

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Olmesartan Medoxomil Clonmel 40 mg film-coated tablet

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 40 mg olmesartan medoxomil

Excipients with known effect

Each film-coated tablet contains 141.00 mg lactose monohydrate

For the full list of excipients, see section 6.1

## 3 PHARMACEUTICAL FORM

Film-coated tablet.

White, oval, biconvex film-coated tablets with a length of 15 mm and a width of 6 mm.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic Indications

Treatment of essential hypertension.

### 4.2 Posology and method of administration

#### Posology:

##### **Adults**

The recommended starting dose of olmesartan medoxomil is 10 mg once daily. In patients whose blood pressure is not adequately controlled at this dose, the dose of olmesartan medoxomil may be increased to 20 mg once daily as the optimal dose. If additional blood pressure reduction is required, olmesartan medoxomil dose may be increased to a maximum of 40 mg daily or hydrochlorothiazide therapy may be added.

The antihypertensive effect of olmesartan medoxomil is substantially present within 2 weeks of initiating therapy and is maximal by about 8 weeks after initiating therapy. This should be borne in mind when considering changing the dose regimen for any patient.

##### **Older people (65 years or older)**

No adjustment of dosage is generally required in older people (see below for dose recommendations in patients with renal impairment). If up-titration to the maximum dose of 40 mg daily is required, blood pressure should be closely monitored.

##### **Renal impairment**

The maximum dose in patients with mild to moderate renal impairment (creatinine clearance of 20 – 60 mL/min) is 20 mg olmesartan medoxomil once daily, owing to limited experience of higher dosages in this patient group. The use of olmesartan medoxomil in patients with severe renal impairment (creatinine clearance < 20 mL/min) is not recommended, since there is only limited experience in this patient group (see sections 4.4 and 5.2).

##### **Hepatic impairment**

No adjustment of dosage recommendations is required for patients with mild hepatic impairment. In patients with moderate hepatic impairment, an initial dose of 10 mg olmesartan medoxomil once daily is recommended and the

maximum dose should not exceed 20 mg once daily. Close monitoring of blood pressure and renal function is advised in hepatically-impaired patients who are already receiving diuretics and/or other antihypertensive agents. There is no experience of olmesartan medoxomil in patients with severe hepatic impairment, therefore use is not recommended in this patient group (see sections 4.4 and 5.2). Olmesartan medoxomil should not be used in patients with biliary obstruction (see section 4.3).

### **Paediatric population**

The safety and efficacy of olmesartan in children and adolescents below 18 years has not been established. Currently available data are described in section 4.8, 5.1 and 5.2 but no recommendation on a posology can be made.

Olmesartan medoxomil should not be used in children below 1 years of age because of safety concerns and lack of data in this age group.

### **Method of administration:**

In order to assist compliance, it is recommended that olmesartan tablets be taken at about the same time each day, with or without food, for example at breakfast time. The tablet should be swallowed with a sufficient amount of fluid (e.g. one glass of water). The tablet should not be chewed.

## **4.3 Contraindications**

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Second and third trimesters of pregnancy (see sections 4.4 and 4.6).
- Biliary obstruction (see section 5.2).
- The concomitant use of Olmesartan Medoxomil Clonmel with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment ( $\text{GFR} < 60 \text{ ml/min/1.73 m}^2$ ) (see sections 4.5 and 5.1).

## **4.4 Special warnings and precautions for use**

### **Intravascular volume depletion:**

Symptomatic hypotension, especially after the first dose, may occur in patients who are volume and/or sodium depleted by vigorous diuretic therapy, dietary salt restriction, diarrhoea or vomiting. Such conditions should be corrected before the administration of olmesartan medoxomil.

### **Other conditions with stimulation of the renin-angiotensin-aldosterone system:**

In patients whose vascular tone and renal function depend predominantly on the activity of the renin-angiotensin-aldosterone system (e.g. patients with severe congestive heart failure or underlying renal disease, including renal artery stenosis), treatment with other drugs that affect this system has been associated with acute hypotension, azotaemia, oliguria or, rarely, acute renal failure. The possibility of similar effects cannot be excluded with angiotensin II receptor antagonists.

### **Renovascular hypertension:**

There is an increased risk of severe hypotension and renal insufficiency when patients with bilateral renal artery stenosis or stenosis of the artery to a single functioning kidney are treated with medicinal products that affect the renin-angiotensin-aldosterone system.

