

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Pantoprazole Mylan 20 mg Gastro-resistant Tablets

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each gastro-resistant tablet contains 22.550 mg of pantoprazole sodium sesquihydrate, equivalent to 20 mg of pantoprazole.

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Gastro-resistant tablet.

Dark yellow film coated, oval, approximately 4.3 mm x 8.4 mm, biconvex tablet that is blank on both sides.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic Indications

*Adults and adolescents 12 years of age and above*  
Symptomatic gastro-oesophageal reflux disease.

For long-term management and prevention of relapse in reflux oesophagitis.

*Adults*  
Prevention of gastroduodenal ulcers induced by non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in patients at risk with a need for continuous NSAID treatment (see section 4.4).

### 4.2 Posology and method of administration

#### Posology

##### Recommended dose

*Adults and adolescents 12 years of age and above*

##### Symptomatic gastro-oesophageal reflux disease

The recommended oral dose is one gastro-resistant tablet Pantoprazole Mylan 20 mg per day. Symptom relief is generally accomplished within 2-4 weeks. If this is not sufficient, symptom relief will normally be achieved within a further 4 weeks. When symptom relief has been achieved, reoccurring symptoms can be controlled using an on-demand regimen of 20 mg once daily, when required. A switch to continuous therapy may be considered in case satisfactory symptom control cannot be maintained with on-demand treatment.

##### Long-term management and prevention of relapse in reflux oesophagitis

For long-term management, a maintenance dose of one gastro-resistant tablet Pantoprazole Mylan 20 mg per day is recommended, increasing to 40 mg pantoprazole per day if a relapse occurs. Pantoprazole Mylan 40 mg is available for this case. After healing of the relapse the dose can be reduced again to 20 mg pantoprazole.

*Adults*

##### Prevention of gastroduodenal ulcers induced by non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in patients at risk with a need for continuous NSAID treatment

The recommended oral dose is one gastro-resistant tablet Pantoprazole Mylan 20 mg per day.

### *Special populations*

#### *Paediatric population below 12 years of age*

Pantoprazole is not recommended for use in children below 12 years of age due to limited data on safety and efficacy in this age group (see section 5.2).

#### *Hepatic impairment*

A daily dose of 20 mg pantoprazole should not be exceeded in patients with severe liver impairment (see section 4.4).

#### *Renal impairment*

No dose adjustment is necessary in patients with impaired renal function (see section 5.2).

#### *Elderly*

No dose adjustment is necessary in older patients (see section 5.2).

### **Method of administration**

For oral use.

Tablets should not be chewed or crushed, and should be swallowed whole 1 hour before a meal with some water.

### **4.3 Contraindications**

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

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

#### *Hepatic impairment*

In patients with severe liver impairment the liver enzymes should be monitored regularly during treatment with pantoprazole, particularly on long-term use. In the case of a rise of the liver enzymes the treatment should be discontinued (see section 4.2).

#### *Co-administration with NSAIDs*

The use of pantoprazole 20 mg as a preventive of gastroduodenal ulcers induced by non-selective nonsteroidal anti-inflammatory drugs (NSAIDs) should be restricted to patients who require continued NSAID treatment and have an increased risk to develop gastrointestinal complications. The increased risk should be assessed according to individual risk factors, e.g. high age (>65 years), history of gastric or duodenal ulcer or upper gastrointestinal bleeding.

#### *Gastric malignancy*

Symptomatic response to pantoprazole may mask the symptoms of gastric malignancy and may delay diagnosis. In the presence of any alarm symptom (e. g. significant unintentional weight loss, recurrent vomiting, dysphagia, haematemesis, anaemia or melaena) and when gastric ulcer is suspected or present, malignancy should be excluded.

Further investigation is to be considered if symptoms persist despite adequate treatment.

#### *Co-administration with HIV protease inhibitors*

Co-administration of pantoprazole is not recommended with HIV protease inhibitors for which absorption is dependent on acidic intragastric pH such as atazanavir, due to significant reduction in their bioavailability (see section 4.5).

#### *Influence on vitamin B<sub>12</sub> absorption*

Pantoprazole, as with all acid-blocking medicines, may reduce the absorption of vitamin B<sub>12</sub> (cyanocobalamin) due to hypo- or achlorhydria. This should be considered in patients with reduced body stores or risk factors for reduced vitamin B<sub>12</sub> absorption on long-term therapy or if respective clinical symptoms are observed.

#### *Long term treatment*

In long-term treatment, especially when exceeding a treatment period of 1 year, patients should be kept under regular surveillance.

#### *Gastrointestinal infections caused by bacteria*

Treatment with pantoprazole may lead to a slightly increased risk of gastrointestinal infections caused by bacteria such as *Salmonella* and *Campylobacter* or *C. difficile*.

#### *Hypomagnesaemia*

Severe hypomagnesaemia has been reported in patients treated with PPIs like pantoprazole for at least three months, and in most cases for a year. Serious manifestations of hypomagnesaemia such as fatigue, tetany, delirium, convulsions, dizziness and ventricular arrhythmia can occur but they may begin insidiously and be overlooked. In most affected patients, hypomagnesaemia improved after magnesium replacement and discontinuation of the PPI.

