mg twice daily should be done at intervals of at least two weeks to the highest dose, as tolerated by the patient. Consideration should be given to reducing the dose of concomitant diuretics. The maximum daily dose administered in clinical trials is 320 mg in divided doses.

Valsartan may be administered with other heart failure therapies. However, the triple combination of an ACE inhibitor, valsartan and a beta blocker or a potassium-sparing diuretic is not recommended (see sections 4.4 and 5.1).
Evaluation of patients with heart failure should always include assessment of renal function.

Additional information on special populations

Elderly
No dose adjustment is required in elderly patients.

Renal impairment
No dose adjustment is required for adult patients with a creatinine clearance >10 ml/min (see sections 4.4 and 5.2).

Hepatic impairment
Valsartan Rowa is contraindicated in patients with severe hepatic impairment, biliary cirrhosis and in patients with cholestasis (see sections 4.3, 4.4 and 5.2). In patients with mild to moderate hepatic impairment without cholestasis, the dose of valsartan should not exceed 80 mg.

Paediatric population

Paediatric hypertension

For children and adolescents who are unable to swallow tablets, the use of the Valsartan oral solution is recommended. The systemic exposure and peak plasma concentration of valsartan is about 1.7-fold and 2.2-fold higher with the solution compared to the tablets.

Children and adolescents 6 to 18 years of age
The initial dose is 40 mg once a daily for children weighing below 35 kg and 80 mg daily for those weighing 35 kg or more. The dose should be adjusted based on blood pressure response. For maximum doses studied in clinical trials please refer to the table below:

Doses higher than those listed have not been studied and are therefore not recommended.

Weight	Maximum dose studied in clinical trials
≥18 kg to < 35 kg	80 mg
≥35kg to < 80 kg	160 mg
≥80kg to≤ 160 kg	320 mg

For children already started on valsartan prior to the age of six years, please refer to the posology for Valsartan oral solution (Children 1 to less than 6 years of age).

Children less than 6 years of age
For children aged 1 to 5 years and for those having difficulties in swallowing the tablet, Valsartan oral solution is recommended. Available data are described in sections 4.8, 5.1 and 5.2. However safety and efficacy of valsartan in children below 1 year of age have not been established.

Switching from oral solution to tablets

If switching from oral solution to tablets is considered clinically essential, initially the same dose in milligrams should be given. Subsequently, frequent blood pressure monitoring should be performed taking into account potential under-dosing and the dose should be titrated further based on blood pressure response and tolerability.

Use in paediatric aged 6 to 18 years with renal impairment
Use in paediatric patients with a creatinine clearance <30 ml/min and paediatric patients undergoing dialysis has not been studied, therefore valsartan is not recommended in these patients. No dose adjustment is required for paediatric patients with a creatinine clearance >30 ml/min. Renal function and serum potassium should be closely monitored (see section 4.4 and 5.2)

Use in paediatric population aged 6 to 18 years with hepatic impairment
As in adults, valsartan is contraindicates in paediatric patients with severe hepatic impairment, biliary cirrhosis and in patients with cholestasis (see sections 4.3, 4.4 and 5.2). There is a limited clinical experience with valsartan in paediatric patients with mild to moderate hepatic impairment. The dose of valsartan should not exceed 80 mg in these patients.

Paediatric heart failure and recent myocardial infarction
Valsartan is not recommended for the treatment of heart failure or recent myocardial infarction in children and adolescents below the age of 18 years due to the lack of data on safety and efficacy.

Method of administration
Valsartan Rowa may be taken independently of a meal and should be administered with water.

4.3 Contraindications

-Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
-Severe hepatic impairment, biliary cirrhosis and cholestasis.
-Second and third trimester of pregnancy (see sections 4.4 and 4.6).
-The concomitant use of Valsartan Rowa with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60 ml/min/1.73 m^2) (see sections 4.5 and 5.1).

4.4 Special warnings and precautions for use

Hyperkalaemia
Concomitant use with potassium supplements, potassium-sparing diuretics, salt substitutes containing potassium, or other agents that may increase potassium levels (heparin, etc.) is not recommended. Monitoring of potassium should be undertaken as appropriate.

Sodium- and/or volume-depleted patients
In severely sodium-depleted and/or volume-depleted patients, such as those receiving high doses of diuretics, symptomatic hypotension may occur in rare cases after initiation of therapy with Valsartan Rowa. Sodium and/or volume depletion should be corrected before starting treatment with Valsartan Rowa, for example by reducing the diuretic dose.

Renal artery stenosis
In patients with bilateral renal artery stenosis or stenosis to a solitary kidney, the safe use of Valsartan Rowa has not been established.

Short-term administration of Valsartan Rowa to twelve patients with renovascular hypertension secondary to unilateral renal artery stenosis did not induce any significant changes in renal haemodynamics, serum creatinine, or blood urea nitrogen (BUN). However, other agents that affect the renin-angiotensin system may increase blood urea and serum creatinine in patients with unilateral renal artery stenosis, therefore monitoring of renal function is recommended when patients are treated with valsartan.

Kidney transplantation
There is currently no experience on the safe use of Valsartan Rowa in patients who have recently undergone kidney transplantation.