### **Renal impairment and kidney transplantation:**

When olmesartan medoxomil is used in patients with impaired renal function, periodic monitoring of serum potassium and creatinine levels is recommended. Use of olmesartan medoxomil is not recommended in patients with severe renal impairment (creatinine clearance  $< 20 \text{ mL/min}$ ) (see sections 4.2, 5.2).

There is no experience of the administration of olmesartan medoxomil in patients with a recent kidney transplant or in patients with end-stage renal impairment (i.e. creatinine clearance  $< 12 \text{ mL/min}$ ).

### **Hepatic impairment:**

There is no experience in patients with severe hepatic impairment and therefore use of olmesartan medoxomil in this patient group is not recommended (see section 4.2 for dosage recommendations in patients with mild or moderate

hepatic impairment).

**Hyperkalaemia:**

The use of medicinal products that affect the renin-angiotensin-aldosterone system may cause hyperkalaemia. The risk, that may be fatal, is increased in elderly, in patients with renal insufficiency and in diabetic patients, in patients concomitantly treated with other medicinal products that may increase potassium levels, and/or in patients with intercurrent events.

Before considering the concomitant use of medicinal products that affect the renin-angiotensin-aldosterone system, the benefit risk ratio should be evaluated and other alternatives considered (see also below section “Dual blockade of the renin-angiotensin-aldosterone system (RAAS)”).

The main risk factors for hyperkalaemia to be considered are:

- Diabetes, renal impairment, age (> 70 years)
- Combination with one or more other medicinal products that affect the renin-angiotensin-aldosterone system and/or potassium supplements. Some medicinal products or therapeutic class of medicinal products may provoke a hyperkalaemia: salt substitutes containing potassium, potassium-sparing diuretics, ACE inhibitors, angiotensin II receptors antagonists, non-steroidal anti-inflammatory drugs (including selective COX-2 inhibitors), heparin, immuno-suppressor as ciclosporin or tacrolimus, trimethoprim.
- Intercurrent events, in particular dehydration, acute cardiac decompensation, metabolic acidosis, worsening of renal function, sudden worsening of the renal condition (e.g. infectious diseases), cellular lysis (e.g. acute limb ischemia, rhabdomyolysis, extended trauma).

Close-monitoring of serum potassium in at risk patients is recommended (see section 4.5).

**Dual blockade of the renin-angiotensin-aldosterone system (RAAS):**

There is evidence that the concomitant use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren increases the risk of hypotension, hyperkalaemia and decreased renal function (including acute renal failure). Dual blockade of RAAS through the combined use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren is therefore not recommended (see sections 4.5 and 5.1).

If dual blockade therapy is considered absolutely necessary, this should only occur under specialist supervision and subject to frequent close monitoring of renal function, electrolytes and blood pressure.

ACE-inhibitors and angiotensin II receptor blockers should not be used concomitantly in patients with diabetic nephropathy.

**Lithium:**

As with other angiotensin-II receptor antagonists, the combination of lithium and olmesartan medoxomil is not recommended (see section 4.5).

**Aortic or mitral valve stenosis; obstructive hypertrophic cardiomyopathy:**

As with other vasodilators, special caution is indicated in patients suffering from aortic or mitral valve stenosis, or obstructive hypertrophic cardiomyopathy.

**Primary aldosteronism:**

Patients with primary aldosteronism generally will not respond to antihypertensive drugs acting through inhibition of the renin-angiotensin system. Therefore, the use of olmesartan medoxomil is not recommended in such patients.

**Sprue-like enteropathy:**

In very rare cases severe, chronic diarrhoea with substantial weight loss has been reported in patients taking olmesartan few months to years after drug initiation, possibly caused by a localised delayed hypersensitivity reaction. Intestinal biopsies of patients often demonstrated villous atrophy. If a patient develops these symptoms during treatment with olmesartan, exclude other aetiologies. Consider discontinuation of olmesartan medoxomil in cases where no other aetiology is identified. In cases where symptoms disappear and sprue-like enteropathy is confirmed by biopsy, treatment with olmesartan medoxomil should not be restarted.

