

IRISH MEDICINES BOARD ACT 1995, as amended

Medicinal Products (Control of Placing on the Market) Regulations, 2007, as amended

PPA1500/037/001
Case No: 2083758

The Irish Medicines Board in exercise of the powers conferred on it by the above mentioned Regulations hereby grants to

Profind Wholesale Ltd.

Unit 625, Kilshane Avenue, Northwest Business Park, Dublin 15, Ireland

an authorisation, subject to the provisions of the said Regulations, in respect of the product

Adalat LA 20 mg Prolonged-Release Tablet

the particulars of which are set out in the attached Schedule. The authorisation is also subject to the general conditions as may be specified in the said Regulations as listed on the reverse of this document.

This authorisation, unless previously revoked, shall continue in force from **28/07/2010**.

Signed on behalf of the Irish Medicines Board this

A person authorised in that behalf by the said Board.

Part II

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Adalat LA 20 mg Prolonged-Release Tablet

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

One tablet contains 20mg nifedipine.

Excipients: Sodium

For a full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Prolonged-release film coated tablet

Product imported from Italy

Pink, circular convex tablets with Adalat 20 marked on one side.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

For the treatment of mild to moderate hypertension.

For the management of chronic stable angina pectoris either as monotherapy or in combination with a beta-blocker.

4.2 Posology and method of administration

For oral administration, the tablets should be swallowed whole with a glass of water, independently of meals. The tablets should be taken at approximately 24-hour intervals, i.e. at the same time each day, preferably during the morning. Adalat LA tablets must be swallowed whole; under no circumstances should they be bitten, chewed or broken up.

In mild to moderate hypertension, the recommended initial dose is one 20 mg tablet once-daily. If necessary, the dosage can be increased according to individual requirements up to a maximum of 90 mg once-daily.

For the management of angina pectoris, the recommended initial dose is one 30 mg tablet once-daily. The dosage can be increased according to individual requirements up to a maximum of 90 mg once-daily.

Patients in whom hypertension or anginal symptoms are controlled on Adalat capsules or Adalat retard may be safely switched to Adalat LA. Prophylactic anti-anginal efficacy is maintained when patients are switched from other calcium antagonists such as diltiazem or verapamil to Adalat LA. Patients switched from other calcium antagonists should initiate therapy at the recommended initial dose of 30 mg Adalat LA once-daily. Subsequent titration to a higher dose may be initiated as warranted clinically.

The pharmacokinetics of nifedipine are altered in the elderly so that lower maintenance doses of nifedipine may be required compared to younger patients.

Co-administration with CYP 3A4 inhibitors of CYP 3A4 inducers may result in the recommendation to adapt the nifedipine dose or not to use nifedipine at all (see section 4.5).

Patients with renal impairment should not require adjustment of dosage.

Treatment may be continued indefinitely.

Nifedipine is not recommended for use in children.

Adalat LA should not be taken with grapefruit juice (see Section 4.5).

4.3 Contraindications

Adalat LA should not be administered to patients with known hypersensitivity to nifedipine or other dihydropyridines because of the theoretical risk of cross-reactivity.

Adalat LA should not be administered during pregnancy or to nursing mothers.

Adalat LA should not be used in cardiogenic shock, clinically significant aortic stenosis, unstable angina pectoris, or during or within one month of a myocardial infarction.

Adalat LA should not be used for the treatment of acute attacks of angina.

The safety of Adalat LA in malignant hypertension has not been established.

Adalat LA should not be used for secondary prevention of myocardial infarction.

Owing to the duration of action of the formulation, Adalat LA should not be administered to patients with hepatic impairment.

Adalat LA should not be administered to patients with a history of gastro-intestinal obstruction, oesophageal obstruction, or any degree of decreased lumen diameter of the gastro-intestinal tract.

Adalat LA is contra-indicated in patients with inflammatory bowel disease or Crohn's disease.

Adalat LA should not be administered concomitantly with rifampicin since effective plasma levels of nifedipine may not be achieved owing to enzyme induction (see Section 4.5).