Primary hyperaldosteronism
Patients with primary hyperaldosteronism should not be treated with Valsartan Rowa as their renin-angiotensin system is not activated.

Aortic and mitral valve stenosis, obstructive hypertrophic cardiomyopathy

As with all other vasodilators, special caution is indicated in patients suffering from aortic or mitral stenosis, or hypertrophic obstructive cardiomyopathy (HOCM).

Impaired renal function

There is currently no experience on the safe use in patients with a creatinine clearance <10 ml/min and patients undergoing dialysis, therefore valsartan should be used with caution in these patients. No dose adjustment is required for adult patients with creatinine clearance >10 ml/min (see sections 4.2 and 5.2).

Hepatic impairment

In patients with mild to moderate hepatic impairment without cholestasis, Valsartan Rowa should be used with caution (see sections 4.2 and 5.2).

Pregnancy

Angiotensin II Receptor Antagonists (AIIRAs) should not be initiated during pregnancy. Unless continued AIIRAs therapy is considered essential, patients planning pregnancy should be changed to alternative anti-hypertensive 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).

Recent myocardial infarction

The combination of captopril and valsartan has shown no additional clinical benefit, instead the risk for adverse events increased compared to treatment with the respective therapies (see sections 4.2 and 5.1). Therefore, the combination of valsartan with an ACE inhibitor is not recommended.

Caution should be observed when initiating therapy in post-myocardial infarction patients. Evaluation of post-myocardial infarction patients should always include assessment of renal function (see section 4.2).

Use of Valsartan Rowa in post-myocardial infarction patients commonly results in some reduction in blood pressure, but discontinuation of therapy because of continuing symptomatic hypotension is not usually necessary provided dosing instructions are followed (see section 4.2).

Heart Failure

The risk of adverse reactions, especially hypotension, hyperkalaemia and decreased renal function (including acute renal failure), may increase when [Product name] is used in combination with an ACE-inhibitor. In patients with heart failure, the triple combination of an ACE inhibitor, a beta blocker and Valsartan Rowa has not shown any clinical benefit (see section 5.1). This combination apparently increases the risk for adverse events and is therefore not recommended. Triple combination of an ACE-inhibitor, a mineralocorticoid receptor antagonist and valsartan is also not recommended. Use of these combinations should be under specialist supervision and subject to frequent close monitoring of renal function, electrolytes and blood pressure.

Caution should be observed when initiating therapy in patients with heart failure. Evaluation of patients with heart failure should always include assessment of renal function (see section 4.2).

Use of Valsartan Rowa in patients with heart failure commonly results in some reduction in blood pressure, but discontinuation of therapy because of continuing symptomatic hypotension is not usually necessary provided dosing instructions are followed (see section 4.2).

In patients whose renal function may depend on the activity of the renin-angiotensin-aldosterone- system (e.g patients with severe congestive heart failure), treatment with ACE-inhibitors has been associated with oliguria and/or progressive azotaemia and in rare cases with acute renal failure and/or death. As valsartan is an angiotensin II receptor blocker, it cannot be excluded that the use of Valsartan Rowa may be associated with impairment of the renal function.

ACE-inhibitors and angiotensin II receptor blockers should not be used concomitantly in patients with diabetic nephropathy.

History of angioedema

Angioedema, including swelling of the larynx and glottis, causing airway obstruction and/or swelling of the face, lips, pharynx, and/or tongue has been reported in patients treated with valsartan; some of these patients previously experienced angioedema with other drugs including ACE inhibitors. Valsartan Rowa should be immediately discontinued in patients who develop angioedema, and Valsartan Rowa should not be re-administered (see section 4.8).

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.

Intestinal angioedema
Intestinal angioedema has been reported in patients treated with angiotensin II receptor antagonists including valsartan (see section 4.8). These patients presented with abdominal pain, nausea, vomiting and diarrhoea. Symptoms resolved after discontinuation of angiotensin II receptor antagonists. If intestinal angioedema is diagnosed, valsartan should be discontinued and appropriate monitoring should be initiated until complete resolution of symptoms has occurred.

Paediatric population

Impaired renal function
Use in paediatric patients with a creatinine clearance <30 ml/min and paediatric patients undergoing dialysis has not been studied, therefore valsartan is not recommended in these patients. No dose adjustment is required for paediatric patients with a creatinine clearance > 30 ml/min (see section 4.2 and 5.2). Renal function and serum potassium should be closely monitored during treatment with valsartan. This applies particularly when valsartan is given in the presence of other conditions (fever, dehydration) likely to impair renal function.

Impaired hepatic function
As in adults valsartan is contraindicated in paediatric patients with severe hepatic impairment, biliary cirrhosis and in patients with cholestasis (see section 4.3 and 5.2). There is limited clinical experience with valsartan in paediatric patients with mild to moderate hepatic impairment. The dose of valsartan should not exceed 80 mg in these patients.

