Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Beclazone 50 micrograms CFC-Free Inhaler Pressurised Inhalation Solution

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each metered dose contains 50 micrograms beclometasone dipropionate.

Excipient with known effect:
Each metered dose contains 2.09 mg alcohol (ethanol).

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Pressurised Inhalation, Solution.

Pressurised container fitted with a metering valve and an actuator.

The colour of the actuator is beige with a brown dust cap.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Prophylactic treatment of mild, moderate, and severe persistent asthma.

Beclazone 50 micrograms CFC-Free Inhaler is indicated in adults, adolescents and children aged 7-12 years.

4.2 Posology and method of administration

Posology

The preparation is intended for oral inhalation only. Patients should be made aware of the prophylactic nature of therapy with inhaled beclometasone dipropionate and that it should be taken regularly even when they are asymptomatic. The initial dose of inhaled beclometasone dipropionate should be appropriate to the severity of the disease.

The dose should be titrated to the lowest dose at which effective control of asthma is maintained.

If patients find that short-acting relief bronchodilator treatment becomes less effective or they need more inhalations than usual, medical attention must be sought.

Adults and children over 12 years of age
The dose range is from 50 mcg twice daily to 500 mcg twice daily (maximum daily dose 1000 mcg) depending on the patient's asthma severity.

The maintenance dose is normally 200-400 mcg per day in divided doses. If necessary, higher doses of up to 1000 micrograms per day may be used.

When asthma symptoms remain under satisfactory control the dose may be gradually reduced to the minimum effective dose to maintain symptom control.

The therapeutic effect occurs after a few days' treatment and reaches its maximum after 2-3 weeks.

When transferring a patient to Beclazone CFC-Free Inhaler from other inhaler devices switch at same dose and titrate individually if necessary.

Paediatric population (7-12 years)
The dose range is from 50 mcg twice daily to 100 mcg twice daily (maximum daily dose 200 mcg per day) depending on the patient's asthma severity.

Beclazone 50 micrograms CFC-Free Inhaler is not recommended for use in children under seven years due to insufficient data on safety and efficacy.

Special patient groups
There is no need to adjust the dose in older people or in those with hepatic or renal impairment.

Method of administration
For inhalation use.

4.3 Contraindications

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

4.4 Special warnings and precautions for use

The management of asthma should follow a stepwise program, and patient response should be monitored clinically and by lung function tests.

Increasing use of bronchodilators, in particular short-acting inhaled β_2-agonists, to relieve symptoms indicates deterioration of asthma control. Under these conditions, the patient's therapy plan should be reassessed.

Sudden and progressive deterioration in asthma control is potentially life-threatening and consideration should be given to increasing corticosteroid dosage. In patients considered at risk, daily flow monitoring may be instituted.

Beclometasone dipropionate inhaler is not intended for the treatment of acute asthma attack but for routine long-term management. Patients will require a fast- and short-acting inhaled bronchodilator to relieve acute asthmatic symptoms.

Lack of response or severe exacerbations of asthma should be treated by increasing the dose of inhaled beclometasone dipropionate and, if necessary, by giving a systemic steroid and/or an antibiotic if there is an infection.

Treatment with Beclazone CFC-Free inhaler should not be stopped abruptly.

Steroid-dependent patients: The transfer of steroid dependent patients to beclometasone dipropionate inhalers, and their subsequent management, needs special care mainly because recovery from impaired adrenocortical function, caused by prolonged systemic steroid therapy, is slow. The patient should be in a reasonably stable state before being given beclometasone dipropionate inhaler in addition to his usual maintenance dose of systemic steroid. After about a week, gradual withdrawal of the systemic steroid is started by reducing the daily dose by 1 mg prednisolone, or its equivalent of other corticosteroids, at not less than weekly intervals. Patients treated with systemic steroids for long periods of time or who have received high doses may have adrenocortical suppression. With these patients adrenocortical function should be monitored regularly and their dose of systemic steroid reduced cautiously. Some patients feel unwell (i.e. headache, nausea, articular or muscular discomfort) during the withdrawal phase despite maintenance or even improvement of respiratory function. They should be encouraged to persevere with the inhaler and withdrawal of systemic steroid continued unless there are objective signs of adrenal insufficiency. Spirometric and clinical assessments should be provided while reducing oral corticotherapy. Most patients can be successfully transferred to beclometasone dipropionate inhalers with maintenance of good respiratory function, but special care is necessary for the first months after the transfer until the pituitary adrenal system has sufficiently recovered to enable the patient to cope with emergencies such as trauma, surgery or infections.

Transferred patients whose adrenocortical function is impaired should carry a warning card indicating that they need supplementary systemic steroid during periods of stress or elective surgery.

They should also be given a supply of oral steroid to use in emergency, for example when the asthma worsens as a result of a chest infection. The dose of beclometasone dipropionate inhaler should be increased at this time and then reduced to the maintenance level after the systemic steroid has been discontinued.

