

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Malusone 250 mg/100 mg Film-coated tablets

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each Malusone tablet contains 250 mg atovaquone and 100 mg proguanil hydrochloride.

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Film-coated tablet.

Pinkish brown to brown coloured, circular, biconvex beveled edge film-coated tablets with '404' debossed on one side and 'G' debossed on the other side.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic Indications

It is indicated for:

- Prophylaxis of *Plasmodium falciparum* malaria in adults and in children weighing more than 40 kg.
- Treatment of acute, uncomplicated *Plasmodium falciparum* malaria in adults and in children weighing 11 kg or more.

Official guidelines and local information on the prevalence of resistance to antimalarial drugs should be taken into consideration. Official guidelines will normally include World Health Organisation (WHO) and public health authorities' guidelines.

### 4.2 Posology and method of administration

#### Method of administration

The daily dose should be taken with food or a milky drink (to ensure maximum absorption of atovaquone) at the same time each day.

If patients are unable to tolerate food, Malusone should be administered, but systemic exposure of atovaquone will be reduced. In the event of vomiting within 1 hour of dosing a repeat dose should be taken.

#### Posology

##### *Prophylaxis:*

Prophylaxis should:

- commence 24 or 48 hours prior to entering a malaria-endemic area,
- continue during the period of the stay,
- continue for 7 days after leaving the area.

In residents (semi-immune subjects) of endemic areas, the safety and effectiveness of atovaquone/proguanil has been established in studies of up to 12 weeks.

Dosage in adults and adolescents more than 40 kg bodyweight:

One Malusone tablet daily.

Malusone 250/100 mg tablets are not recommended for malaria prophylaxis in persons under 40 kg bodyweight.

*Treatment:*Dosage in adults

Four Malusone tablets as a single dose for three consecutive days.

Dosage in Children weighing 11 kg or more

11 - 20 kg bodyweight. One tablet daily for three consecutive days.

21 - 30 kg bodyweight. Two tablets as a single dose for three consecutive days.

31 - 40 kg bodyweight. Three tablets as a single dose for three consecutive days.

> 40 kg bodyweight. Dose as for adults.

Special populations*Dosage in the elderly*

A pharmacokinetic study indicates that no dosage adjustments are needed in the elderly (See Section 5.2).

*Dosage in hepatic impairment*

A pharmacokinetic study indicates that no dosage adjustments are needed in patients with mild to moderate hepatic impairment. Although no studies have been conducted in patients with severe hepatic impairment, no special precautions or dosage adjustment are anticipated (See Section 5.2).

*Dosage in renal impairment*

Pharmacokinetic studies indicate that no dosage adjustments are needed in patients with mild to moderate renal impairment. In patients with severe renal impairment (creatinine clearance < 30 ml/min) alternatives to Malusone for treatment of acute *Plasmodium falciparum* malaria should be recommended whenever possible (See Sections 4.4 and 5.2). For prophylaxis of *Plasmodium falciparum* malaria in patients with severe renal impairments see Section 4.3

**4.3 Contraindications**

Hypersensitivity to the active substances or to any of the excipients listed in section 6.1.

Malusone is contraindicated for prophylaxis of *Plasmodium falciparum* malaria in patients with severe renal impairment (creatinine clearance < 30 ml/min).

**4.4 Special warnings and precautions for use**

Persons taking atovaquone/proguanil for prophylaxis or treatment of malaria should take a repeat dose if they vomit within 1 hour of dosing. In the event of diarrhoea, normal dosing should be continued. Absorption of atovaquone may be reduced in patients with diarrhoea or vomiting, but in patients who did not withdraw, diarrhoea or vomiting was not associated with reduced efficacy in clinical trials of atovaquone/proguanil for malaria prophylaxis. However, as with other antimalarial agents, all subjects including those with diarrhoea or vomiting should be advised to continue to comply with personal protection measures (repellants, impregnated bednets).

In patients with acute malaria who present with diarrhoea or vomiting, alternative therapy should be considered. If atovaquone/proguanil is used to treat malaria in these patients, parasitaemia and the patient's clinical condition should be closely monitored.

Atovaquone/proguanil has not been evaluated for the treatment of cerebral malaria or other severe manifestations of complicated malaria including hyperparasitaemia, pulmonary oedema or renal failure.