Excipients:
This medicine contains sorbitol.
Valsartan Rowa 80 mg film-coated tablets contain 9.25 mg sorbitol in each tablet.
Valsartan Rowa 80 mg film-coated tablets contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine. Valsartan Rowa 80 mg film-coated tablets contains sodium. This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium-free'

4.5 Interaction with other medicinal products and other forms of interaction

Dual blockade of the Renin-Angiotensin-Aldosterone-System (RAAS) with ARBs, ACEIs, or aliskiren
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).

Concomitant use not recommended.

Lithium
Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with angiotensin converting enzyme inhibitors or angiotensin II receptor antagonists including with valsartan. If the combination proves necessary, a careful monitoring of serum lithium levels is recommended. If a diuretic is also used, the risk of lithium
toxicity may presumably be increased further.

Potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium and other substances that may increase potassium levels.
If a medicinal product that affects potassium levels is considered necessary in combination with valsartan, monitoring of potassium plasma levels is advised.

Caution required with concomitant use
Non-steroidal anti-inflammatory medicines (NSAIDs), including selective COX-2 inhibitors, acetylsalicylic acid >3 g/day), and non-selective NSAIDs

When angiotensin II antagonists are administered simultaneously with NSAIDs, attenuation of the antihypertensive effect may occur. Furthermore, concomitant use of angiotensin II antagonists and NSAIDs may lead to an increased risk of worsening of renal function and an increase in serum potassium. Therefore, monitoring of renal function at the beginning of the treatment is recommended, as well as adequate hydration of the patient.

Transporters
In vitro data indicates that valsartan is a substrate of the hepatic uptake transporter OATP1B1/OATP1B3 and the hepatic efflux transporter MRP2. The clinical relevance of this finding is unknown. Co-administration of inhibitors of the uptake transporter (eg. rifampin, ciclosporin) or efflux transporter (eg. ritonavir) may increase the systemic exposure to valsartan. Exercise appropriate care when initiating or ending concomitant treatment with such drugs.

Others
In drug interaction studies with valsartan, no interactions of clinical significance have been found with valsartan or any of the following substances: cimetidine, warfarin, furosemide, digoxin, atenolol, indometacin, hydrochlorothiazide, amlodipine, glibenclamide.

Paediatric population
In hypertension in children and adolescents, where underlying renal abnormalities are common, caution is recommended with the concomitant use of valsartan and other substances that inhibit the renin angiotensis aldosterone system which may increase serum potassium. Renal function and serum potassium should be closely monitored.

4.6 Fertility, pregnancy and lactation

Pregnancy:

The use of Angiotensin II Receptor Antagonists (AIIRAs) is not recommended during the first trimester of pregnancy (see section 4.4). The use of AIIRAs is contra-indicated during the second and third 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 AIIRAs, similar risks may exist for this class of drugs. Unless continued AIIRA therapy is considered essential, patients planning pregnancy should be changed to alternative anti-hypertensive 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.
AIIRAs therapy exposure during the second and third trimesters is known to induce human fetotoxicity (decreased renal function, oligohydramnios, skull ossification retardation) and neonatal toxicity (renal failure, hypotension, hyperkalemia); see also section 5.3 "Preclinical safety data".

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 also sections 4.3 and 4.4).

Breastfeeding
Because no information is available regarding the use of valsartan during breastfeeding, Valsartan Rowa is not recommended and alternative treatments with better established safety profiles during breast-feeding are preferable, especially while nursing a newborn or preterm infant.

Fertility
Valsartan Rowa had no adverse effects on the reproductive performance of male or female rats at oral doses up to 200mg/kg/day. This dose is 6 times the maximum recommended human dose on a mg/m^2 basis (calculations assume an oral dose of 320 mg/day and a 60-kg patient).

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive have been performed. When driving vehicles or operating machines it should be taken into account that dizziness or weariness may occur.

4.8 Undesirable effects

In controlled clinical studies in adult patients with hypertension, the overall incidence of adverse reactions (ADRs) was comparable with placebo and is consistent with the pharmacology of valsartan. The incidence of ADRs did not appear to be related to dose or treatment duration and also showed no association with gender, age or race.

The ADRs reported from clinical studies, post-marketing experience and laboratory findings are listed below according to system organ class.

Adverse reactions are ranked by frequency, the most frequent first, 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 (frequency cannot be estimated from the available data).

Within each frequency grouping, adverse reactions are ranked in order of decreasing seriousness.

For all the ADRs reported from post-marketing experience and laboratory findings, it is not possible to apply any ADR frequency and therefore they are mentioned with a "not known" frequency.