Patients with high blood levels of Candida precipitins, indicating a previous infection, are more likely to develop candidiasis of the mouth and throat (thrush), (see section 4.8 "Undesirable effects"). All patients may find it helpful to rinse their mouth with water after using the inhaler.

Paradoxical bronchospasm may occur with an immediate increase in wheezing after dosing. This should be treated immediately with a fast-acting inhaled bronchodilator. If such does appear, use should cease and alternative therapy introduced.

Replacement of systemic steroid treatment with beclometasone dipropionate inhaler sometimes unmasks allergies such as allergic rhinitis or eczema previously controlled by the systemic drug. These allergies should be symptomatically treated with antihistamine and/or topical preparations.

Patients should be instructed in the proper use of the inhaler to ensure that the drug reaches the target areas within the lungs. Actuation of the aerosol should be synchronised with inspiration. They should also be made aware that beclometasone dipropionate inhaler has to be used regularly for optimum benefit even when they are asymptomatic. Patients being treated with Beclazone 50 or 100 micrograms CFC-Free Inhaler may be transferred directly to treatment with Beclazone 250 micrograms CFC-Free Inhaler (at the same total daily dose up to a maximum of 1000 mcg)). In the majority of patients no significant effects on plasma or urinary free cortisol occur until doses of 1000 mcg per day are exceeded. Some patients receiving 2,000 mcg of beclometasone dipropionate CFC-Free per day have shown reduced plasma or urinary free cortisol although short-term adrenal reserve remains intact. In any patients the risk of developing adrenal suppression should be balanced against the therapeutic advantages and precautions should be taken to provide systemic steroid cover in situation of prolonged stress.

Particular care should be taken to minimise the use of topical corticosteroids in patients with immunosuppression.

Particular care is required in patients with a history of, or existent tuberculosis.

Special care is needed in patients with viral, bacterial, and fungal infections of the eye or the mouth or respiratory tract. In case of bacterial infection of the respiratory tract an adequate antibiotic co-medication may be required.

Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for prolonged periods. The effects are much less likely to occur than with oral corticosteroids. Possible systemic effects include adrenal suppression, growth retardation in children and adolescents, decrease in bone mineral density, cataract, glaucoma, blurred vision and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). It is important, therefore that the dose of inhaled corticosteroid is titrated to the lowest dose at which effective control of asthma is maintained (see section 4.8).

It is recommended that the height of children receiving prolonged treatment with inhaled corticosteroids is regularly monitored. If growth is slowed, therapy should be reviewed with the aim of reducing the dose of inhaled corticosteroid if possible, to the lowest dose at which effective control of asthma is maintained. In addition, consideration should be given to referring the patient to a paediatric respiratory specialist.

Certain individuals can show greater susceptibility to the effects of inhaled corticosteroid than do most patients.

Prolonged treatment with high doses of inhaled corticosteroids, particularly higher than the recommended dose, may result in clinically significant adrenal suppression. Additional systemic corticosteroid cover should be considered during periods of stress or elective surgery.

Visual disturbance
Visual disturbance may be reported with systemic and topical corticosteroid use. If a patient presents with symptoms such as blurred vision or other visual disturbances, the patient should be considered for referral to an ophthalmologist for evaluation of possible causes which may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy (CSCR) which have been reported after use of systemic and topical corticosteroids

Excipient(s)

Ethanol
The small amount of alcohol in this medicine will not have any noticeable effects.

4.5 Interaction with other medicinal products and other forms of interactions

Concurrent administration of barbiturates, phenytoin or rifampicin may enhance the metabolism and reduce the effects of oral corticosteroids. Response to anti-coagulants may be reduced and, on some occasions enhanced, by oral corticosteroids. Concurrent administration of oral corticosteroids or the potassium-depleting diuretics such as thiazides or frusemide may cause excessive potassium loss. No known interactions have been reported for inhaled beclometasone dipropionate.

Beclomethasone is less dependent on CYP3A metabolism than some other corticosteroids, and in general interactions are unlikely; however the possibility of systemic effects with concomitant use of strong CYP3A inhibitors (e.g. ritonavir, cobicistat) cannot be excluded, and therefore caution and appropriate monitoring is advised with the use of such agents.

Beclazone CFC-Free Inhaler contains a small amount of ethanol. There is a theoretical potential for interaction in particularly sensitive patients taking disulfiram or metronidazole.

4.6 Fertility, pregnancy and lactation

Pregnancy
No specific studies have been performed examining the safety in human pregnancy for BDP HFA. Beclometasone inhalation may be associated with intrauterine growth retardation in humans. Studies in animals have shown reproductive toxicity (see section 5.3). The use of beclometasone in pregnancy requires that the possible benefits of the drug be weighed against the possible hazards.

Breast-feeding
No specific studies have been performed examining the safety in human lactation for BDP HFA.
The transfer of beclometasone into milk has not been examined. It is reasonable to assume that beclometasone is excreted in milk but at the doses used for inhalation there is low potential for significant levels in breast milk. Beclometasone dipropionate should only be used in a nursing mother if the expected benefit justifies the risk to the newborn/infant.