**Ethnic differences:**

As with all other angiotensin II antagonists, the blood pressure lowering effect of olmesartan medoxomil is somewhat less in black patients than in non-black patients, possibly because of a higher prevalence of low-renin status in the black hypertensive population.

**Pregnancy:**

Angiotensin II antagonists should not be initiated during pregnancy. Unless continued angiotensin II antagonists therapy is considered essential, patients planning pregnancy should be changed to alternative anti-hypertensive treatments which have an established safety profile for use in pregnancy. When pregnancy is diagnosed, treatment with angiotensin II antagonists should be stopped immediately, and, if appropriate, alternative therapy should be started (see sections 4.3 and 4.6).

**Other:**

As with any antihypertensive agent, excessive blood pressure decrease in patients with ischaemic heart disease or ischaemic cerebrovascular disease could result in a myocardial infarction or stroke.

This medicinal product contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp-lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

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

Interaction studies have only been performed in adults.

**Effects of other medicinal products on olmesartan medoxomil:***Other antihypertensive medications:*

The blood pressure lowering effect of olmesartan medoxomil can be increased by concomitant use of other antihypertensive medications.

*ACE-inhibitors, angiotensin II receptor blockers or aliskiren:*

Clinical trial data has shown that dual blockade of the renin-angiotensin-aldosterone-system (RAAS) through the combined use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren is associated with a higher frequency of adverse events such as hypotension, hyperkalaemia and decreased renal function (including acute renal failure) compared to the use of a single RAAS-acting agent (see sections 4.3, 4.4 and 5.1).

*Potassium supplements and potassium sparing diuretics:*

Based on experience with the use of other drugs that affect the renin-angiotensin system, concomitant use of potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium or other drugs that may increase serum potassium levels (e.g. heparin) may lead to increases in serum potassium (see section 4.4). Such concomitant use is therefore not recommended.

*Non-steroidal anti-inflammatory drugs (NSAIDs):*

NSAIDs (including acetylsalicylic acid at doses > 3 g/day and also COX-2 inhibitors) and angiotensin-II receptor antagonists may act synergistically by decreasing glomerular filtration. The risk of the concomitant use of NSAIDs and angiotensin II antagonists is the occurrence of acute renal failure.

Monitoring of renal function at the beginning of treatment should be recommended as well as regular hydration of the patient.

Additionally, concomitant treatment can reduce the antihypertensive effect of angiotensin II receptor antagonists, leading to their partial loss of efficacy.

*Bile acid sequestering agent colesevelam:*

Concurrent administration of the bile acid sequestering agent colesevelam hydrochloride reduces the systemic exposure and peak plasma concentration of olmesartan and reduces  $t_{1/2}$ . Administration of olmesartan medoxomil at least 4 hours prior to colesevelam hydrochloride decreased the drug interaction effect. Administering olmesartan medoxomil at least 4 hours before the colesevelam hydrochloride dose should be considered (see section 5.2).

*Other compounds:*

After treatment with antacid (aluminium magnesium hydroxide), a modest reduction in bioavailability of olmesartan was observed. Coadministration of warfarin and digoxin had no effect on the pharmacokinetics of olmesartan.

**Effects of olmesartan medoxomil on other medicinal products:***Lithium:*

Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with angiotensin converting enzyme inhibitors and angiotensin II antagonists. Therefore use of olmesartan medoxomil and lithium in combination is not recommended (see section 4.4). If use of the combination proves necessary, careful monitoring of serum lithium levels is recommended.

*Other compounds:*

Compounds which have been investigated in specific clinical studies in healthy volunteers include warfarin, digoxin, an antacid (magnesium aluminium hydroxide), hydrochlorothiazide and pravastatin. No clinically relevant interactions were observed and in particular olmesartan medoxomil had no significant effect on the pharmacokinetics or pharmacodynamics of warfarin or the pharmacokinetics of digoxin.

Olmesartan had no clinically relevant inhibitory effects on *in vitro* human cytochrome P450 enzymes 1A1/2, 2A6, 2C8/9, 2C19, 2D6, 2E1 and 3A4, and had no or minimal inducing effects on rat cytochrome P450 activities. Therefore *in vivo* interaction studies with known cytochrome P450 enzyme inhibitors and inducers were not conducted, and no clinically relevant interactions between olmesartan and drugs metabolised by the above cytochrome P450 enzymes are expected.