- Hypertension

Blood and lymphatic system disorders	
Not known	Decrease in haemoglobin, Decrease in haematocrit, Neutropenia, Thrombocytopenia
Immune system disorders	
Not known	Hypersensitivity including serum sickness
Metabolism and nutrition disorders	
Not known	Increase of serum potassium, Hyponatraemia
Ear and labyrinth system disorders	
Uncommon	Vertigo
Vascular disorders	
Not known	Vasculitis
Respiratory, thoracic and mediastinal disorders	
Uncommon	Cough
Gastrointestinal disorders	
Uncommon	Abdominal pain
Very rare	Intestinal angioedema
Hepato-biliary disorders	
Not known	Elevation of liver function values including increase of serum bilirubin
Skin and subcutaneous tissue disorders	
Not known	Angioedema, Dermatitis bullous, Rash, Pruritus
Musculoskeletal and connective tissue disorders	
Not known	Myalgia
Renal and urinary disorders	
Not known	Renal failure and impairment, Elevation of serum creatinine
General disorders and administration site conditions	
Uncommon	Fatigue

Paediatric population

Hypertension

The antihypertensive effect of valsartan has been evaluated in two randomised, double-blind clinical studies (each followed by an extension period or study) and one open-label study. These studies included 711 paediatric patients from 6 to less than18

years of age with and without chronic kidney disease (CKD), of which 560 patients received valsartan. With the exception of isolated gastrointestinal disorders (such as abdominal pain, nausea, vomiting) and dizziness, no relevant differences in terms of type, frequency and severity of adverse reactions were identified between the safety profile for paediatric patients aged 6 to less than 18 years and that previously reported for adult patients.

Neurocognitive and developmental assessment of paediatric patients aged 6 to 16 years of age revealed no overall clinically relevant adverse impact after treatment with Valsartan Rowa for up to one year.

A pooled analysis of 560 paediatric hypertensive patients (aged 6-17 years) receiving either valsartan monotherapy [n=483] or combination antihypertensive therapy including valsartan [n=77] was conducted. Of the 560 patients, 85 (15.2%) had CKD (baseline GFR <90 mL/min/1.73m2). Overall, 45 (8.0%) patients discontinued a study due to adverse events. Overall 111 (19.8%) patients experienced an adverse drug reaction (ADR), with headache (5.4%), dizziness (2.3%), and hyperkalemia (2.3%) being the most frequent. In patients with CKD, the most frequent ADRs were hyperkalaemia (12.9%), headache (7.1%), blood creatinine increased (5.9%), and hypotension (4.7%). In patients without CKD, the most frequent ADRs were headache (5.1%) and dizziness (2.7%). ADRs were observed more frequently in patients receiving valsartan in combination with other antihypertensive medications than valsartan alone.

The antihypertensive effect of valsartan in children 1 to less than 6 years of age has been evaluated in three randomised, double-blind clinical studies (each followed by an extension period). In the first
study in 90 children aged 1 to less than 6 years, two deaths and isolated cases of marked liver transaminases elevations were observed. These cases occurred in a population who had significant
comorbidities. A causal relationship to valsartan has not been established. In the two subsequent studies in which 202 children aged 1 to less than 6 years were randomised, no significant
liver transaminase elevations or death occurred with valsartan treatment.

The safety profile seen in controlled-clinical studies in adult patients with post-myocardial infarction and/or heart failure varies from the overall safety profile seen in hypertensive patients. This may relate to the patients underlying disease. ADRs that occurred in adult patients with post-myocardial infarction and/or heart failure patients are listed below:

- Post-myocardial infarction and/or heart failure (studied in adult patients only)

Blood and lymphatic system disorders	
Not know	Thrombocytopenia
Immune system disorders	
Not known	Hypersensitivity including serum sickness
Metabolism and nutrition disorders	
Uncommon	Hyperkalaemia
Not known	Increase of serum potassium, Hyponatraemia
Nervous system disorders	
Common	Dizziness, Postural dizziness
Uncommon	Syncope, Headache
Ear and labyrinth system disorders	
Uncommon	Vertigo
Cardiac disorders	
Uncommon	Cardiac failure
Vascular disorders	
Common	Hypotension, Orthostatic hypotension
Not known	Vasculitis
Respiratory, thoracic and mediastinal disorders	
Uncommon	Cough
Gastrointestinal disorders	
Uncommon	Nausea, Diarrhoea
Hepato-biliary disorders	
Not known	Elevation of liver function values
Skin and subcutaneous tissue disorders	
Uncommon	Angioedema
Not known	Dermatitis bullous, Rash, Pruritis

Musculoskeletal and connective tissue disorders	
Not known	Myalgia
Renal and urinary disorders	
Common	Renal failure and impairment
Uncommon	Acute renal failure, Elevation of serum creatinine
Not known	Increase in Blood Urea Nitrogen
General disorders and administration site conditions	
Uncommon	Asthenia, Fatigue

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 HPRA Pharmacovigilance. Website: www.hpra.ie

4.9 Overdose

Symptoms
A Valsartan Rowa overdose could possibly cause a marked hypotension that under certain circumstances could lead to depressed level of consciousness, circulatory collapse and/or shock.

Therapy
Therapeutic measures depend on when the medicine was taken, as well as the type and severity of the symptoms. Here restoration of stable circulatory conditions should be the main concern.

If hypotension occurs, the patient should be placed in a supine position and blood volume correction should be undertaken. Valsartan is unlikely to be removed by haemodialysis.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Angiotensin II Antagonists, plain, ATC code: C09CA03
Valsartan is an orally active, potent, and specific angiotensin II (Ang II) receptor antagonist. It acts selectively on the AT_1 receptor subtype, which is responsible for the known actions of angiotensin II. The increased plasma levels of Ang II following AT_1 receptor blockade with valsartan may stimulate the unblocked AT_2 receptor, which appears to counterbalance the effect of the AT_1 receptor. Valsartan does not exhibit any partial agonist activity at the AT_1 receptor and has much (about 20,000 fold) greater affinity for the AT_1 receptor than for the AT_2 receptor. Valsartan is not known to bind to or block other hormone receptors or ion channels known to be important in cardiovascular regulation.

