

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Madopar 200mg/50mg Hard Capsules

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each capsule contains 200mg levodopa and 50mg benserazide (as benserazide hydrochloride).

For a full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Capsules, hard (Capsules)

Product imported from the UK:

Light brown and pale blue capsules imprinted with the name 'ROCHE' in black ink on both sections

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

In the management of Parkinsonism of idiopathic, post-encephalitic or arteriosclerotic type.

4.2 Posology and method of administration

Adults over the age of 25 years only:

Madopar 200mg/50mg capsules are only for maintenance therapy once the optimal dosage has been determined using Madopar 100mg/25mg dispersible tablets.

Patients not previously treated with levodopa: The recommended initial dose is one dispersible tablet of Madopar 50mg/12.5mg three or four times daily. If the disease is at an advanced stage, the starting dose should be one dispersible tablet of Madopar 100mg/25mg three times daily.

The daily dosage should then be increased by one dispersible tablet of Madopar 100mg/25mg, or the equivalent, once or twice weekly until a full therapeutic effect is obtained, or side effects supervene.

In some elderly patients, it may suffice to initiate treatment with one dispersible tablet of Madopar 50mg/12.5mg once or twice daily, increasing by one capsule every third or fourth day.

The effective dose usually lies within the range of four to eight dispersible tablets of Madopar 100mg/25mg (two to four capsules of Madopar 200mg/50mg) daily in divided doses, most patients requiring no more than six dispersible tablets of Madopar 100mg/25mg daily.

Optimal improvement is usually seen in one to three weeks but the full therapeutic effect of Madopar may not be apparent for some time. It is advisable, therefore, to allow several weeks to elapse before contemplating dosage increments above the average dose range. If satisfactory improvement is still not achieved, the dose of Madopar may be increased but with caution. It is rarely necessary to give more than 10 dispersible tablets of Madopar 100mg/25mg (five capsules of Madopar 200mg/50mg) per day.

Treatment should be continued for at least six months before failure is concluded from absence of clinical response.

Madopar 50mg/12.5mg dispersible tablets may be used to facilitate adjustment of dosage to the needs of the individual patient. Patients who experience fluctuations in response may be helped by dividing the dosage into smaller, more frequent doses with the aid of Madopar 50mg/12.5mg dispersible tablets without, however, altering the total daily dose.

Patients previously treated with levodopa

The following procedure is recommended: Levodopa alone should be discontinued and Madopar started on the following day. The patient should be initiated on a total of one less Madopar 100mg/25mg dispersible tablet daily than the total number of 500mg levodopa tablets or capsules previously taken (for example, if the patient had previously taken 2g levodopa daily, then he should start on three dispersible tablets of Madopar 100mg/25mg daily on the following day). Observe the patient for one week and then, if necessary increase the dosage in the manner described for new patients.

Patients previously treated with other levodopa/decarboxylase inhibitor combinations: Previous therapy should be withdrawn for 12 hours. In order to minimise the potential for any effects of levodopa withdrawal, it may be beneficial to discontinue previous therapy at night and institute Madopar therapy the following morning. The initial Madopar dose should be one dispersible tablet of Madopar 50mg/12.5mg three or four times daily. This dose may then be increased in the manner described for patients not previously treated with levodopa.

Other anti-Parkinsonian drugs may be given with Madopar. Existing treatment with other anti-Parkinsonian drugs *e.g.* anticholinergics or amantadine, should be continued during initiation of Madopar therapy. However, as treatment with Madopar proceeds and the therapeutic effect becomes apparent, the dosage of the other drugs may need to be reduced or the drugs gradually withdrawn.

Elderly

Although there may be an age-related decrease in tolerance to levodopa in the elderly, Madopar appears to be well tolerated and side effects are generally not troublesome.

Children

Not to be given to patients under 25 years of age, therefore no dosage recommendations are made for administration of Madopar capsules to children.

Madopar capsules are for oral administration. They should be taken with, or immediately after, meals.

4.3 Contraindications

Madopar must not be given to patients with a known hypersensitivity to levodopa or benserazide.