**4.6 Fertility, pregnancy and lactation****Pregnancy**

The use of angiotensin II receptor antagonists is not recommended during the first trimester of pregnancy (see section 4.4). The use of angiotensin II receptor antagonists is contraindicated during the 2nd and 3rd trimester of pregnancy (see sections 4.3 and 4.4).

Epidemiological evidence regarding the risk of teratogenicity following exposure to ACE inhibitors during the first trimester of pregnancy has not been conclusive; however a small increase in risk cannot be excluded. *Whilst there is no controlled epidemiological data on the risk with angiotensin II antagonists, similar risks may exist for this class of drugs.* Unless continued angiotensin receptor blocker therapy is considered essential, patients planning pregnancy should be changed to alternative anti-hypertensive treatments which have an established safety profile for use in pregnancy. When pregnancy is diagnosed, treatment with angiotensin II antagonists should be stopped immediately, and, if appropriate, alternative therapy should be started.

Angiotensin II antagonists therapy exposure during the second and third trimesters is known to induce human fetotoxicity (decreased renal function, oligohydramnios, skull ossification retardation) and neonatal toxicity (renal failure, hypotension, hyperkalaemia). (See also section 5.3).

Should exposure to angiotensin II antagonists have occurred from the second trimester of pregnancy, ultrasound check of renal function and skull is recommended. Infants whose mothers have taken angiotensin II antagonists should be closely observed for hypotension (see also sections 4.3 and 4.4).

**Breastfeeding**

Olmesartan is excreted in the milk of lactating rats but it is not known whether olmesartan is excreted in human milk. Because no information is available regarding the use of olmesartan during breastfeeding, olmesartan is not recommended and alternative treatments with better established safety profiles during breastfeeding are preferable, especially while nursing a newborn or preterm infant.

## 4.7 Effects on ability to drive and use machines

Olmesartan has minor or moderate influence on the ability to drive and use machines. Dizziness or fatigue may occasionally occur in patients taking antihypertensive therapy, which may impair the ability to react.

## 4.8 Undesirable effects

### Summary of the safety profile:

The most commonly reported adverse reactions during treatment with olmesartan are headache (7.7 %), influenza-like symptoms (4.0 %) and dizziness (3.7 %).

In placebo-controlled monotherapy studies, the only adverse drug reaction that was unequivocally related to treatment was dizziness (2.5 % incidence on olmesartan medoxomil and 0.9 % on placebo).

The incidence was also somewhat higher on olmesartan medoxomil compared with placebo for hypertriglyceridaemia (2.0 % versus 1.1 %) and for raised creatine phosphokinase (1.3 % versus 0.7 %).

### Tabulated list of adverse reactions:

Adverse reactions from olmesartan in clinical trials, post-authorisation safety studies and spontaneous reporting are summarized in the below table.

The following terminologies have been used in order to classify the occurrence of adverse reactions 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 ( $<1/10,000$ ).

#### Blood and lymphatic system disorders

Uncommon: Thrombocytopenia

#### Immune system disorders

Uncommon: Anaphylactic reaction

#### Metabolism and nutrition disorders

Common: Hypertriglyceridaemia, Hyperuricaemia

Rare: Hyperkalaemia

#### Nervous system disorders

Common: Dizziness, Headache

#### Ear and labyrinth disorders

Uncommon: Vertigo

#### Cardiac disorders

Uncommon: Angina pectoris

#### Vascular disorders

Rare: Hypotension

#### Respiratory, thoracic and mediastinal disorders

Common: Bronchitis, Pharyngitis, Cough, Rhinitis

#### Gastrointestinal disorders

Common: Gastroenteritis, Diarrhoea, Abdominal pain, Nausea, Dyspepsia

Uncommon: Vomiting

Very rare: Sprue-like enteropathy (see section 4.4)

#### Skin and subcutaneous tissue disorders

Uncommon: Exanthema, Allergic dermatitis, Urticaria, Rash, Pruritus

Rare: Angioedema

### Musculoskeletal and connective tissue disorders

Common: Arthritis, Back pain, Skeletal pain

Uncommon: Myalgia

Rare: Muscle spasm

### Renal and urinary disorders

Common: Haematuria, Urinary tract infection

Rare: Acute renal failure, Renal insufficiency

### General disorders and administration site conditions

Common: Pain, Chest pain, Peripheral oedema, Influenza-like symptoms, Fatigue

Uncommon: Face oedema, Asthenia, Malaise

Rare: Lethargy

### Investigations

Common: Hepatic enzymes increased, Blood urea increased, Blood creatine phosphokinase increased

Rare: Blood creatinine increased

Single cases of rhabdomyolysis have been reported in temporal association with the intake of angiotensin II receptor blockers.