Valsartan does not inhibit ACE (also known as kininase II) which converts Ang I to Ang II and degrades bradykinin. Since there is no effect on ACE and no potentiation of bradykinin or substance P, angiotensin II antagonists are unlikely to be associated with coughing. In clinical trials where valsartan was compared with an ACE inhibitor, the incidence of dry cough was significantly ($P<0.05$) less in patients treated with valsartan than in those treated with an ACE inhibitor (2.6% versus 7.9% respectively). In a clinical trial of patients with a history of dry cough during ACE inhibitor therapy, 19.5% of trial subjects receiving valsartan and 19.0% of those receiving a thiazide diuretic experienced cough compared to 68.5% of those treated with an ACE inhibitor ($P<0.05$).

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."

Hypertension
Administration of Valsartan Rowa to patients with hypertension results in reduction of blood pressure without affecting pulse rate.
In most patients, after administration of a single oral dose, onset of antihypertensive activity occurs within 2 hours, and the peak reduction of blood pressure is achieved within 4-6 hours. The antihypertensive effect persists over 24 hours after dosing. During repeated dosing, the antihypertensive effect is substantially present within 2 weeks, and maximal effects are attained within 4 weeks and persist during long-term therapy. Combined with hydrochlorothiazide, a significant additional reduction in blood pressure is achieved.
Abrupt withdrawal of Valsartan Rowa has not been associated with rebound hypertension or other adverse clinical events.
In hypertensive patients with type 2 diabetes and microalbuminuria, valsartan has been shown to reduce the urinary excretion of albumin. The MARVAL (Micro Albuminuria Reduction with Valsartan) study assessed the reduction in urinary albumin excretion (UAE) with valsartan (80-160 mg/od) versus amlodipine (5-10 mg/od), in 332 type 2 diabetic patients (mean age: 58 years; 265 men) with microalbuminuria (valsartan: 58 µg/min; amlodipine: 55.4 µg/min), normal or high blood pressure and with preserved renal function (blood creatinine <120 µmol/l). At 24 weeks, UAE was reduced ($p<0.001$) by 42% (–24.2 µg/min; 95% CI: –40.4 to –19.1) with valsartan and approximately 3% (–1.7 µg/min; 95% CI: –5.6 to 14.9) with amlodipine despite similar rates of blood pressure reduction in both groups.
The Valsartan Rowa Reduction of Proteinuria (DROP) study further examined the efficacy of valsartan in reducing UAE in 391 hypertensive patients (BP=150/88 mmHg) with type 2 diabetes, albuminuria (mean=102 µg/min; 20-700 µg/min) and preserved renal function (mean serum creatinine = 80 µmol/l). Patients were randomized to one of 3 doses of valsartan (160, 320 and 640 mg/od) and treated for 30 weeks. The purpose of the study was to determine the optimal dose of valsartan for reducing UAE in hypertensive patients with type 2 diabetes. At 30 weeks, the percentage change in UAE was significantly reduced by 36% from baseline with valsartan 160 mg (95%CI: 22 to 47%), and by 44% with valsartan 320 mg (95%CI: 31 to 54%). It was concluded that 160-320 mg of valsartan produced clinically relevant reductions in UAE in hypertensive patients with type 2 diabetes.

Recent myocardial infarction
The valsartan In Acute myocardial infarction trial (VALIANT) was a randomised, controlled, multinational, double-blind study in 14,703 patients with acute myocardial infarction and signs, symptoms or radiological evidence of congestive heart failure and/or evidence of left ventricular systolic dysfunction (manifested as an ejection fraction ≤40% by radionuclide ventriculography or ≤35% by echocardiography or ventricular contrast angiography). Patients were randomised within 12 hours to 10 days after the onset of myocardial infarction symptoms to valsartan, captopril, or the combination of both. The mean treatment duration was two years. The primary endpoint was time to all-cause mortality.

Valsartan was as effective as captopril in reducing all-cause mortality after myocardial infarction. All-cause mortality was similar in the valsartan (19.9%), captopril (19.5%), and valsartan + captopril (19.3%) groups. Combining valsartan with captopril did not add further benefit over captopril alone. There was no difference between valsartan and captopril in all-cause mortality based on age, gender, race, baseline therapies or underlying disease. Valsartan was also effective in prolonging the time to and reducing cardiovascular mortality, hospitalisation for heart failure, recurrent myocardial infarction, resuscitated cardiac arrest, and non-fatal stroke (secondary composite endpoint).

The safety profile of valsartan was consistent with the clinical course of patients treated in the post-myocardial infarction setting. Regarding renal function, doubling of serum creatinine was observed in 4.2% of valsartan-treated patients, 4.8% of valsartan+captopril-treated patients, and 3.4% of captopril-treated patients. Discontinuations due to various types of renal dysfunction occurred in 1.1% of valsartan-treated patients, 1.3% in valsartan+captopril patients, and 0.8% of captopril patients. An assessment of renal function should be included in the evaluation of patients post-myocardial infarction.