4.4 Special warnings and precautions for use

Adalat LA tablets must be swallowed whole; under no circumstances should they be bitten, chewed or broken up.

The outer membrane of the Adalat LA tablet is not digested and, therefore, what appears to be the complete tablet may be seen in the toilet or associated with the patient's stools.

Caution should be exercised in patients with hypotension as there is a risk of further reduction in blood pressure.

Adalat LA may be used in combination with beta-blocking drugs and other antihypertensive agents but the possibility of an additive effect resulting in postural hypotension should be borne in mind. Adalat LA will not prevent possible rebound effects after cessation of other antihypertensive therapy.

Adalat LA should be used with caution in patients whose cardiac reserve is poor. Deterioration of heart failure has occasionally been observed with nifedipine.

Ischaemic pain has been reported in a small proportion of patients following the introduction of nifedipine therapy.

Although a 'steal' effect has not been demonstrated, patients experiencing this effect should discontinue nifedipine therapy.

Diabetic patients taking Adalat LA may require adjustment of their control.

In dialysis patients with malignant hypertension and hypovolaemia, a marked decrease in blood pressure can occur.

There are no safety and efficacy data from well-controlled studies in pregnant women (see section 4.6).

Animal studies have shown a variety of embryotoxic, placentotoxic and fetotoxic effects (see Section 5.3) when administered during and after the period of organogenesis.

Whilst nifedipine is contra-indicated in pregnancy, particular care must be exercised when administering nifedipine in combination with i.v. magnesium sulphate to pregnant women.

Co-administration of nifedipine with erythromycin, ketoconazole, itraconazole, fluconazole, fluoxetine, indinavir, nelfinavir, ritonavir, amprenavir and saquinavir, may theoretically result in an increase in nifedipine plasma concentrations. Upon co-administration with any of these cytochrome P450 3A4 inhibitors, blood pressure should be monitored and, if necessary, a reduction in the nifedipine dose considered (see Section 4.5).

As the outer membrane of the Adalat LA tablet is not digested, care should be exercised as obstructive symptoms may occur, particularly in patients with pre-existing severe gastrointestinal narrowing. Bezoars can occur in very rare cases and may require surgical intervention.

Adalat LA must not be administered to patients with Kock pouch (ileostomy after proctocolectomy).

A false positive effect may be experienced when performing a barium contrast x-ray.

4.5 Interaction with other medicinal products and other forms of interaction

Drugs that affect nifedipine

Nifedipine is metabolised via the cytochrome P450 3A4 system, located both in the intestinal mucosa and in the liver. Drugs that are known to either inhibit or to induce this enzyme system may therefore alter the first pass (after oral administration) or the clearance of nifedipine.

The extent as well as the duration of interactions should be taken into account when administering nifedipine together with the following drugs:

Rifampicin: Rifampicin strongly induces the cytochrome P450 3A4 system. Upon co-administration with rifampicin, the bioavailability of nifedipine is distinctly reduced and thus its efficacy weakened. The use of nifedipine in combination with rifampicin is therefore contraindicated (see section 4.3).

Upon co-administration of weak to moderate inhibitors of the cytochrome P450 3A4 system (listed immediately below), the blood pressure should be monitored and, if necessary, a reduction in the nifedipine dose considered (see Sections 4.2 and 4.4). In the majority of these cases, no formal studies to assess the potential for a drug interaction between nifedipine and the drug(s) listed have been undertaken, thus far.

Macrolide antibiotics (e.g., erythromycin): Certain macrolide antibiotics are known to inhibit the cytochrome P450 3A4 mediated metabolism of other drugs. Therefore the potential for an increase of nifedipine plasma concentrations upon co-administration of both drugs cannot be excluded (see Section 4.4).

Azithromycin, although structurally related to the class of macrolide antibiotics is void of CYP 3A4 inhibition.

Anti-HIV protease inhibitors (e.g., ritonavir): Drugs of this class have been shown to inhibit *in vitro* the cytochrome P450 3A4 mediated metabolism of nifedipine. When administered together with nifedipine, a substantial increase in plasma concentrations of nifedipine due to a decreased first pass metabolism and a decreased elimination cannot be excluded (see Section 4.4).

