

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Plaquenil 200mg Film-coated Tablets

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 200 mg hydroxychloroquine sulphate.

Excipient: lactose monohydrate

For full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Film-coated Tablets

*Product imported from the UK:*

White, round, film-coated tablets with HCQ on one side and 200 on the other.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic Indications

#### Adults

Plaquenil tablets are recommended for the treatment of rheumatoid arthritis, discoid and systemic lupus erythematosus, and dermatological conditions caused or aggravated by sunlight.

#### Paediatric Population

Treatment of juvenile idiopathic arthritis (in combination with other therapies), discoid and systemic lupus erythematosus.

### 4.2 Posology and method of administration

Plaquenil tablets are for oral administration. Each dose should be taken with a meal or glass of milk.

Hydroxychloroquine is cumulative in action and will require several weeks to exert its beneficial effects, whereas minor side effects may occur relatively early.

For rheumatic disease treatment should be discontinued if there is no improvement by 6 months. In light-sensitive diseases treatment should only be given during periods of maximum exposure to light.

#### Adults (including the elderly)

The minimum effective dose should be employed. This dose should not exceed 6.5mg/kg/day (calculated from ideal body weight and not actual body weight) and will be either 200mg or 400mg per day. The 400mg tablet should not be used in adults with an ideal body weight of less than 62kg.

#### Paediatric Population

The minimum effective dose should be employed and should not exceed 6.5mg/kg/day based on ideal body weight. The 200mg tablet is therefore not suitable for use in children with an ideal body weight of less than 31kg.

### 4.3 Contraindications

- known hypersensitivity to 4-aminoquinoline compounds
- pre-existing maculopathy of the eye
- pregnancy (see section 4.6 Pregnancy and lactation)
- below 6 years of age (200mg tablets not adapted for weight <35kg)

### 4.4 Special warnings and precautions for use

#### General

- All patients should have an ophthalmological examination before treatment with Plaquenil is initiated. Thereafter, ophthalmological examinations must be repeated at least every 12 months.
- Retinal toxicity is largely dose-related. The risk of retinal damage is small with daily doses of up to 6.5 mg/kg body weight. Exceeding the recommended dose sharply increases the risk of retinal toxicity.

The examination should include testing visual acuity and colour vision, careful ophthalmoscopy, fundoscopy and central visual field testing with a red target.

This examination should be more frequent and adapted to the patient in the following situations:

- daily dosage exceeds 6.5mg/kg lean body weight. Absolute body weight used as a guide to dosage could result in an overdosage in the obese.
- renal insufficiency
- visual acuity below 6/8
- age above 65 years
- cumulative dose more than 200 g.

Plaquenil should be discontinued immediately in any patient who develops a pigmentary abnormality, visual field defect or any other abnormalities not explained by difficulty in accommodation (see also section 4.8). Patients should continue to be observed as retinal changes and visual disturbances may progress even after cessation of therapy (see also section 4.8).

Cases of cardiomyopathy resulting in cardiac failure have been reported in patients treated with Plaquenil (see Section 4.8 and Section 4.9). Clinical monitoring for signs and symptoms of cardiomyopathy is advised and Plaquenil should be discontinued if cardiomyopathy develops. Chronic toxicity should be considered when conduction disorders (bundle branch block / atrio-ventricular heart block) as well as biventricular hypertrophy are diagnosed (see Section 4.8).

Plaquenil should be used with caution in patients taking medicines which may cause adverse ocular or skin reactions. Caution should also be applied when it is used in the following:

- patients with hepatic or renal disease, and in those taking medicines known to affect those organs. Estimation of plasma hydroxychloroquine levels should be undertaken in patients with severely compromised renal or hepatic function, and dosage adjusted accordingly.
- patients with severe gastrointestinal, neurological or blood disorders.