Madopar is contra-indicated in narrow-angle glaucoma; severe psychoses; severe endocrine, renal hepatic or cardiac disorders.

It should not be given in conjunction with, or within 2 weeks of withdrawal of, monoamine oxidase (MAO) inhibitors except selective MAO-B inhibitors (*e.g.* selegiline) or selective MAO-A inhibitors (*e.g.* moclobemide).

It should not be given to patients under 25 years of age.

It should not be given to pregnant women or to women of childbearing potential in the absence of adequate contraception. If pregnancy occurs in a woman taking Madopar, the drug must be discontinued.

Suspicion has arisen that levodopa may activate a malignant melanoma. Therefore, Madopar should not be used in persons who have a history of, or who may be suffering from, a malignant melanoma.

4.4 Special warnings and precautions for use

When other drugs must be given in conjunction with Madopar, the patient should be carefully observed for unusual side-effects or potentiating effects.

In the event of general anaesthesia being required, Madopar therapy may be continued as long as the patient is able to take fluids and medication by mouth. If therapy is temporarily interrupted, the usual daily dosage may be administered as soon as the patient is able to take oral medication. Whenever therapy has been interrupted for longer periods, dosage should again be adjusted gradually. However, in many cases the patient can rapidly be returned to his previous therapeutic dosage.

If a patient has to undergo emergency surgery, when Madopar has not been withdrawn, anaesthesia with halothane should be avoided.

There have been occasional reports of a neuroleptic malignant-like syndrome, involving hyperthermia, on abrupt withdrawal of levodopa preparations. Sudden discontinuation of Madopar, without close supervision, or "drug holidays" should therefore be avoided.

Pyridoxine (vitamin B₆) may be given with Madopar since the presence of a decarboxylase inhibitor protects against the peripheral levodopa transformation facilitated by pyridoxine.

Levodopa has been associated with somnolence and episodes of sudden sleep onset. Sudden onset of sleep during daily activities, in some cases without awareness or warning signs, has been reported very rarely. Patients must be informed of this and advised to exercise caution while driving or operating machines during treatment with levodopa. Patients who have experienced somnolence and/or an episode of sudden sleep onset must refrain from driving or operating machines. Furthermore a reduction of dosage or termination of therapy may be considered.

Impulse control disorders

Patients should be regularly monitored for the development of impulse control disorders. Patients and carers should be made aware that behavioural symptoms of impulse control disorders including pathological gambling, increased libido, hypersexuality, compulsive spending or buying, binge eating and compulsive eating can occur in patients treated with dopamine agonists and/or other dopaminergic treatments containing levodopa including Madopar 200mg/50mg Hard Capsules. Review of treatment is recommended if such symptoms develop.

Care should be taken when using Madopar in the following circumstances: in endocrine, renal, pulmonary or cardiovascular disease, particularly where there is a history of myocardial infarction or arrhythmia; psychiatric disturbances (e.g. depression); hepatic disorder; peptic ulcer; osteomalacia; where sympathomimetic drugs may be required (e.g. bronchial asthma), due to possible potentiation of the cardiovascular effects of levodopa; where antihypertensive drugs are being used, due to possible increased hypotensive action.

Periodic evaluation of hepatic, haemopoietic, renal and cardiovascular function is advised. Patients with diabetes should undergo frequent blood sugar tests and the dosage of anti-diabetic agents should be adjusted to blood sugar levels.

Patients who improve on Madopar therapy should be advised to resume normal activities gradually as rapid mobilisation may increase the risk of injury.

4.5 Interaction with other medicinal products and other forms of interaction

Ferrous sulphate decreases maximum plasma concentration and the AUC of levodopa by 30 – 50%. The pharmacokinetic changes observed during co-treatment with ferrous sulphate appear to be clinically significant in some but not all patients.

Opioids and drugs which interfere with central amine mechanisms, such as rauwolfia alkaloids (reserpine), tetrabenazine (Nitoman), metoclopramide, phenothiazines, thioxanthenes, butyrophenones, amphetamines and papaverine should be avoided where possible. If, however, their administration is considered essential, extreme care should be exercised and a

close watch kept for any signs of potentiation, antagonism, or other interactions and for unusual side-effects.