Azole anti-mycotics (e.g., ketoconazole): Drugs of this class are known to inhibit the cytochrome P450 3A4 system. When administered orally together with nifedipine, a substantial increase in systemic bioavailability of nifedipine due to a decreased first pass metabolism cannot be excluded (see Section 4.4).

Fluoxetine: Fluoxetine has been shown to inhibit *in vitro* the cytochrome P450 3A4 mediated metabolism of nifedipine. Therefore an increase of nifedipine plasma concentrations upon co-administration of both drugs cannot be excluded (see Section 4.4).

Nefazodone: Nefazodone is known to inhibit the cytochrome P450 3A4 mediated metabolism of other drugs. Therefore an increase in nifedipine plasma concentrations upon co-administration of both drugs cannot be excluded (see Section 4.4).

Quinupristin/dalfopristin and cisapride: Simultaneous administration of quinupristin/dalfopristin and nifedipine, or cisapride and nifedipine, may lead to increased plasma concentrations of nifedipine (see Section 4.4).

Valproic acid: As valproic acid has been shown to increase the plasma concentrations of the structurally similar calcium channel blocker, nimodipine, due to enzyme inhibition, an increase in nifedipine plasma concentrations and hence an increase in efficacy cannot be excluded (see Section 4.4).

Cimetidine: Due to its inhibition of cytochrome P450 3A4, cimetidine elevates the plasma concentrations of nifedipine and may potentiate the antihypertensive effect (see Section 4.4).

Diltiazem: Diltiazem decreases the clearance of nifedipine and, hence, increases plasma nifedipine levels. Therefore, caution should be taken when both drugs are used in combination and a reduction of the nifedipine dose may be necessary.

Further studies

Cytochrome P450 3A4 system-inducing anti-epileptic drugs, such as phenytoin, carbamazepine and phenobarbital: phenytoin induces the cytochrome P450 3A4 system. Upon co-administration with phenytoin, the bioavailability of nifedipine is reduced and thus its efficacy weakened. When both drugs are administered concomitantly, the clinical response to nifedipine should be monitored and, if necessary, an increase of the nifedipine dose considered. If the dose of nifedipine is increased during co-administration of both drugs, a reduction of the nifedipine dose should be considered when the treatment with phenytoin is discontinued.

No formal studies have been performed to investigate the potential interaction between nifedipine and carbamazepine or phenobarbital. As both drugs have been shown to reduce the plasma concentrations of the structurally similar calcium channel blocker, nimodipine, due to enzyme induction, a decrease in nifedipine plasma concentrations and hence a decrease in efficacy cannot be excluded.

Effects of nifedipine on other drugs

Nifedipine may increase the blood pressure lowering effect of concomitant applied *antihypertensives*, such as:

- diuretics
- beta-blockers
- ACE-inhibitors
- AT-1 antagonists
- other calcium antagonists
- alpha-adrenergic blocking agents

- PDE5 inhibitors
- alpha-methyldopa

When nifedipine is administered simultaneously with beta-receptor blockers the patient should be carefully monitored, since deterioration of heart failure is also known to develop in isolated cases.

Digoxin: The simultaneous administration of nifedipine and digoxin may lead to reduced digoxin clearance and, hence, an increase in the plasma digoxin level. The patient should therefore be checked for symptoms of digoxin overdosage as a precaution and, if necessary, the glycoside dose should be reduced taking account of the plasma concentration of digoxin.

Quinidine: When nifedipine and quinidine have been administered simultaneously, lowered quinidine levels, or after discontinuation of nifedipine, a distinct increase in plasma concentrations of quinidine, have been observed in individual cases. For this reason, when nifedipine is either additionally administered or discontinued, monitoring of the quinidine plasma concentration, and if necessary, adjustment of the quinidine dose are recommended. Some authors reported increased plasma concentrations of nifedipine upon co-administration of both drugs, while others did not observe an alteration in the pharmacokinetics of nifedipine.

Therefore the blood pressure should be carefully monitored, if quinidine is added to an existing therapy with nifedipine. If necessary, the dose of nifedipine should be decreased.