Caution is also advised in patients with a sensitivity to quinine, those with glucose-6-phosphate dehydrogenase deficiency, those with porphyria cutanea tarda which can be exacerbated by hydroxychloroquine, and in patients with psoriasis since it appears to increase the risk of skin reactions.

Although the risk of bone-marrow depression is low, periodic blood counts are advisable in all patients on long-term therapy and Plaquenil should be discontinued if abnormalities develop.

Suicidal behaviour has been reported in very rare cases in patients treated with hydroxychloroquine.

Small children are particularly sensitive to the toxic effects of 4-aminoquinolines; therefore, patients should be warned to keep Plaquenil out of the reach of children.

All patients on long-term therapy should undergo periodic examination of skeletal muscle function and tendon reflexes. If weakness occurs, the drug should be withdrawn.

Patients with Rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Hydroxychloroquine has been shown to cause severe hypoglycaemia including loss of consciousness that could be life threatening in patients treated with and without antidiabetic medications. Patients treated with hydroxychloroquine should be warned about the risk of hypoglycaemia and the associated clinical signs and symptoms. Patients presenting with clinical symptoms suggestive of hypoglycaemia during treatment with hydroxychloroquine should have their blood glucose level checked and treatment reviewed as necessary.

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

**Hydroxychloroquine sulphate** has been reported to increase plasma digoxin levels. Serum digoxin levels should be closely monitored in patients receiving concomitant treatment.

**Hydroxychloroquine sulphate** may also be subject to several of the known interactions of chloroquine even though specific reports have not appeared. These include: potentiation of its direct blocking action at the neuromuscular junction by aminoglycoside antibiotics; inhibition of its metabolism by cimetidine which may increase plasma concentration of the antimalarial; antagonism of effect of neostigmine and pyridostigmine; reduction of the antibody response to primary immunisation with intradermal human diploid-cell rabies vaccine.

Halofantrine prolongs the QT interval and should not be administered with other drugs that have the potential to induce cardiac arrhythmias, including hydroxychloroquine. Also, there may be an increased risk of inducing ventricular arrhythmias if hydroxychloroquine is used concomitantly with other arrhythmogenic drugs, such as amiodarone and moxifloxacin.

An increased plasma ciclosporin level was reported when ciclosporin and hydroxychloroquine were co-administered.

Administration of hydroxychloroquine with antimalarials known to lower the convulsion threshold (e.g mefloquine) may increase the risk of convulsions.

The activity of antiepileptic drugs might be impaired if co-administered with hydroxychloroquine.

As with chloroquine, antacids may reduce absorption of hydroxychloroquine so it is advised that a four hour interval be observed between Plaquenil and antacid dosaging.

In a single-dose interaction study, chloroquine has been reported to reduce the bioavailability of praziquantel. It is not known if there is a similar effect when hydroxychloroquine and praziquantel are coadministered. Per extrapolation, due to the similarities in structure and pharmacokinetic parameters between hydroxychloroquine and chloroquine, a similar effect may be expected for hydroxychloroquine.

There is a theoretical risk of inhibition of intra-cellular  $\alpha$ -galactosidase activity when hydroxychloroquine is co-administered with agalsidase.

Concurrent use with drugs with oculotoxic or haemotoxic potential should be avoided if possible.

As hydroxychloroquine may enhance the effects of a hypoglycaemic treatment, a decrease in doses of insulin or antidiabetic drugs may be required.

## 4.6 Fertility, pregnancy and lactation

### Pregnancy:

Hydroxychloroquine crosses the placenta. Data are limited regarding the use of hydroxychloroquine during pregnancy. It should be noted that 4-aminoquinolines in therapeutic doses have been associated with central nervous system damage, including, ototoxicity (auditory and vestibular toxicity, congenital deafness), retinal hemorrhages and abnormal retinal pigmentation. Therefore Plaquenil should not be used in pregnancy unless considered essential by the physician.