Combination with other anti-Parkinsonian agents (anticholinergics, amantadine, dopamine agonists) is permissible, though both the desired and undesired effects of treatment may be intensified. When initiating an adjuvant treatment with a COMT inhibitor, a reduction of the dosage of Madopar may be necessary. Anticholinergics should not be withdrawn abruptly when Madopar therapy is instituted, as levodopa does not begin to take effect for some time.

Use with antihypertensive agents may increase the hypotensive response, while sympathomimetics may increase the cardiovascular side-effects of levodopa.

Levodopa may interfere chemically with several diagnostic laboratory tests including those for glucose, ketone bodies, or catecholamines in urine and for glucose or uric acid in blood. Levodopa therapy has been reported to inhibit the response to protirelin in tests of thyroid function.

4.6 Fertility, pregnancy and lactation

Madopar is contra-indicated in pregnancy and in women of childbearing potential in the absence of adequate contraception, since there is evidence of harmful effects in studies in pregnant rabbits and the benserazide component has been found to be associated with skeletal malformations in the rat. If pregnancy occurs in a woman taking Madopar, the drug must be discontinued. Patients taking Madopar should not breast-feed their infants.

4.7 Effects on ability to drive and use machines

Patients being treated with levodopa and presenting with somnolence and/or sudden sleep episodes must be informed to refrain from driving or engaging in activities where impaired alertness may put themselves or others at risk of serious injury or death (e.g. operating machines) until such recurrent episodes and somnolence have resolved (see Section 4.4).

4.8 Undesirable effects

Gastrointestinal:

- Anorexia, nausea, vomiting, diarrhoea (less commonly than with levodopa) mainly occurring in the early stages of treatment may be controlled by taking Madopar with some food or liquid or increasing the dose slowly.
- Gastro-intestinal bleeding has been reported with levodopa therapy.
- Isolated cases of loss or alterations of taste.

Skin:

- rarely allergic reactions such as pruritus and rash.

Cardiovascular:

- Occasional reports of cardiac arrhythmias and orthostatic hypotension (less frequently than with levodopa alone). Orthostatic disorders usually improve following dosage reduction.

Haematological:

- Rare cases of haemolytic anaemia, transient leucopenia and thrombocytopenia.

Neuropsychiatric:

- Psychiatric disturbances are common in Parkinsonian patients, including those treated with levodopa, including mild elation, anxiety, agitation, insomnia, drowsiness, depression, aggression, delusions, hallucinations, temporal disorientation and “unmasking” of psychoses.
- Levodopa is associated with somnolence and has been associated very rarely with excessive daytime somnolence and sudden sleep onset episodes.
- Involuntary movements (e.g. choreiform or athetotic, oral dyskinesias, “paddling” foot) are common, particularly on long-term administration. These are usually dose-dependent and may disappear or become tolerable after dose adjustment.

Impulse control disorders

- Pathological gambling, increased libido and hypersexuality, compulsive spending or buying, binge eating and compulsive eating can occur in patients treated with dopamine agonists and/or other dopaminergic treatments containing levodopa including Madopar 200mg/50mg Hard Capsules (see section 4.4. 'Special warnings and precautions for use').

Laboratory abnormalities:

- Transient rises in SGOT, SGPT and alkaline phosphatase values have been noted.
- Increase of gamma-Glutamyltransferase has been reported.
- Serum uric acid and blood urea nitrogen levels are occasionally increased.

Others:

- Flushing and sweating have been reported with levodopa.
- Urine passed during treatment may be altered in colour; usually red-tinged, this will turn dark on standing. These changes are due to metabolites and is no cause for concern.

Tolerance to Madopar varies widely between patients and is often related to the rate of dosage increases. With long-term administration, fluctuations in the therapeutic response may be encountered. They include "freezing" episodes, end-of-dose deterioration and the so-called "on-off" effect. Patients may be helped by dosage reduction or by giving smaller and more frequent doses.

4.9 Overdose**Symptoms and signs**

Symptoms and signs of overdosage are qualitatively similar to the side-effects of madopar but may be of greater severity.