There was no difference in all-cause mortality, cardiovascular mortality or morbidity when beta blockers were administered together with the combination of valsartan + captopril, valsartan alone, or captopril alone. Irrespective of treatment, mortality was lower in the group of patients treated with a beta blocker, suggesting that the known beta blocker benefit in this population was maintained in this trial.

Heart failure
Val-HeFT was a randomised, controlled, multinational clinical trial of valsartan compared with placebo on morbidity and mortality in 5,010 NYHA class II (62%), III (36%) and IV (2%) heart failure patients receiving usual therapy with LVEF <40% and left ventricular internal diastolic diameter (LVIDD) >2.9 cm/m2. Baseline therapy included ACE inhibitors (93%), diuretics (86%), digoxin (67%) and beta blockers (36%). The mean duration of follow-up was nearly two years. The mean daily dose of valsartan in Val-HeFT was 254 mg. The study had two primary endpoints: all cause mortality (time to death) and composite mortality and heart failure morbidity (time to first morbid event) defined as death, sudden death with resuscitation, hospitalisation for heart failure, or administration of intravenous inotropic or vasodilator agents for four hours or more without hospitalisation.

All cause mortality was similar (p=NS) in the valsartan (19.7%) and placebo (19.4%) groups. The primary benefit was a 27.5% (95% CI: 17 to 37%) reduction in risk for time to first heart failure hospitalisation (13.9% vs. 18.5%). Results appearing to favour placebo (composite mortality and morbidity was 21.9% in placebo vs. 25.4% in valsartan group) were observed for those patients receiving the triple combination of an ACE inhibitor, a beta blocker and valsartan.

In a subgroup of patients not receiving an ACE inhibitor (n=366), the morbidity benefits were greatest. In this subgroup all-cause mortality was significantly reduced with valsartan compared to placebo by 33% (95% CI: –6% to 58%) (17.3% valsartan vs. 27.1% placebo) and the composite mortality and morbidity risk was significantly reduced by 44% (24.9% valsartan vs. 42.5% placebo).

In patients receiving an ACE inhibitor without a beta-blocker, all cause mortality was similar (p=NS) in the valsartan (21.8%) and placebo (22.5%) groups. Composite mortality and morbidity risk was significantly reduced by 18.3% (95% CI: 8% to 28%) with valsartan compared with placebo (31.0% vs. 36.3%).

In the overall Val-HeFT population, valsartan treated patients showed significant improvement in NYHA class, and heart failure signs and symptoms, including dyspnoea, fatigue, oedema and rales compared to placebo. Patients treated with valsartan had a better quality of life as demonstrated by change in the Minnesota Living with Heart Failure Quality of Life score from baseline at endpoint than placebo. Ejection fraction in valsartan treated patients was significantly increased and LVIDD significantly reduced from baseline at endpoint compared to placebo.

Paediatric population
Hypertension

The antihypertensive effects of valsartan have been evaluated in four randomized, double-blind clinical studies in 561 paediatric patients from 6 to 18 years of age and 165 paediatric patients 1 to 6 years of age.
Renal and urinary disorders, and obesity were the most common underlying medical conditions potentially contributing to hypertension in the children enrolled in these studies.

Clinical experience in children at or above 6 years of age
In a clinical study involving 261 hypertensive paediatric patients 6 to 16 years of age, patients who weighed <35 kg received 10, 40 or 80 mg of valsartan tablets daily (low, medium and high doses), and patients who weighed ≥35 kg received 20, 80, and 160 mg of valsartan tablets daily (low, medium and high doses). At the end of 2 weeks, valsartan reduced both systolic and diastolic blood pressure in a dose-dependent manner.

Overall, the three dose levels of valsartan (low, medium and high) significantly reduced systolic blood pressure by 8, 10, 12 mm Hg from the baseline, respectively. Patients were re-randomized to either continue receiving the same dose of valsartan or were switched to placebo. In patients who continued to receive the medium and high doses of valsartan, systolic blood pressure at trough was -4 and -7 mm Hg lower than patients who received the placebo treatment. In patients receiving the low dose of valsartan, systolic blood pressure at trough was similar to that of patients who received the placebo treatment. Overall, the dosedependent antihypertensive effect of valsartan was consistent across all the demographic subgroups.

In another clinical study involving 300 hypertensive paediatric patients 6 to 18 years of age, eligible patients were randomized to receive valsartan or enalapril tablets for 12 weeks. Children weighing between ≥18 kg and <35 kg received valsartan 80 mg or enalapril 10 mg; those between ≥35 kg and <80 kg received valsartan 160 mg or enalapril 20 mg; those≥80 kg received valsartan 320 mg or enalapril 40 mg. Reductions in systolic blood pressure were comparable in patients receiving valsartan (15

mmHg) and enalapril (14 mm Hg) (non-inferiority p-value <0.0001). Consistent results were observed for diastolic blood pressure with reductions of 9.1 mmHg and 8.5 mmHg with valsartan and enalapril, respectively.