Occasionally, severe allergic reactions (including anaphylaxis) have been reported in patients taking atovaquone/proguanil. If patients experience an allergic reaction (see section 4.8) atovaquone/proguanil should be discontinued promptly and appropriate treatment initiated.

Atovaquone/proguanil has been shown to have no efficacy against hypnozoites of *Plasmodium vivax* as parasite relapse occurred commonly when *Plasmodium vivax* malaria was treated with atovaquone/proguanil alone. Travellers with intense exposure to *Plasmodium vivax* or *Plasmodium ovale*, and those who develop malaria caused by either of these parasites, will require additional treatment with a drug that is active against hypnozoites.

In the event of recrudescence infections due to *Plasmodium falciparum* after treatment with atovaquone/proguanil, or failure of chemoprophylaxis with atovaquone/proguanil, patients should be treated with a different blood schizonticide as such events can reflect a resistance of the parasite.

Parasitaemia should be closely monitored in patients receiving concurrent tetracycline (see section 4.5).

The concomitant administration of Atovaquone atovaquone/proguanil and efavirenz or boosted protease-inhibitors should be avoided whenever possible (see section 4.5). The concomitant administration of atovaquone/proguanil and rifampicin or rifabutin is not recommended (see section 4.5).

Concurrent use of metoclopramide is not recommended. Another antiemetic treatment should be given (see section 4.5).

Caution is advised when initiating or withdrawing malaria prophylaxis or treatment with atovaquone/proguanil in patients on continuous treatment with warfarin and other coumarin based anticoagulants (see section 4.5).

Atovaquone can increase the levels of etoposide and its metabolite (see section 4.5). In patients with severe renal impairment (creatinine clearance < 30 ml/min) alternatives to atovaquone/proguanil for treatment of acute *Plasmodium falciparum* malaria should be recommended whenever possible (see sections 4.2, 4.3 and 5.2)

The safety and effectiveness of atovaquone 250 mg/proguanil hydrochloride 100 mg tablets has not been established for prophylaxis of malaria in patients who weigh less than 40 kg, or in the treatment of malaria in paediatric patients who weigh less than 11 kg.

## 4.5 Interaction with other medicinal products and other forms of interaction

Concomitant administration of rifampicin or rifabutin is not recommended as it is known to reduce plasma concentrations of atovaquone levels by approximately 50 % and 34 %, respectively. (see section 4.4).

Concomitant treatment with metoclopramide has been associated with a significant decrease (about 50 %) in plasma concentrations of atovaquone (see section 4.4). Another antiemetic treatment should be given.

When given with efavirenz or boosted protease-inhibitors, atovaquone concentrations have been observed to decrease as much as 75 %. This combination should be avoided whenever possible (see section 4.4). Concomitant administration of atovaquone and indinavir results in a decrease in the  $C_{min}$  of indinavir (23 % decrease; 90 % CI 8-35 %). Caution should be exercised when prescribing atovaquone with indinavir due to the decrease in the trough levels of indinavir.

Proguanil may potentiate the effect of warfarin and other coumarin based anticoagulants which may lead to an increase in the risk of haemorrhage. The mechanism of this potential drug interaction has not been established. Caution is advised when initiating or withdrawing malaria prophylaxis or treatment with atovaquone/proguanil in patients on continuous treatment with oral anticoagulants. The dose of the oral anticoagulant may need to be adjusted during atovaquone/proguanil treatment or after its withdrawal, based on INR results.

Concomitant treatment with tetracycline has been associated with decreases in plasma concentrations of atovaquone.

The co-administration of atovaquone at doses of 45 mg/kg/day in children (n=9) with acute lymphoblastic leukaemia for prophylaxis of PCP was found to increase the plasma concentrations (AUC) of etoposide and its metabolite etoposide catechol by a median of 8.6 % (P=0.055) and 28.4 % (P=0.031) (respectively compared to the co-administration of etoposide and sulfamethoxazole-trimethoprim). Caution should be advised in patients receiving concomitant therapy with etoposide (see section 4.4).

Proguanil is primarily metabolised by CYP2C19. However, potential pharmacokinetic interactions with other substrates, inhibitors (e.g. moclobemide, fluvoxamine) or inducers (e.g. artemisinin, carbamazepine) of CYP2C19 are unknown (see section 5.2)

4.6 Fertility, pregnancy and lactation

Pregnancy

The safety of atovaquone and proguanil hydrochloride when administered concurrently for use in human pregnancy has not been established and the potential risk is unknown.