For patients expected to be on prolonged treatment or who take PPIs with digoxin or other medicines that may cause hypomagnesaemia (e.g. diuretics), healthcare professionals should consider measuring magnesium levels before starting PPI treatment and periodically during treatment.

#### *Bone fractures*

Proton pump inhibitors, especially if used in high doses and over long durations (>1 year), may modestly increase the risk of hip, wrist and spine fracture, predominantly in the elderly or in presence of other recognised risk factors. Observational studies suggest that proton pump inhibitors may increase the overall risk of fractures by 10-40%. Some of this increase may be due to other risk factors. Patients at risk of osteoporosis should receive care according to current clinical guidelines and they should have an adequate intake of vitamin D and calcium.

#### *Subacute cutaneous lupus erythematosus (SCLE)*

Proton pump inhibitors are associated with very infrequent cases of SCLE. If lesions occur, especially in sun-exposed areas of the skin, and if accompanied by arthralgia, the patient should seek medical help promptly and the healthcare professional should consider stopping pantoprazole. SCLE after previous treatment with a proton pump inhibitor may increase the risk of SCLE with other proton pump inhibitors.

#### *Interference with laboratory tests*

Increased Chromogranin A (CgA) level may interfere with investigations for neuroendocrine tumours. To avoid this interference, pantoprazole treatment should be stopped for at least 5 days before CgA measurements (see section 5.1). If CgA and gastrin levels have not returned to reference range after initial measurement, measurements should be repeated 14 days after cessation of proton pump inhibitor treatment.

### **4.5 Interaction with other medicinal products and other forms of interactions**

#### *Medicinal products with pH-dependent absorption pharmacokinetics*

Because of profound and long-lasting inhibition of gastric acid secretion, pantoprazole may interfere with the absorption of other medicinal products where gastric pH is an important determinant of oral bioavailability, e.g. some azole antifungals such as ketoconazole, itraconazole, posaconazole and other medicine such as erlotinib.

#### *HIV protease inhibitors*

Co-administration of pantoprazole is not recommended with HIV protease inhibitors for which absorption is dependent on acidic intragastric pH such as atazanavir due to significant reduction in their bioavailability (see section 4.4).

If the combination of HIV protease inhibitors with a proton pump inhibitor is judged unavoidable, close clinical monitoring (e.g. virus load) is recommended. A pantoprazole dose of 20 mg per day should not be exceeded. Dosage of the HIV protease inhibitor may need to be adjusted.

#### *Coumarin anticoagulants (phenprocoumon or warfarin)*

Co-administration of pantoprazole with warfarin or phenprocoumon did not affect the pharmacokinetic of warfarin, phenprocoumon or International Normalised Ratio (INR). However, there have been reports of increased INR and prothrombin time in patients receiving PPIs and warfarin or phenprocoumon concomitantly. Increase in INR and prothrombin time may lead to abnormal bleeding, and even death. Patients treated with pantoprazole and warfarin or phenprocoumon may need to be monitored for increase in INR and prothrombin time.

#### *Methotrexate*

Concomitant use of high dose methotrexate (e.g. 300 mg) and proton-pump inhibitors has been reported to increase methotrexate levels in some patients. Therefore in settings where high-dose methotrexate is used, for example cancer and psoriasis, a temporary withdrawal of pantoprazole may need to be considered.

#### *Other interactions studies*

Pantoprazole is extensively metabolised in the liver via the cytochrome P450 enzyme system. The main metabolic pathway is demethylation by CYP2C19 and other metabolic pathways include oxidation by CYP3A4.

Interaction studies with medicinal products also metabolised with these pathways, like carbamazepine, diazepam, glibenclamide, nifedipine, phenytoin and an oral contraceptive containing levonorgestrel and ethinyl oestradiol did not reveal clinically significant interactions.

An interaction of pantoprazole with other medicinal products or compounds, which are metabolised using the same enzyme system, cannot be excluded.

Results from a range of interaction studies demonstrate that pantoprazole does not affect the metabolism of active substances metabolised by CYP1A2 (such as caffeine, theophylline), CYP2C9 (such as piroxicam, diclofenac, naproxen), CYP2D6 (such as metoprolol), CYP2E1 (such as ethanol) or does not interfere with p-glycoprotein related absorption of digoxin.

There were no interactions with concomitantly administered antacids.

Interaction studies have also been performed by concomitantly administering pantoprazole with the respective antibiotics (clarithromycin, metronidazole, amoxicillin). No clinically relevant interactions were found.

#### Medicinal products that inhibit or induce CYP2C19:

Inhibitors of CYP2C19 such as fluvoxamine could increase the systemic exposure of pantoprazole. A dose reduction may be considered for patients treated long-term with high doses of pantoprazole, or those with hepatic impairment.

Enzyme inducers affecting CYP2C19 and CYP3A4 such as rifampicin and St John's wort (*Hypericum perforatum*) may reduce the plasma concentrations of PPIs that are metabolized through these enzyme systems.