In a third, open label clinical study, involving 150 paediatric hypertensive patients 6 to 17 years of age, eligible patients (systolic BP ≥95th percentile for age, gender and height) received valsartan for 18 months to evaluate safety and tolerability. Out of the 150 patients participating in this study, 41 patients also received concomitant antihypertensive medication. Patients were dosed based on their weight categories for starting and maintenance doses. Patients weighing >18 to < 35 kg, ≥35 to < 80 kg and ≥ 80 to < 160 kg received 40 mg, 80 mg and 160 mg and the doses were titrated to 80 mg, 160 mg and 320 mg respectively after one week. One half of the patients enrolled (50.0%, n=75) had CKD with 29.3% (44) of patients having CKD Stage 2 (GFR 60 – 89 mL/min/1.73m2) or Stage 3 (GFR 30-59 mL/min/1.73m2). Mean reductions in systolic blood pressure were 14.9 mmHg in all patients (baseline 133.5 mmHg), 18.4 mmHg in patients with CKD (baseline 131.9 mmHg) and 11.5 mmHg in patients without CKD (baseline 135.1 mmHg). The percentage of patients who achieved overall BP control (both systolic and diastolic BP <95th percentile) was slightly higher in the CKD group (79.5%) compared to the non-CKD group (72.2%).

Clinical experience in children less than 6 years of age
Three clinical studies were conducted in 291 patients aged 1 to 5 years. No children below the age of 1 year were enrolled in these studies.
In the first study of 90 patients, dose-response could not be demonstrated, but in the second study of 75 patients, higher doses of valsartan were associated with greater blood pressure reductions.

The third study was a 6 week, randomised double-blind study to evaluate the dose response of valsartan in 126 children 1 to 5 years of age with hypertension with or without CKD randomised to either 0.25 mg/kg or 4 mg/kg body weight respectively. At endpoint, the reduction in Mean systolic blood pressure (MSBP)/ Mean diastolic blood pressure (MDBP) with valsartan 4.0 mg/kg compared to valsartan 0.25 mg/kg was 8.5/6.8 mmHg vs. 4.1/0.3 mmHg, respectively; p=0.0157/p<0.0001). Similarly, the CKD subgroup also showed reductions in MSBP/MDBP with valsartan 4.0 mg/kg compared to 0.25 mg/kg (9.2/6.5 mmHg vs 1.2/ +1.3 mmHg).

The European Medicines Agency has waived the obligation to submit the results of studies with < Valsartan Rowa in all subsets of the paediatric population in heart failure and heart failure after recent myocardial infarction. See section 4.2 for information on paediatric use.

5.2 Pharmacokinetic properties

Absorption:
Following oral administration of valsartan alone, peak plasma concentrations of valsartan are reached in 2–4 hourswith tablets and 1–2 hours with solution formulation. Mean absolute bioavailability is 23% and 39% with tablets and solution formulation, respectively. The systemic exposure and peak plasma concentration of valsartan is about 1.7-fold and 2.2-fold higher with the solution compared to the tablets.

Food decreases exposure (as measured by AUC) to valsartan by about 40% and peak plasma concentration (Cmax) by about 50%, although from about 8 h post dosing plasma valsartan concentrations are similar for the fed and fasted groups. This reduction in AUC is not, however, accompanied by a clinically significant reduction in the therapeutic effect, and valsartan can therefore be given either with or without food.

Distribution:
The steady-state volume of distribution of valsartan after intravenous administration is about 17 litres, indicating that valsartan does not distribute into tissues extensively. Valsartan is highly bound to serum proteins (94–97%), mainly serum albumin.

Biotransformation:
Valsartan is not biotransformed to a high extent as only about 20% of dose is recovered as metabolites. A hydroxy metabolite has been identified in plasma at low concentrations (less than 10% of the valsartan AUC). This metabolite is pharmacologically inactive.

Elimination:
Valsartan shows multiexponential decay kinetics ($t_{½\alpha}$ <1 h and $t_{½\beta}$ about 9 h). Valsartan is primarily eliminated by biliary excretion in faeces (about 83% of dose) and renally in urine (about 13% of dose), mainly as unchanged drug. Following intravenous administration, plasma clearance of valsartan is about 2 l/h and its renal clearance is 0.62 l/h (about 30% of total clearance). The half-life of valsartan is 6 hours.

In Heart failure patients:
The average time to peak concentration and elimination half-life of valsartan in heart failure patients are similar to that observed in healthy volunteers. AUC and Cmax values of valsartan are almost proportional with increasing dose over the clinical dosing range (40 to 160 mg twice a day). The average accumulation factor is about 1.7. The apparent clearance of valsartan following oral administration is approximately 4.5 l/h. Age does not affect the apparent clearance in heart failure patients.

Special populations

Elderly

A somewhat higher systemic exposure to valsartan was observed in some elderly subjects than in young subjects; however, this has not been shown to have any clinical significance.