Overdose may lead to cardiovascular side effects (e.g. cardiac arrhythmias), psychiatric disturbances (e.g. confusion and insomnia), gastro-intestinal effects (e.g. nausea and vomiting) and abnormal involuntary movements (see section 4.8).

Treatment

Monitor the patients vital signs and institute supportive measures as indicated by the patients clinical state. In particular patients may require symptomatic treatment for cardiovascular effects (e.g. antiarrhythmics) or central nervous system effects (e.g. respiratory stimulants, neuroleptics).

5 PHARMACOLOGICAL PROPERTIES**5.1 Pharmacodynamic properties**

Madopar is an anti-Parkinsonian agent. A combination of levodopa, the precursor of dopamine, the levels of which are reduced in Parkinsonism, and benserazide, a peripheral inhibitor of decarboxylase, in the ratio of 4:1. Benserazide permits higher levels of levodopa to reach the brain by decreasing the peripheral metabolism of the latter to dopamine, which cannot reach the brain.

5.2 Pharmacokinetic properties**Absorption**

After oral administration, Madopar, levodopa and benserazide are mainly absorbed in the upper regions of the small intestine, and absorption there is independent of the site. Maximum plasma concentrations of levodopa are reached after approximately one hour after ingestion. The absolute bioavailability of levodopa from standard Madopar is approximately 98%.

The maximum plasma concentration of levodopa and the extent of absorption (AUC) increase proportionally with dose (50 – 200mg levodopa).

Food intake reduces the rate and extent of levodopa absorption by approximately 30% and 15% respectively.

Distribution

Levodopa crosses the blood-brain barrier by a saturable transport system. It is not bound to plasma proteins. Benserazide does not cross the blood-brain barrier at therapeutic doses. Benserazide is concentrated mainly in the kidneys, lungs, small intestine and liver.

Metabolism

The 2 major routes of metabolism of levodopa are decarboxylation to form dopamine, which in turn is converted to a minor degree to norepinephrine, and to a greater extent, to inactive metabolites, and O-methylation, forming 3-O-methyldopa, which has an elimination half-life of approx. 15 hours and accumulates in patients receiving therapeutic doses of Madopar. Decreased peripheral decarboxylation of levodopa when it is administered with benserazide is reflected in higher plasma levels of levodopa and 3-O-methyldopa.

Benserazide is hydroxylated to trihydroxyhydrazine in the intestinal mucosa and liver. This metabolite is a potent inhibitor of the aromatic amino acid decarboxylase.

Elimination

In the presence of the peripheral decarboxylase inhibitor, benserazide, the elimination half-life of levodopa is approximately 1.5 hours. In elderly patients the elimination half-life is slightly (approx. 25%) longer. Clearance of levodopa is 430ml/min. Benserazide is almost entirely eliminated by metabolism. The metabolites are mainly excreted in the urine (64%) and to a smaller extent in the faeces (24%).

5.3 Preclinical safety data

None stated.

6 PHARMACEUTICAL PARTICULARS**6.1 List of excipients**

Microcrystalline cellulose (E460)
 Povidone K90 (E1201)
 Talc (E553b)
 Magnesium stearate (E572)
 Gelatin
 Indigo carmine (E132)
 Titanium dioxide (E171)
 Iron oxide (E172)
 Black iron oxide (E172)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

The shelf-life expiry date of this product is the date shown on the container and outer package of the product on the market in the country of origin.

6.4 Special precautions for storage

Do not store above 25°C. Store in the original package. Keep bottle tightly closed to protect from moisture.

6.5 Nature and contents of container

Amber glass bottles with polyethylene closure and integrated desiccant containing 100 capsules.

6.6 Special precautions for disposal of a used medicinal product or waste materials derived from such medicinal product and other handling of the product

No special requirements.

7 PARALLEL PRODUCT AUTHORISATION HOLDER

B & S Healthcare
Unit 4, Bradfield Road
Ruislip
Middlesex
HA4 0NU
United Kingdom

8 PARALLEL PRODUCT AUTHORISATION NUMBER

PPA1328/139/1

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 15th of October 2010

10 DATE OF REVISION OF THE TEXT

March 2013