### Additional information on special populations

#### *Paediatric population*

The safety of olmesartan medoxomil was monitored in 361 children and adolescents, aged 1-17 years old during 2 clinical trials. Whilst the nature and severity of the adverse events are similar to that of the adults, the frequency of the following is higher in the children:

- Epistaxis is a common adverse event in children (i.e.  $\geq 1/100$  to  $< 1/10$ ) that has not been reported in adults.
- During the 3 weeks of double blind study, the incidence of treatment emergent dizziness and headache nearly doubled in children 6-17 years of age in the high olmesartan medoxomil dose group.

The overall safety profile for olmesartan medoxomil in paediatric patients does not differ significantly from the safety profile in adults.

#### *Elderly (age 65 years or over)*

In older people the frequency of hypotension is slightly increased from rare to uncommon.

### 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**

Only limited information is available regarding overdosage in humans. The most likely effect of overdosage is hypotension. In the event of overdosage, the patient should be carefully monitored and treatment should be symptomatic and supportive.

No information is available regarding the dialysability of olmesartan.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Angiotensin II antagonists, ATC code: C09C A 08.

#### Mechanism of action / Pharmacodynamic effects

Olmесartan medoxomil is a potent, orally active, selective angiotensin II receptor (type AT1) antagonist. It is expected to block all actions of angiotensin II mediated by the AT1 receptor, regardless of the source or route of synthesis of angiotensin II. The selective antagonism of the angiotensin II (AT1) receptors results in increases in plasma renin levels and angiotensin I and II concentrations, and some decrease in plasma aldosterone concentrations.

Angiotensin II is the primary vasoactive hormone of the renin-angiotensin-aldosterone system and plays a significant role in the pathophysiology of hypertension via the type 1 (AT1) receptor.

#### Clinical efficacy and safety

In hypertension, olmesartan medoxomil causes a dose-dependent, long-lasting reduction in arterial blood pressure. There has been no evidence of first-dose hypotension, of tachyphylaxis during long-term treatment, or of rebound hypertension after cessation of therapy.

Once daily dosing with olmesartan medoxomil provides an effective and smooth reduction in blood pressure over the 24 hour dose interval. Once daily dosing produced similar decreases in blood pressure as twice daily dosing at the same total daily dose.

With continuous treatment, maximum reductions in blood pressure are achieved by 8 weeks after the initiation of therapy, although a substantial proportion of the blood pressure lowering effect is already observed after 2 weeks of treatment. When used together with hydrochlorothiazide, the reduction in blood pressure is additive and coadministration is well tolerated.

The effect of olmesartan on mortality and morbidity is not yet known.

The Randomised Olmesartan and Diabetes Microalbuminuria Prevention (ROADMAP) study in 4447 patients with type 2 diabetes, normo-albuminuria and at least one additional cardiovascular risk factor, investigated whether treatment with olmesartan could delay the onset of microalbuminuria. During the median follow-up duration of 3.2 years, patients received either olmesartan or placebo in addition to other antihypertensive agents, except ACE inhibitors or ARBs.

For the primary endpoint, the study demonstrated a significant risk reduction in the time to onset of microalbuminuria, in favour of olmesartan. After adjustment for BP differences this risk reduction was no longer statistically significant. 8.2 % (178 of 2160) of the patients in the olmesartan group and 9.8 % (210 of 2139) in the placebo group developed microalbuminuria.

For the secondary endpoints, cardiovascular events occurred in 96 patients (4.3 %) with olmesartan and in 94 patients (4.2 %) with placebo. The incidence of cardiovascular mortality was higher with olmesartan compared to placebo treatment (15 patients (0.7 %) vs. 3 patients (0.1 %)), despite similar rates for non-fatal stroke (14 patients (0.6 %) vs. 8 patients (0.4 %)), non-fatal myocardial infarction (17 patients (0.8 %) vs. 26 patients (1.2 %)) and non-cardiovascular mortality (11 patients (0.5 %) vs. 12 patients (0.5 %)). Overall mortality with olmesartan was numerically increased (26 patients (1.2 %) vs. 15 patients (0.7 %)), which was mainly driven by a higher number of fatal cardiovascular events.