Impaired renal function
As expected for a compound where renal clearance accounts for only 30% of total plasma clearance, no correlation was seen between renal function and systemic exposure to valsartan. Dose adjustment is therefore not required in patients with renal impairment (creatinine clearance >10 ml/min). There is currently no experience on the safe use in patients with a creatinine clearance <10 ml/min and patients undergoing dialysis, therefore valsartan should be used with caution in these patients (see sections 4.2 and 4.4). Valsartan is highly bound to plasma protein and is unlikely to be removed by dialysis.

Hepatic impairment
Approximately 70% of the dose absorbed is eliminated in the bile, essentially in the unchanged form. Valsartan does not undergo any noteworthy biotransformation. A doubling of exposure (AUC) was observed in patients with mild to moderate hepatic impairment compared to healthy subjects. However, no correlation was observed between plasma valsartan concentration versus degree of hepatic dysfunction. > Valsartan Rowa has not been studied in patients with severe hepatic dysfunction (see sections 4.2, 4.3 and 4.4).

Paediatric population

In a study of 26 paediatric hypertensive patients (aged 1 to 16 years) given a single dose of a suspension of valsartan (mean: 0.9 to 2 mg/kg, with a maximum dose of 80 mg), the clearance (litres/h/kg) of valsartan was comparable across the age range of 1 to 16 years and similar to that of adults receiving the same formulation. (see Absorption information under section 5.2).

Impaired renal function
Use in paediatric patients with a creatinine clearance <30 ml/min and paediatric patients undergoing dialysis has not been studied, therefore valsartan is not recommended in these patients. No dose adjustment is required for paediatric patients with a creatinine clearance >30 ml/min. Renal function and serum potassium should be closely monitored (see sections 4.2 and 4.4).

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential.
In rats, maternally toxic doses (600 mg/kg/day) during the last days of gestation and lactation led to lower survival, lower weight gain and delayed development (pinna detachment and ear-canal opening) in the offspring (see section 4.6). These doses in rats (600 mg/kg/day) are approximately 18 times the maximum recommended human dose on a mg/m2 basis (calculations assume an oral dose of 320 mg/day and a 60-kg patient).

In non-clinical safety studies, high doses of valsartan (200 to 600 mg/kg body weight) caused in rats a reduction of red blood cell parameters (erythrocytes, haemoglobin, haematocrit) and evidence of changes in renal haemodynamics (slightly raised plasma urea, and renal tubular hyperplasia and basophilia in males). These doses in rats (200 and 600 mg/kg/day) are approximately 6 and 18 times the maximum recommended human dose on a mg/m2 basis (calculations assume an oral dose of 320 mg/day and a 60-kg patient).
In marmosets at similar doses, the changes were similar though more severe, particularly in the kidney where the changes developed to a nephropathy which included raised urea and creatinine.
Hypertrophy of the renal juxtaglomerular cells was also seen in both species. All changes were considered to be caused by the pharmacological action of valsartan which produces prolonged hypotension, particularly in marmosets. For therapeutic doses of valsartan in humans, the hypertrophy of the renal juxtaglomerular cells does not seem to have any relevance.

Paediatric population
Daily oral dosing of neonatal/juvenile rats (from a postnatal day 7 to postnatal day 70) with valsartan at doses as low as 1 mg/kg/day (about 10-35% of the maximum recommended paediatric dose of 4 mg/kg/day on systemic exposure basis) produced persistent, irreversible kidney damage. These effects above mentioned represent an expected exaggerated pharmacological effect of angiotensin converting enzyme inhibitors and angiotensin II type 1 blockers; such effects are observed if rats are treated during the first 13 days of life.
This period coincides with 36 weeks of gestation in humans, which could occasionally extend up to 44 weeks after conception in humans. The rats in the juvenile valsartan study were dosed up to day 70, and effects on renal maturation (postnatal 4-6 weeks) cannot be excluded. Functional renal maturation is an ongoing process within the first year of life in humans. Consequently, a clinical relevance in children <1 year of age cannot be excluded, while preclinical data do not indicate a safety concern for children older than 1 year.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core
Cellulose, microcrystalline (E 460)
Silica, colloidal anhydrous (E 551)
Sorbitol (E-420)
Magnesium carbonate (E 504)
Maize starch, pregelatinised
Povidone K-25 (E 1201)
Sodium stearylfumarate
Sodium lauryl sulphate
Crospovidone Type A (E 1202)

Film coating
Lactose monohydrate
Hypromellose (E 464)
Titanium dioxide (E 171)
Macrogol 4000
Red iron oxide (E 172).

6.2 Incompatibilities

Not applicable

6.3 Shelf life

3 years

6.4 Special precautions for storage

Do not store above 30°C. Store in the original package in order to protect from moisture.

6.5 Nature and contents of container

PVC/PE/PVDC/aluminium blister.

Pack sizes: 7, 14, 28, 56, 98, 280 film-coated tablets

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

No special requirements.
Any unused product or waste should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

Rowa Pharmaceuticals Limited
Newtown
Bantry
Co. Cork
Ireland

8 MARKETING AUTHORISATION NUMBER

PA0074/083/002

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Date of last renewal: 31st January 2013

10 DATE OF REVISION OF THE TEXT

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