### Lactation:

Careful consideration should be given to using hydroxychloroquine during lactation, since it has been shown to be excreted in small amounts in human breast milk, and it is known that infants are extremely sensitive to the toxic effects of 4-aminoquinolines.

## 4.7 Effects on ability to drive and use machines

Impaired visual accommodation soon after the start of treatment, which can cause blurring of vision, has been reported and patients should be warned regarding driving or operating machinery. If the condition is not self-limiting it will resolve on reducing the dose or stopping treatment.

## 4.8 Undesirable effects

*The following CIOMS frequency rating is used, when applicable:*

*Very common ( $\geq 1/10$ ), Common ( $\geq 1/100$  to  $< 1/10$ ), Uncommon ( $\geq 1/1,000$  to  $< 1/100$ ), Rare ( $\geq 1/10,000$  to  $< 1/1,000$ ), Very rare ( $< 1/10,000$ ), not known (cannot be estimated from the available data).*

### *Blood and lymphatic system disorders*

*Not known:* Bone marrow depression, anemia, aplastic anemia, agranulocytosis, leucopenia, thrombocytopenia.

### *Immune system disorders*

*Not known:* Urticaria, angioedema, bronchospasm

### *Metabolism and nutrition disorders*

*Common:* Anorexia

*Not known:* Hypoglycemia

Hydroxychloroquine may exacerbate porphyria.

### *Psychiatric disorders*

*Common:* Affect lability

*Uncommon:* Nervousness

*Not known:* Psychosis, suicidal behaviour

### *Nervous system disorders*

*Common:* Headache

*Uncommon:* Dizziness

*Not known:* Convulsions have been reported with this class of drugs.

### *Eye disorders*

*Common:* Blurring of vision due to a disturbance of accommodation which is dose dependent and reversible

*Uncommon:* Retinopathy, with changes in pigmentation and visual field defects. In its early form, it appears reversible on discontinuation of hydroxychloroquine. If allowed to develop, there may be a risk of progression even after treatment withdrawal.

Patients with retinal changes may be asymptomatic initially, or may have scotomatous vision with paracentral, pericentral ring types, temporal scotomas and abnormal colour vision.

Corneal changes including edema and opacities have been reported. They are either symptomless or may cause disturbances such as halos, blurring of vision, or photophobia. They may be transient or are reversible on stopping treatment.

*Not known:*

Cases of maculopathies and macular degeneration have been reported and may be irreversible.

#### *Ear and labyrinth disorders*

*Uncommon:* Vertigo, tinnitus

*Not known:* Hearing loss

#### *Cardiac disorders*

*Not known:*

Cardiomyopathy which may result in cardiac failure (see Section 4.4 and Section 4.9)

Chronic toxicity should be considered when conduction disorders (bundle branch block / atrio-ventricular heart block) as well as biventricular hypertrophy are found. Drug withdrawal may lead to recovery.

#### *Gastrointestinal disorders*

*Very common:* Abdominal pain, nausea

*Common:* Diarrhoea, vomiting

These symptoms usually resolve immediately on reducing the dose or on stopping the treatment.

#### *Hepatobiliary disorders*

*Uncommon:* Abnormal liver function tests

*Not known:* Fulminant hepatic failure

#### *Skin and subcutaneous tissue disorders*

*Common:* Skin rash, pruritus

*Uncommon:* Pigmentation disorders in skin and mucous membranes, bleaching of hair, alopecia

These usually resolve readily on stopping treatment.

*Not known:* Bullous eruptions including erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis, Drug Rash with Eosinophilia and Systemic Symptoms (DRESS syndrome), photosensitivity, exfoliative dermatitis, acute generalized exanthematous pustulosis (AGEP).

AGEP has to be distinguished from psoriasis, although hydroxychloroquine may precipitate attacks of psoriasis. It may be associated with fever and hyperleukocytosis. Outcome is usually favourable after drug withdrawal.