The Olmesartan Reducing Incidence of End-stage Renal Disease in Diabetic Nephropathy Trial (ORIENT) investigated the effects of olmesartan on renal and cardiovascular outcomes in 577 randomised Japanese and Chinese type 2 diabetic patients with overt nephropathy. During a median follow-up of 3.1 years, patients received either olmesartan or placebo in addition to other antihypertensive agents including ACE inhibitors.

The primary composite endpoint (time to first event of the doubling of serum creatinine, end-stage renal disease, all-cause death) occurred in 116 patients in the olmesartan group (41.1 %) and 129 patients in the placebo group (45.4 %) (HR 0.97 (95 % CI 0.75 to 1.24); p=0.791). The composite secondary cardiovascular endpoint occurred in 40 olmesartan-treated patients (14.2 %) and 53 placebo-treated patients (18.7 %). This composite cardiovascular endpoint



included cardiovascular death in 10 (3.5 %) patients receiving olmesartan versus 3 (1.1 %) receiving placebo, overall mortality 19 (6.7 %) versus 20 (7.0 %), non-fatal stroke 8 (2.8 %) versus 11 (3.9 %) and non-fatal myocardial infarction 3 (1.1 %) versus 7 (2.5 %), respectively.

### Paediatric population

The antihypertensive effects of olmesartan medoxomil in the paediatric population were evaluated in a randomised, double-blind, placebo-controlled study in 302 hypertensive patients aged 6 to 17 years. The study population consisted of an all black cohort of 112 patients and a mixed racial cohort of 190 patients, including 38 blacks. The aetiology of the hypertension was predominantly essential hypertension (87 % of the black cohort and 67 % of the mixed cohort). Patients who weighed 20 to < 35 kg were randomised to 2.5 mg (low dose) or 20 mg (high dose) of olmesartan medoxomil once daily and patients who weighed  $\geq$  35 kg were randomized to 5 mg (low dose) or 40 mg (high dose) of olmesartan medoxomil once daily. Olmesartan medoxomil significantly reduced both systolic and diastolic blood pressure in a weight-adjusted dose-dependent manner. Olmesartan medoxomil at both low and high doses significantly reduced systolic blood pressure by 6.6 and 11.9 mmHg from the baseline, respectively. This effect was also observed during the 2 weeks randomised withdrawal phase, whereby both mean systolic and diastolic blood pressures demonstrated a statistically significant rebound in the placebo group compared to olmesartan medoxomil group. The treatment was effective in both, paediatric patients with primary and secondary hypertension. As observed in adult populations, the blood pressure reductions were smaller in black patients.

In the same study, 59 patients aged 1 to 5 years who weighed  $\geq$  5 kg received 0.3 mg/kg of olmesartan medoxomil once daily for three weeks in an open label phase and then were randomised to receiving olmesartan medoxomil or placebo in a double-blind phase. At the end of the second week of withdrawal, the mean systolic/diastolic blood pressure at trough was 3/3 mmHg lower in the group randomised to olmesartan medoxomil; this difference in blood pressure was not statistically significant (95 % C.I. -2 to 7/-1 to 7).

### Other information

Two large randomised, controlled trials (ONTARGET (ONgoing Telmisartan Alone and in combination with Ramipril Global Endpoint Trial) and VA NEPHRON-D (The Veterans Affairs Nephropathy in Diabetes)) have examined the use of the combination of an ACE-inhibitor with an angiotensin II receptor blocker.

ONTARGET was a study conducted in patients with a history of cardiovascular or cerebrovascular disease, or type 2 diabetes mellitus accompanied by evidence of end-organ damage. VA NEPHRON-D was a study in patients with type 2 diabetes mellitus and diabetic nephropathy.

These studies have shown no significant beneficial effect on renal and/or cardiovascular outcomes and mortality, while an increased risk of hyperkalaemia, acute kidney injury and/or hypotension as compared to monotherapy was observed. Given their similar pharmacodynamic properties, these results are also relevant for other ACE-inhibitors and angiotensin II receptor blockers.