4.7 Effects on ability to drive and use machines

Beclazone 50 micrograms CFC-Free Inhaler has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

Very common (³1/10)
Common (³1/100 to <1/10)
Uncommon (³1/1,000 to <1/100)
Rare (³1/10,000 to <1/1,000)
Very rare (<1/10,000)
Not known (cannot be estimated from the available data)

Adults

Infections and infestations Very common	Candidiasis in mouth and throat
Immune system disorders Rare	Angioedema, respiratory symptoms (dyspnoea and/or bronchospasm) and anaphylactoid/anaphylactic reactions
Endocrine disorders Very rare	Cushing's syndrome, Cushingoid features, Adrenal suppression (systemic effect)
Eye disorders Very rare Not known	Cataract, glaucoma (systemic effect) Blurred vision

Respiratory, thoracic and mediastinal disorders Common Rare	 Hoarseness and throat irritation Paradoxical bronchospasm
Skin and subcutaneous tissue disorders Uncommon	 Urticaria, rash, pruritus, erythema
Musculoskeletal and connective tissue disorders Very rare	 Decreased bone mineral density (systemic effect).
Psychiatric disorders Not known	 Psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes.

Paediatric population

Endocrine disorders Very rare	 Growth retardation in children and adolescents
Psychiatric disorders Very rare Not known	 Anxiety, sleep disorders and behavioural changes, including hyperactivity and irritability (predominantly in children) Depression, aggression (predominantly in children)

As with other inhalation therapy, paradoxical bronchospasm may occur with an immediate increase in wheezing after dosing. This should be treated immediately with a fast-acting inhaled bronchodilator. Beclazone CFC-Free Inhaler should be discontinued immediately, the patient assessed, and if necessary alternative therapy instituted.

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

The acute toxicity of beclometasone dipropionate is low. The only harmful effect that follows inhalation of large amounts of the drug over a short period is suppression of hypothalamic pituitary adrenal (HPA) function. No special emergency action need be taken. Treatment with beclometasone dipropionate should be continued at the recommended dose to control the asthma; HPA function recovers in a day or two.

In the unlikely event of grossly excessive intake of beclometasone dipropionate for weeks or months on end, a degree of adrenocortical atrophy could occur in addition to suppression of HPA function. The patient should be treated as steroid dependent and transferred to a suitable maintenance dose of a systemic steroid such as prednisolone. Once the patient's condition has stabilised he should be transferred to beclometasone dipropionate by the method described above (See section 4.4).

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Glucocorticoid, ATC Code: R03B A01

Mechanism of action
Beclometasone dipropionate given by inhalation has a glucocorticoid anti-inflammatory action within the lungs.

Pharmacodynamic effects
The exact mechanism responsible for this anti-inflammatory effect is unknown.

5.2 Pharmacokinetic properties

Absorption and distribution
Beclometasone dipropionate is readily absorbed after oral inhalation. About 25% of an inhaled dose reaches the lungs.

Elimination
The drug and its metabolites are excreted chiefly in the faeces via biliary elimination, and to a lesser extent in the urine.

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, toxicity to reproduction and development.

Preclinical studies in rats and dogs with beclometasone dipropionate formulated in HFA-134a propellant have shown dose related typical signs of glucocorticoid excess.

Beclometasone Dipropionate is non-genotoxic. No evidence of carcinogenicity was observed in a 95-week study in rats.

Studies in animals with beclometasone and other corticosteroids have shown foetal abnormalities (cleft palate) and embryolethality at high doses and growth retardation and functional deficiencies (adrenal suppression, increased risk of cardiovascular disease) at lower doses.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Ethanol anhydrous 99.5%
Norflurane (HFA 134a)

6.2 Incompatibilities

Not Applicable.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

Do not store above 25°C. Do not refrigerate or freeze.

The canister contains a pressurised liquid. Do not expose to temperatures higher than 50°C. Do not pierce the canister.

6.5 Nature and contents of container

Pressurised container fitted with a metering valve.

The can is of 19ml nominal capacity manufactured from aluminium with either a debossed or a plain base. The can opening is configured to accept 20mm valves. Each pack contains a single inhaler which supplies a minimum of 200 actuations.

6.6 Special precautions for disposal and other handling

The canister is pressurised; it must not be burnt, punctured or broken even when apparently empty.

Medicines no longer required should not be disposed of via wastewater or the municipal sewage system. Return them to the pharmacy or ask your pharmacist how to dispose of them in accordance with the national regulations. These measures will help to protect the environment.

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

7 MARKETING AUTHORISATION HOLDER

Norton Waterford
T/A IVAX Pharmaceuticals Ireland
Unit 301
IDA Industrial Park
Cork Road, Waterford
Ireland

8 MARKETING AUTHORISATION NUMBER

PA0436/021/009

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 14th November 1997
Date of last renewal: 4th November 2007

10 DATE OF REVISION OF THE TEXT

April 2023