Animal studies showed no evidence for teratogenicity of the combination. The individual components have shown no effects on parturition or pre- and post-natal development. Maternal toxicity was seen in pregnant rabbits during a teratogenicity study (see section 5.3). The use of atovaquone/proguanil in pregnancy should only be considered if the expected benefit to the mother outweighs any potential risk to the foetus.

The proguanil component of atovaquone/proguanil acts by inhibiting parasitic dihydrofolate reductase. There are no clinical data indicating that folate supplementation diminishes drug efficacy. For pregnant women or women who have the intention to get pregnant receiving folate supplements to prevent neural tube birth defects, such supplements should be continued while taking atovaquone/proguanil.

Breastfeeding

The atovaquone concentrations in milk, in a rat study, were 30 % of the concurrent atovaquone concentrations in maternal plasma. It is not known whether atovaquone is excreted in human milk.

Proguanil is excreted in human milk in small quantities.

Atovaquone/proguanil should not be taken by breastfeeding women.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. Dizziness has been reported. Patients should be warned that if affected they should not drive, operate machinery or take part in activities where this may put themselves or others at risk.

4.8 Undesirable effects

In clinical trials of atovaquone/proguanil in the treatment of malaria, the most commonly reported adverse reactions, were abdominal pain, headache, anorexia, nausea, vomiting, diarrhoea and coughing. In clinical trials of atovaquone/proguanil for prophylaxis of malaria, the most commonly reported adverse reactions were headache, abdominal pain and diarrhoea.

The following table provides a summary of adverse reactions that have been reported to have a suspected (at least possible) casual relationship to treatment with atovaquone/proguanil in clinical trials and spontaneous post-marketing reports. The following convention is used for the classification of frequency: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); not known (cannot be estimated from the available data).

There are limited long term safety data in children. In particular, the long-term effects of atovaquone/proguanil on growth, puberty and general development have not been studied.

System Organ Class	Very Common	Common	Uncommon	Not known <sup>2</sup>
Blood and lymphatic system disorders		Anaemia Neutropenia <sup>1</sup>		Pancytopenia

<i>Immune system disorders</i>		Allergic reactions		Angioedema <sup>3</sup> Anaphylaxis (see section 4.4) Vasculitis <sup>3</sup>
<i>Metabolism and nutrition disorders</i>		Hyponatraemia <sup>1</sup> Anorexia	Elevated amylase levels <sup>1</sup>	
<i>Psychiatric disorders</i>		Abnormal dreams Depression	Anxiety	Panic attack Crying Hallucinations Nightmares
<i>Nervous system disorders</i>	Headache	Insomnia Dizziness		Seizure
<i>Cardiac disorders</i>			Palpitations	Tachycardia
<i>Gastrointestinal disorders</i>	Nausea <sup>1</sup> Vomiting Diarrhoea Abdominal pain		Stomatitis	Gastric intolerance <sup>3</sup> Oral ulceration <sup>3</sup>
<i>Hepatobiliary disorders</i>		Elevated liver enzymes <sup>1</sup>		Hepatitis Cholestasis <sup>3</sup>
<i>Skin and subcutaneous tissue disorders</i>		Pruritus Rash	Hair loss Urticaria	Stevens-Johnson syndrome Erythema multiforme Blister <sup>3</sup> Skin exfoliation Photosensitivity reactions
<i>General disorders and administration site conditions</i>		Fever		
<i>Respiratory, thoracic and mediastinal disorders</i>		Cough		

1. Frequency taken from atovaquone label. Patients participating in clinical trials with atovaquone have received higher doses and have often had complications of advanced Human Immunodeficiency Virus (HIV) disease. These events may have been seen at a lower frequency or not at all in clinical trials with atovaquone/proguanil.
2. Observed from post-marketing spontaneous reports and the frequency is therefore unknown
3. Observed with proguanil.

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, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: [www.hpra.ie](http://www.hpra.ie); E-mail: [medsafety@hpra.ie](mailto:medsafety@hpra.ie).