ACE-inhibitors and angiotensin II receptor blockers should therefore not be used concomitantly in patients with diabetic nephropathy.

ALTITUDE (Aliskiren Trial in Type 2 Diabetes Using Cardiovascular and Renal Disease Endpoints) was a study designed to test the benefit of adding aliskiren to a standard therapy of an ACE-inhibitor or an angiotensin II receptor blocker in patients with type 2 diabetes mellitus and chronic kidney disease, cardiovascular disease, or both. The study was terminated early because of an increased risk of adverse outcomes. Cardiovascular death and stroke were both numerically more frequent in the aliskiren group than in the placebo group and adverse events and serious adverse events of interest (hyperkalaemia, hypotension and renal dysfunction) were more frequently reported in the aliskiren group than in the placebo group.

## **5.2 Pharmacokinetic properties**

### **Absorption and distribution**

Olmesartan medoxomil is a prodrug. It is rapidly converted to the pharmacologically active metabolite, olmesartan, by esterases in the gut mucosa and in portal blood during absorption from the gastrointestinal tract.

No intact olmesartan medoxomil or intact side chain medoxomil moiety have been detected in plasma or excreta. The mean absolute bioavailability of olmesartan from a tablet formulation was 25.6%.

The mean peak plasma concentration ( $C_{max}$ ) of olmesartan is reached within about 2 hours after oral dosing with

olmesartan medoxomil, and olmesartan plasma concentrations increase approximately linearly with increasing single oral doses up to about 80 mg.

Food had minimal effect on the bioavailability of olmesartan and therefore olmesartan medoxomil may be administered with or without food.

No clinically relevant gender-related differences in the pharmacokinetics of olmesartan have been observed.

Olmесartan is highly bound to plasma protein (99.7%), but the potential for clinically significant protein binding displacement interactions between olmesartan and other highly bound coadministered drugs is low (as confirmed by the lack of a clinically significant interaction between olmesartan medoxomil and warfarin). The binding of olmesartan to blood cells is negligible. The mean volume of distribution after intravenous dosing is low (16 – 29 L).

### **Biotransformation and elimination**

Total plasma clearance was typically 1.3 L/h (CV, 19 %) and was relatively slow compared to hepatic blood flow (ca 90 L/h). Following a single oral dose of <sup>14</sup>C-labelled olmesartan medoxomil, 10 – 16 % of the administered radioactivity was excreted in the urine (the vast majority within 24 hours of dose administration) and the remainder of the recovered radioactivity was excreted in the faeces. Based on the systemic availability of 25.6 %, it can be calculated that absorbed olmesartan is cleared by both renal excretion (ca 40 %) and hepato-biliary excretion (ca 60 %). All recovered radioactivity was identified as olmesartan. No other significant metabolite was detected. Enterohepatic recycling of olmesartan is minimal. Since a large proportion of olmesartan is excreted via the biliary route, use in patients with biliary obstruction is contraindicated (see section 4.3).

The terminal elimination half-life of olmesartan varied between 10 and 15 hours after multiple oral dosing. Steady state was reached after the first few doses and no further accumulation was evident after 14 days of repeated dosing. Renal clearance was approximately 0.5 – 0.7 L/h and was independent of dose.

### **Pharmacokinetics in special populations**

#### *Paediatric population:*

The pharmacokinetics of olmesartan was studied in paediatric hypertensive patients aged 1 to 16 years. The clearance of olmesartan in paediatric patients was similar to that in adult patients when adjusted by the body weight.

There is no pharmacokinetic information available in renally impaired paediatric subjects.

#### *Older people (age 65 years or older):*

In hypertensive patients, the AUC at steady state was increased by ca 35% in older people (65 – 75 years old) and by ca 44% in very old people (≥ 75 years old) compared with the younger age group. This may be at least in part related to a mean decrease in renal function in this group of patients.

#### *Renal impairment:*

In renally impaired patients, the AUC at steady state increased by 62 %, 82 % and 179 % in patients with mild, moderate and severe renal impairment, respectively, compared to healthy controls (see sections 4.2, 4.4).