Tacrolimus: Tacrolimus has been shown to be metabolised via the cytochrome P450 3A4 system. Data recently published indicate that the dose of tacrolimus administered simultaneously with nifedipine may be reduced in individual cases. Upon co-administration of both drugs, the tacrolimus plasma concentrations should be monitored and, if necessary, a reduction in the tacrolimus dose considered.

Drug food interactions

Grapefruit juice inhibits the cytochrome P450 3A4 system. Administration of nifedipine together with grapefruit juice thus results in elevated plasma concentrations and prolonged action of nifedipine due to a decreased first pass metabolism or reduced clearance. As a consequence, the blood pressure lowering effect of nifedipine may be increased. After regular intake of grapefruit juice, this effect may last for at least three days after the last ingestion of grapefruit juice.

Ingestion of grapefruit/grapefruit juice is therefore to be avoided while taking nifedipine (see Section 4.2).

Drugs shown not to interact with nifedipine

The following drugs have been shown to have no effect on the pharmacokinetics of nifedipine when administered concomitantly: ajmaline, aspirin, benazepril, candesartan cilexetil, debrisoquine, doxazosin, irbesartan, omeprazole, orlistat, pantoprazole, ranitidine, rosiglitazone, talinolol and triamterene hydrochlorothiazide.

Other forms of interaction

Nifedipine may increase the spectrophotometric values of urinary vanillylmandelic acid falsely. However, HPLC measurements are unaffected.

4.6 Pregnancy and lactation

Adalat LA is contra-indicated during pregnancy.

Adalat LA should not be used by women who intend to get pregnant in the near future.

The safety of Adalat LA for use in human pregnancy has not been established. Evaluation of experimental animal studies has shown reproductive toxicity consisting of embryotoxicity and teratogenic effects at maternally toxic doses.

Adalat LA is contra-indicated in breastfeeding. Nifedipine passes into the breast milk. As there is no experience of possible effects on infants, breastfeeding should first be stopped if nifedipine treatment becomes necessary during the breastfeeding period.

In single cases of *in vitro* fertilisation calcium antagonists like nifedipine have been associated with reversible biochemical changes in the spermatozoa's head section that may result in impaired sperm function. In those men who are repeatedly unsuccessful in fathering a child by *in vitro* fertilisation, and where no other explanation can be found, calcium antagonists like nifedipine should be considered as possible causes.

4.7 Effects on ability to drive and use machines

Reactions to the drug, which vary in intensity from individual to individual, may impair the ability to drive or to operate machinery. This applies particularly at the start of treatment, on changing the medication and in combination with alcohol.

4.8 Undesirable effects

Adverse drug reactions (ADRs) based on placebo-controlled studies with nifedipine sorted by CIOMS III categories of frequency (clinical trial data base: nifedipine n = 2,661; placebo n = 1,486; status: 22 Feb 2006 and the ACTION study: nifedipine n = 3,825; placebo n = 3,840) are listed below:

ADRs listed under "common" were observed with a frequency below 3% with the exception of oedema (9.9%) and headache (3.9%). ADRs derived from post marketing reports (status:15 Feb 2006) are printed in ***bold italic***.

Clinical Description	Common ≥1% to <10%	Uncommon >0.1% to <1%	Rare >0.01% to <0.1%	Very Rare <0.01%
<u>Immune System Disorder</u>				
Acute hypersensitivity reactions		Allergic reaction Allergic oedema/angioedema	Pruritus Urticaria Rash	<i>Anaphylactic/ anaphylactoid reaction</i>
<u>Psychiatric Disorders</u>				
Behavioural disturbances and sleep disorders		Anxiety reactions Sleep disorders		
<u>Nervous System Disorders</u>				
Unspecific cerebrovascular symptoms	Headache	Vertigo Migraine		
Unspecific neurological symptoms		Dizziness Tremor		
Unspecific altered peripheral perception			Par/dysaesthesia	
<u>Eye Disorders</u>				
Unspecific eye disorders		Visual disturbances		
<u>Cardiac Disorders</u>				
Unspecific arrhythmias		Tachycardia Palpitations		
<u>Vascular Disorders</u>				
Unspecific vascular symptoms	Oedema Vasodilatation	Hypotension Syncope		