## 4.9 Overdose

There is insufficient experience to predict the consequences or suggest specific management of atovaquone/proguanil overdose. However, in the reported cases of atovaquone overdose, the observed effects were consistent with known undesirable effects of the drug. If overdose occurs, the patient should be monitored and standard supportive treatment applied.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antimalarials, Biguanides, Proguanil, combinations ATC Code: P01BB51

Atovaquone/Proguanil 250 mg/100 mg film-coated tablets are a fixed dose combination of atovaquone and proguanil hydrochloride which acts as a blood schizonticide and also has activity against hepatic schizonts of *Plasmodium falciparum*.

#### Mechanism of action

The constituents of Atovaquone 250 mg/proguanil hydrochloride 100 mg tablets, atovaquone and proguanil hydrochloride, interfere with two different pathways involved in the biosynthesis of pyrimidines required for nucleic acid replication. The mechanism of action of atovaquone against *P. falciparum* is via inhibition of mitochondrial electron transport, at the level of the cytochrome bc<sub>1</sub> complex, and collapse of mitochondrial membrane potential. One mechanism of action of proguanil, via its metabolite cycloguanil, is inhibition of dihydrofolate reductase, which disrupts deoxythymidylate synthesis. Proguanil also has antimalarial activity independent of its metabolism to cycloguanil, and proguanil, but not cycloguanil, is able to potentiate the ability of atovaquone to collapse mitochondrial membrane potential in malaria parasites. This latter mechanism may explain the synergy seen when atovaquone and proguanil are used in combination.

#### Resistance

Cases of failures to respond to atovaquone/proguanil associated with resistance of *P. falciparum* strains have been published in the literature. The mechanism of resistance may include involvement of point mutations in the target gene of atovaquone, *P. falciparum* mitochondrial *cytochrome b* gene. However, the mechanism of resistance has not been elucidated entirely.

The prevalence of resistance may vary geographically and with time. Information on resistance can be obtained from official guidelines such as public health authorities' and WHO guidelines.

### 5.2 Pharmacokinetic properties

There are no pharmacokinetic interactions between atovaquone and proguanil at the recommended dose. In clinical trials, where children have received atovaquone/proguanil dosed by bodyweight, trough levels of atovaquone, proguanil and cycloguanil in children are generally within the range observed in adults.

#### Absorption

Atovaquone is a highly lipophilic compound with low aqueous solubility. In HIV-infected patients, the absolute bioavailability of a 750 mg single dose of atovaquone tablets taken with food is 23% with an inter-subject variability of about 45%.

Dietary fat taken with atovaquone increases the rate and extent of absorption, increasing AUC 2-3 times and C<sub>max</sub> 5 times over fasting. Patients are recommended to take atovaquone/proguanil tablets with food, preferably a fatty meal or a milky drink (see section 4.2).

Proguanil hydrochloride is rapidly and extensively absorbed regardless of food intake.

### Distribution

Apparent volume of distribution of atovaquone and proguanil is a function of bodyweight.

Atovaquone is highly protein bound (>99%) but does not displace other highly protein bound drugs *in vitro*, indicating that significant drug interactions arising from displacement are unlikely.

Following oral administration, the volume of distribution of atovaquone in adults and children is approximately 8.8 L/kg.

Proguanil is 75% protein bound. Following oral administration, the volume of distribution of proguanil in adults and children ranged from 20 to 42 L/kg.

In human plasma the binding of atovaquone and proguanil was unaffected by the presence of the other.

### Metabolism

There is no evidence that atovaquone is metabolised and there is negligible excretion of atovaquone in urine with the parent drug being predominantly (>90%) eliminated unchanged in faeces.

Proguanil hydrochloride is partially metabolised, primarily by the polymorphic cytochrome P450 isoenzyme 2C19, with less than 40% being excreted unchanged in the urine. Its metabolites, cycloguanil and 4-chlorophenylbiguanide, are also excreted in the urine.

During administration of atovaquone/proguanil at recommended doses proguanil metabolism status appears to have no implications for treatment or prophylaxis of malaria.

### Elimination

The elimination half life of atovaquone is about 2-3 days in adults and 1-2 days in children.

The elimination half lives of proguanil and cycloguanil are about 12-15 hours in both adults and children.

Oral clearance for atovaquone and proguanil increases with increased bodyweight and is about 70% higher in an 80 kg subject relative to a 40 kg subject. The mean oral clearance in paediatric and adult patients weighing 10 to 80 kg ranged from 0.8 to 10.8 L/h for atovaquone and from 15 to 106 L/h for proguanil.