#### *Hepatic impairment:*

After single oral administration, olmesartan AUC values were 6 % and 65 % higher in mildly and moderately hepatically impaired patients, respectively, than in their corresponding matched healthy controls. The unbound fraction of olmesartan at 2 hours post-dose in healthy subjects, in patients with mild hepatic impairment and in patients with moderate hepatic impairment was 0.26 %, 0.34 % and 0.41 %, respectively. Following repeated dosing in patients with moderate hepatic impairment, olmesartan mean AUC was again about 65 % higher than in matched healthy controls. Olmesartan mean C<sub>max</sub> values were similar in hepatically-impaired and healthy subjects. Olmesartan medoxomil has not been evaluated in patients with severe hepatic impairment (see sections 4.2 and 4.4).

### **Drug interactions**

#### *Bile acid sequestering agent colesevelam:*

Concomitant administration of 40 mg olmesartan medoxomil and 3750 mg colesevelam hydrochloride in healthy

subjects resulted in 28 % reduction in C<sub>max</sub> and 39 % reduction in AUC of olmesartan. Lesser effects, 4 % and 15 % reduction in C<sub>max</sub> and AUC respectively, were observed when olmesartan medoxomil was administered 4 hours prior to colesevelam hydrochloride. Elimination half-life of olmesartan was reduced by 50 – 52 % irrespectively of whether administered concomitantly or 4 hours prior to colesevelam hydrochloride (see section 4.5).

### 5.3 Preclinical safety data

In chronic toxicity studies in rats and dogs, olmesartan medoxomil showed similar effects to other AT1 receptor antagonists and ACE inhibitors: raised blood urea (BUN) and creatinine (through functional changes to the kidneys caused by blocking AT1 receptors); reduction in heart weight; a reduction of red cell parameters (erythrocytes, haemoglobin, haematocrit); histological indications of renal damage (regenerative lesions of the renal epithelium, thickening of the basal membrane, dilatation of the tubules). These adverse effects caused by the pharmacological action of olmesartan medoxomil have also occurred in preclinical trials on other AT1 receptor antagonists and ACE inhibitors and can be reduced by simultaneous oral administration of sodium chloride.

In both species, increased plasma renin activity and hypertrophy/hyperplasia of the juxtaglomerular cells of the kidney were observed. These changes, which are a typical effect of the class of ACE inhibitors and other AT1 receptor antagonists, would appear to have no clinical relevance.

Like other AT1 receptor antagonists olmesartan medoxomil was found to increase the incidence of chromosome breaks in cell cultures *in vitro*. No relevant effects were observed in several *in vivo* studies using olmesartan medoxomil at very high oral doses of up to 2000 mg/kg. The overall data of a comprehensive genotoxicity testing suggest that olmesartan is very unlikely to exert genotoxic effects under conditions of clinical use.

Olmесartan medoxomil was not carcinogenic, neither in rats in a 2 year study nor in mice when tested in two 6 month carcinogenicity studies using transgenic models.

In reproductive studies in rats, olmesartan medoxomil did not affect fertility and there was no evidence of a teratogenic effect. In common with other angiotensin II antagonists, survival of offspring was reduced following exposure to olmesartan medoxomil and pelvic dilatation of the kidney was seen after exposure of the dams in late pregnancy and lactation. In common with other antihypertensive agents, olmesartan medoxomil was shown to be more toxic to pregnant rabbits than to pregnant rats, however, there was no indication of a fetotoxic effect.

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## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

#### **Tablet core**

Lactose monohydrate  
Microcrystalline cellulose  
Crospovidone  
Silica, colloidal anhydrous  
Magnesium stearate

#### **Tablet coat**

Hypromellose  
Polyethylene glycol  
Titanium dioxide

### **6.2 Incompatibilities**

Not applicable.

### **6.3 Shelf life**

30 months

### **6.4 Special precautions for storage**

Store below 30°C

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

10, 14, 28, 30, 56, 60, 90, 98, 100 film-coated tablets available in blister packs of oPA-Alu-PVC form foil.

Not all pack sizes may be marketed.

### **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 MARKETING AUTHORISATION HOLDER**

Clonmel Healthcare Ltd  
Waterford Road  
Clonmel  
Co. Tipperary  
Ireland

**8 MARKETING AUTHORISATION NUMBER**

PA0126/273/003

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

Date of first authorisation: 20<sup>th</sup> May 2016

**10 DATE OF REVISION OF THE TEXT**

August 2017