<u>Respiratory Disorders</u>				
Upper respiratory tract symptoms		Nosebleed Nasal congestion		<i>Dyspnoea</i>
<u>Gastrointestinal Disorders</u>				
Gastro-intestinal symptoms	Constipation	Gastrointestinal and abdominal pain Nausea Dyspepsia Flatulence Dry mouth	Gingival hyperplasia	<i>Bezoar Dysphagia Intestinal obstruction Intestinal ulcer Vomiting</i>
<u>Hepatobiliary Disorders</u>				
Mild to moderate hepatic reactions		Transient increase in liver enzymes		
<u>Skin and Subcutaneous Tissue Disorders</u>				
Unspecific skin reactions		Erythema		
<u>Musculoskeletal and Connective Tissue Disorders</u>				
Unspecific joint and muscular disorders		Muscle cramps Joint swelling		
<u>Renal and Urinary Disorders</u>				
Urinary disorders		Polyuria Dysuria		
<u>Reproductive System Disorders</u>				
Sexual dysfunction		Erectile dysfunction		
<u>General Disorders and Administration Site Conditions</u>				
General feeling of illness	Feeling unwell	Unspecific pain Chills		

In dialysis patients with malignant hypertension and hypovolaemia a distinct fall in blood pressure can occur as a result of vasodilation.

4.9 Overdose

Symptoms

The following symptoms are observed in cases of severe nifedipine intoxication:

Disturbances of consciousness to the point of coma, a drop in blood pressure, tachycardiac/bradycardiac heart rhythm disturbances, hyperglycaemia, metabolic acidosis, hypoxia, cardiogenic shock with pulmonary oedema.

Treatment

As far as treatment is concerned, elimination of the active substance and the restoration of stable cardiovascular conditions have priority.

After oral ingestion, thorough gastric lavage is indicated, if necessary in combination with irrigation of the small intestine.

Particularly in cases of intoxication with slow-release products like Adalat LA, elimination must be as complete as possible, including the small intestine, to prevent the otherwise inevitable subsequent absorption of the active substance.

Haemodialysis serves no purpose, as nifedipine is not dialysable, but plasmapheresis is advisable (high plasma protein binding, relatively low volume of distribution).

Hypotension as a result of cardiogenic shock and arterial vasodilatation can be treated with calcium (10-20 ml of a 10 % calcium gluconate solution administered slowly I.V. and repeated if necessary). As a result the serum calcium can reach the upper normal range to slightly elevated levels. If an insufficient increase in blood pressure is achieved with calcium, vasoconstricting sympathomimetics such as dopamine or noradrenaline should be administered. The dosage of these drugs should be determined solely by the patient's response.

Symptomatic bradycardia may be treated with beta-sympathomimetics, and in life-threatening bradycardiac disturbances of heart rhythm, temporary cardiac pacemaker therapy can be advisable.

Additional liquid or volume must be administered with caution because of the danger of overloading the heart.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

ATC code: C08CA05

Nifedipine is a calcium antagonist of the 1,4-dihydropyridine type. Calcium antagonists reduce the transmembranal influx of calcium ions through the slow calcium channel into the cell. As a specific and potent calcium antagonist, nifedipine acts particularly on the cells of the myocardium and the smooth muscle cells of the coronary arteries and the peripheral resistance vessels. The main action of nifedipine is to relax arterial smooth muscle, both in the coronary and peripheral circulation. The Adalat LA tablet is formulated to achieve controlled delivery of nifedipine in a release profile sufficient to enable once-daily administration to be effective in clinical use.

In hypertension, the main action of nifedipine is to cause peripheral vasodilatation and thus reduce peripheral resistance. Nifedipine administered once-daily provides 24-hour control of raised blood pressure. Nifedipine causes reduction in blood pressure such that the percentage lowering is proportional to its initial level. In normotensive individuals, nifedipine has little or no effect on blood pressure.