### Pharmacokinetics in the elderly

There is no clinically significant change in the average rate or extent of absorption of atovaquone or proguanil between elderly and young patients. Systemic availability of cycloguanil is higher in the elderly compared to the young patients (AUC is increased by 140% and  $C_{max}$  is increased by 80%), but there is no clinically significant change in its elimination half life (see section 4.2).

### Pharmacokinetics in renal impairment

In patients with mild to moderate renal impairment, oral clearance and/or AUC data for atovaquone, proguanil and cycloguanil are within the range of values observed in patients with normal renal function.

Atovaquone  $C_{max}$  and AUC are reduced by 64% and 54%, respectively, in patients with severe renal impairment.

In patients with severe renal impairment, the elimination half lives for proguanil ( $t_{1/2}$  39h) and cycloguanil ( $t_{1/2}$  37 h) are prolonged, resulting in the potential for drug accumulation with repeated dosing (see sections 4.2 and 4.4).

### Pharmacokinetics in hepatic impairment

In patients with mild to moderate hepatic impairment there is no clinically significant change in exposure to atovaquone when compared to healthy patients.

In patients with mild to moderate hepatic impairment there is an 85% increase in proguanil AUC with no change in elimination half life and there is a 65-68% decrease in  $C_{max}$  and AUC for cycloguanil.

No data are available in patients with severe hepatic impairment (see section 4.2).

## **5.3 Preclinical safety data**

### Repeat dose toxicity:

Findings in repeat dose toxicity studies with atovaquone/proguanil hydrochloride combination were entirely proguanil related and were observed at doses providing no significant margin of exposure in comparison with the expected clinical exposure. As proguanil has been used extensively and safely in the treatment and prophylaxis of malaria at doses similar to those used in the combination, these findings are considered of little relevance to the clinical situation.

### Reproductive toxicity studies:

In rats and rabbits there was no evidence of teratogenicity for the combination. No data are available regarding the effects of the combination on fertility or pre- and post-natal development, but studies on the individual components of atovaquone/proguanil have shown no effects on these parameters. In a rabbit teratogenicity study using the combination, unexplained maternal toxicity was found at a systemic exposure similar to that observed in humans following clinical use.

#### Mutagenicity:

A wide range of mutagenicity tests have shown no evidence that atovaquone or proguanil have mutagenic activity as single agents.

Mutagenicity studies have not been performed with atovaquone in combination with proguanil.

Cycloguanil, the active metabolite of proguanil, was also negative in the Ames test, but was positive in the Mouse Lymphoma assay and the Mouse Micronucleus assay. These positive effects with cycloguanil (a dihydrofolate antagonist) were significantly reduced or abolished with folic acid supplementation.

#### Carcinogenicity:

Oncogenicity studies of atovaquone alone in mice showed an increased incidence of hepatocellular adenomas and carcinomas. No such findings were observed in rats and mutagenicity tests were negative. These findings appear to be due to the inherent susceptibility of mice to atovaquone and are considered of no relevance in the clinical situation.

Oncogenicity studies on proguanil alone showed no evidence of carcinogenicity in rats and mice.

Oncogenicity studies on proguanil in combination with atovaquone have not been performed.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

#### Core

Poloxamer 188  
Microcrystalline Cellulose  
Low-substituted Hydroxypropyl Cellulose  
Povidone K30  
Sodium Starch Glycolate Type A  
Silica colloidal anhydrous  
Magnesium Stearate

#### Coating

Hypromellose  
Titanium Dioxide E171  
Iron Oxide Red E172  
Macrogol 400  
Macrogol 8000

### **6.2 Incompatibilities**

Not applicable.

### **6.3 Shelf life**

36 months



## **6.4 Special precautions for storage**

This medicinal product does not require any special storage conditions

## **6.5 Nature and contents of container**

PVC/PVDC (clear) and hard tempered PVC/PVDC-Aluminium foil blisters containing 12 tablets  
Pack size: 12, 24, 36

Not all pack sizes may be marketed.

## **6.6 Special precautions for disposal**

No special requirements.

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

## **7 MARKETING AUTHORISATION HOLDER**

Clonmel Healthcare Ltd  
Waterford Road,  
Clonmel,  
Co Tipperary,  
Ireland

## **8 MARKETING AUTHORISATION NUMBER**

PA126/233/001

## **9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 5th October 2012

Date of last renewal: 15th March 2017

## **10 DATE OF REVISION OF THE TEXT**

May 2017