#### *Musculoskeletal and connective tissue disorders*

*Uncommon:* Sensorymotor disorders

*Not known:*

Skeletal muscle myopathy or neuromyopathy leading to progressive weakness and atrophy of proximal muscle groups.

Myopathy may be reversible after drug discontinuation, but recovery may take many months.

Depression of tendon reflexes and abnormal nerve conduction studies

### **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 preferably through the online reporting option accessible from the IMB homepage. A downloadable report form is also accessible from the IMB website, which may be completed manually and submitted to the IMB via 'freepost', in addition to the traditional post-paid 'yellow card' option.

**FREEPOST**

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## 4.9 Overdose

Overdosage with the 4-aminoquinolines is dangerous particularly in infants, as little as 1-2g having proved fatal.

The symptoms of overdosage may include headache, visual disturbances, cardiovascular collapse, convulsions, hypokalaemia, rhythm and conduction disorders, including QT prolongation, torsade de pointe, ventricular tachycardia and ventricular fibrillation, followed by sudden and potentially fatal respiratory and cardiac arrest. Immediate medical attention is required, as these effects may appear shortly after the overdose. The stomach should be immediately evacuated, either by emesis or by gastric lavage. Activated charcoal in a dose at least five times that of the overdosage may inhibit further absorption if introduced into the stomach by tube, following lavage, and within 30 minutes of ingestion of the overdose.

Consideration should be given to administration of parenteral diazepam in cases of overdosage; it has been shown to be beneficial in reversing chloroquine cardiotoxicity.

Respiratory support and shock management should be instituted as necessary.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Antimalarial agents like chloroquine and hydroxychloroquine have several pharmacological actions which may be involved in their therapeutic effect in the treatment of rheumatic disease, but the role of each is not known. These include interaction with sulphhydryl groups, interference with enzyme activity (including phospholipase, NADH - cytochrome C reductase, cholinesterase, proteases and hydrolases), DNA binding, stabilisation of lysosomal membranes, inhibition of prostaglandin formation, inhibition of polymorphonuclear cell chemotaxis and phagocytosis, possible interference with interleukin 1 production from monocytes and inhibition of neutrophil superoxide release.

### 5.2 Pharmacokinetic properties

Hydroxychloroquine is rapidly absorbed following oral administration. Mean bioavailability is approximately 74%. It is widely distributed throughout the body, accumulating within blood cells and other tissues such as liver, lungs, kidneys and eyes. It is partially converted to active ethylated metabolites in the liver and eliminated principally via the kidney, 23 to 25% unchanged, but also via the bile. Excretion is slow, the terminal elimination half-life being approximately 50 days (whole blood) and 32 days (plasma).

Hydroxychloroquine crosses the placenta and is likely to resemble chloroquine in entering breast milk.

### 5.3 Preclinical safety data

There are no preclinical safety data of relevance to the prescriber, which are additional to that already included in other sections of the SPC.

## 6 PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Lactose monohydrate  
Maize starch

Magnesium stearate  
Povidone

Opadry OY-L-28900, containing:  
Hypromellose  
Macrogol 4000  
Titanium dioxide (E171)  
Lactose monohydrate

## 6.2 Incompatibilities

Not applicable.

## 6.3 Shelf life

The shelf life expiry date of this pack shall be the date shown on the contained 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.

## 6.5 Nature and contents of container

PVC/aluminium foil blisters, 10 tablets per blister, in an over-labelled outer carton.  
Pack size - 60 tablets

## 6.6 Special precautions for disposal and other handling

No special requirements

## 7 PARALLEL PRODUCT AUTHORISATION HOLDER

IMED Healthcare Ltd.  
New Road  
Buncrana  
Co. Donegal  
Ireland

## 8 PARALLEL PRODUCT AUTHORISATION NUMBER

PPA 1463/055/001

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

Date of first authorisation: 30<sup>th</sup> September 2011

## 10 DATE OF REVISION OF THE TEXT

May 2014