In angina, Adalat LA reduces peripheral and coronary vascular resistance, leading to an increase in coronary blood flow, cardiac output and stroke volume, whilst decreasing after-load. Additionally, nifedipine dilates submaximally both clear and atherosclerotic coronary arteries, thus protecting the heart against coronary artery spasm and improving perfusion to the ischaemic myocardium. Nifedipine reduces the frequency of painful attacks and the ischaemic ECG changes irrespective of the relative contribution from coronary artery spasm or atherosclerosis.

In a multi-national, randomised, double-blind, prospective study involving 6321 hypertensive patients with at least one additional risk factor followed over 3 to 4.8 years, Adalat LA 30 and 60 (nifedipine GITS) were shown to reduce cardiovascular and cerebrovascular events to a comparable degree as a standard diuretic combination.

In the multicentre, randomized, placebo-controlled, double-blind ACTION trial with a follow-up of 5 years involving 7665 patients with stable angina pectoris on best practice standard treatment. The effects on clinical outcomes of nifedipine LA vs placebo were investigated.

The primary endpoint for efficacy (combined rate of death from any cause, acute myocardial infarction, refractory angina, new overt heart failure, debilitating stroke, and peripheral revascularization) did not differ between patients assigned nifedipine LA (n= 3825) and patients allocated placebo (n=3840) ($P=0.54$).

In a predefined subgroup analysis which included 3997 angina patients with hypertension at baseline nifedipine LA led to a significant 13% reduction of the primary endpoint for efficacy.

Nifedipine LA has been demonstrated to be safe as the primary endpoint for safety (combined rate of death from any cause, acute myocardial infarction, and debilitating stroke) was similar in both treatment groups ($P=0.86$).

Nifedipine LA had a positive effect on two of the three predefined secondary endpoints. The combined rate of death, major cardiovascular events, revascularization, and coronary angiography (CAG) was reduced by 11% ($P=0.0012$), the main reason being the pronounced reduction in the need for coronary angiography. There were 150 fewer CAGs as the first event in the nifedipine group when compared to placebo. Any vascular event was reduced by 9% ($P=0.027$), the main reason being the reduced need for percutaneous coronary interventions and bypass surgery. In total, there were 89 fewer procedures as first events in the nifedipine group compared to placebo. The outcome of the third secondary endpoint 'major cardiovascular event' did not show differences between the two treatment groups ($P=0.26$).

5.2 Pharmacokinetic properties

General characteristics:

Adalat La tablets are formulated to provide nifedipine at an approximately constant rate over 24 hours. Nifedipine is released from the tablet at a zero-order rate by a membrane-controlled, osmotic push-pull process. The pharmacokinetic profile of this formulation is characterized by low peak-trough fluctuation. 0-24 hour plasma concentration versus time profiles at steady-state are plateau-like, rendering the Adalat LA tablet appropriate for once-a-day administration.

The delivery rate is independent of gastrointestinal pH or motility. Upon swallowing, the biologically inert components of the tablet remain intact during gastrointestinal transit and are eliminated in the faeces as an insoluble shell.

Orally administered nifedipine is almost completely absorbed in the gastro-intestinal tract. The systemic availability of orally administered nifedipine immediate release formulations (nifedipine capsules) is 45-56% owing to a first pass effect. At steady-state, the bioavailability of Adalat LA tablets ranges from 68-86% relative to Adalat capsules. Administration in the presence of food slightly alters the early rate of absorption but does not influence the extent of drug availability.

Nifedipine is about 95% bound to plasma protein (albumin). The distribution half-life after intravenous administration has been determined to be 5 to 6 minutes.

After oral administration nifedipine is metabolised in the gut wall and in the liver primarily by oxidative processes. These metabolites show no pharmacodynamic activity. Nifedipine is eliminated in the form of its metabolites, predominantly via the kidneys, with approximately 5-15% being excreted via the bile in the faeces. Non-metabolised nifedipine can be detected only in traces (below 1.0%) in the urine.

The terminal elimination half-life is 1.7 to 3.4h in conventional formulations (nifedipine capsules). The terminal half-life following Adalat LA administration does not represent a meaningful parameter as a plateau-like plasma concentration is maintained during release from the tablets and absorption.

Characteristics in patients:

There are no significant differences in the pharmacokinetics of nifedipine between healthy subjects and subjects with renal impairment. Therefore, dosage adjustment is not needed in these patients.

In patients with hepatic impairment, the elimination half-life is distinctly prolonged and the total clearance is reduced. Owing to the duration of action of the formulation, Adalat LA should not be administered in these patients.

5.3 Preclinical safety data

Preclinical data reveal no special hazard for humans based on conventional studies of single and repeated dose toxicity, genotoxicity and carcinogenic potential.

Following acute oral and intravenous administration of nifedipine in various animal species, the following LD₅₀ (mg/kg) values were obtained:

Mouse:	Oral: 494 (421-572)*;	i.v.: 4.2 (3.8-4.6)*.
Rat:	Oral: 1022 (950-1087)*;	i.v.: 15.5 (13.7-17.5)*.
Rabbit:	Oral: 250-500;	i.v.: 2-3.
Cat:	Oral: ~ 100;	i.v.: 0.5-8.
Dog:	Oral: > 250;	i.v.: 2-3.

* 95% confidence interval.

In subacute and subchronic toxicity studies in rats and dogs, nifedipine was tolerated without damage at doses of up to 50 mg/kg (rats) and 100 mg/kg (dogs) p.o. over periods of thirteen and four weeks, respectively. Following intravenous administration, dogs tolerated up to 0.1 mg/kg nifedipine for six days without damage. Rats tolerated daily intravenous administration of 2.5 mg/kg nifedipine over a period of three weeks without damage.

In chronic toxicity studies in dogs with treatment lasting up to one year, nifedipine was tolerated without damage at doses up to and including 100 mg/kg p.o. In rats, toxic effects occurred at concentrations above 100 ppm in the feed (approximately 5-7 mg/kg bodyweight).

In a carcinogenicity study in rats (two years), there was no evidence of a carcinogenic effect of nifedipine.

Nifedipine has been shown to produce teratogenic findings in rats, mice and rabbits, including digital anomalies, malformation of the extremities, cleft palates, cleft sternum, and malformation of the ribs.

Digital anomalies and malformation of the extremities are possibly a result of compromised uterine blood flow, but have also been observed in animals treated with nifedipine solely after the end of the organogenesis period.

Nifedipine administration was associated with a variety of embryotoxic, placentotoxic and fetotoxic effects, including stunted fetuses (rats, mice, rabbits), small placentas and underdeveloped chorionic villi (monkeys), embryonic and fetal deaths (rats, mice, rabbits) and prolonged pregnancy/decreased neonatal survival (rats; not evaluated in other species). All of the doses associated with the teratogenic, embryotoxic or fetotoxic effects in animals were maternally toxic and several times the recommended maximum dose for humans.

In *in vitro* and *in vivo* tests, nifedipine has not been associated with mutagenic properties.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet Core

Polyethylene oxide
 Hypromellose
 Magnesium Stearate
 Sodium chloride
 Ferric oxide, red (E172)

Tablet Coating

Hypromellose
 Ferric oxide, red (E172)
 Cellulose acetate
 Macrogol
 Hydroxypropylcellulose
 Titanium dioxide (E171)
 Propylene glycol

Black Printing Ink

6.2 Incompatibilities

Not applicable.

6.3 Shelf Life

The shelf-life expiry date of this product is the date shown on the blister strips and outer carton of the product as marketed in the country of origin.

6.4 Special precautions for storage

Store in the original container. The tablets should be protected from strong light. Do not store above 30°C.

6.5 Nature and contents of container

Re-packaged cardboard carton containing four blister strips (7 tablets per strip).
Pack size: 28

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

Profind Wholesale Ltd
Unit 625, Kilshane Avenue
Northwest Business Park
Dublin 15
Ireland

8 PARALLEL PRODUCT AUTHORISATION NUMBER

PPA 1500/037/001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 8th January 2010

10 DATE OF REVISION OF THE TEXT

July 2010