### **4.6 Fertility, pregnancy and lactation**

#### Pregnancy

A moderate amount of data on pregnant women (between 300-1000 pregnancy outcomes) indicate no malformative or fetoneonatal toxicity of pantoprazole.

Animal studies have shown reproductive toxicity (see section 5.3). As a precautionary measure, it is preferable to avoid the use of pantoprazole during pregnancy.

#### Breast-feeding

Animal studies have shown excretion of pantoprazole in breast milk. There is insufficient information on the excretion of pantoprazole in human milk but excretion into human milk has been reported. A risk to the newborns/infants cannot be excluded. Therefore a decision on whether to discontinue breast-feeding or to discontinue/abstain from pantoprazole therapy should take into account the benefit of breastfeeding for the child and the benefit of pantoprazole for the woman.

#### Fertility

There was no evidence of impaired fertility following the administration of pantoprazole in animal studies (see section 5.3).

### **4.7 Effects on ability to drive and use machines**

Pantoprazole may have a minor influence on the ability to drive and use machines.

Adverse drug reactions, such as dizziness and visual disturbances may occur (see section 4.8). If affected, patients should not drive or operate machines.

### **4.8 Undesirable effects**

Approximately 5% of patients can be expected to experience adverse drug reactions (ADRs). The most commonly reported ADRs are diarrhoea and headache, both occurring in approximately 1% of patients.

The table below lists adverse reactions reported with pantoprazole, ranked under the following frequency classification:

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).

For all adverse reactions reported from post-marketing experience, it is not possible to apply any Adverse Reaction frequency and therefore they are mentioned with a "not known" frequency.

Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

Table 1. Adverse reactions with pantoprazole in clinical trials and post-marketing experience

<b>Frequency</b>	<b>Common</b>	<b>Uncommon</b>	<b>Rare</b>	<b>Very rare</b>	<b>Not known</b>
<b>System</b>					
<b>Organ Class</b>					
Blood and lymphatic system disorders			Agranulocytosis	Thrombocytopenia; Leukopenia; Pancytopenia	
Immune system disorders			Hypersensitivity (including anaphylactic reactions and anaphylactic shock)		
Metabolism and nutrition disorders			Hyperlipidaemias and lipid increases (triglycerides, cholesterol); Weight changes		Hyponatraemia Hypomagnesaemia (see section 4.4); Hypocalcaemia in association with hypomagnesaemia; Hypokalaemia
Psychiatric disorders		Sleep disorders	Depression (and all aggravations)	Disorientation (and all aggravations)	Hallucination; Confusion (especially in pre-disposed patients, as well as the aggravation of these symptoms in case of pre-existence)
Nervous system disorders		Headache; Dizziness	Taste disorders		Paraesthesia
Eye disorders			Disturbances in vision/ blurred vision		
Gastrointestinal disorders	Fundic gland polyps (benign)	Diarrhoea; Nausea/ vomiting; Abdominal distension and bloating; Constipation; Dry mouth; Abdominal pain and discomfort			Microscopic coliti
Hepatobiliary disorders		Liver enzymes increased (transaminases, $\gamma$ -GT)	Bilirubin increased		Hepatocellular injury; Jaundice; Hepatocellular failure

Frequency System Organ Class	Common	Uncommon	Rare	Very rare	Not known
Skin and sub-cutaneous tissue disorders		Rash/ exanthema/ eruption; Pruritus	Urticaria; Angioedema		Stevens-Johnson syndrome; Lyell syndrome; Erythema multi-forme; Subacute cutaneous lupus erythematosus (see section 4.4); Photosensitivity
Musculoskeletal and connective tissue disorders		Fracture of the hip, wrist or spine (see section 4.4)	Arthralgia; Myalgia		Muscle spasm as a consequence of electrolyte disturbances
Renal and urinary disorders					Interstitial nephritis (with possible progression to renal failure)
Reproductive system and breast disorders			Gynaecomastia		
General disorders and administration site conditions		Asthenia, fatigue and malaise	Body temperature increased; Oedema peripheral		

#### 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 16762517. Website: [www.hpra.ie](http://www.hpra.ie); E-mail: [medsafety@hpra.ie](mailto:medsafety@hpra.ie).

#### **4.9 Overdose**

There are no known symptoms of overdose in man.

Systemic exposure with up to 240 mg administered intravenously over 2 minutes were well tolerated.

As pantoprazole is extensively protein bound, it is not readily dialysable.

In the case of an overdose with clinical signs of intoxication, apart from symptomatic and supportive treatment, no specific therapeutic recommendations can be made.

### **5 PHARMACOLOGICAL PROPERTIES**

#### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Drugs for acid related disorders, Proton pump inhibitors, ATC code: A02BC02

##### Mechanism of action

Pantoprazole is a substituted benzimidazole which inhibits the secretion of hydrochloric acid in the stomach by specific blockade of the proton pumps of the parietal cells.

##### Pharmacodynamic effects

Pantoprazole is converted to its active form in the acidic environment in the parietal cells where it inhibits the H<sup>+</sup>, K<sup>+</sup>-ATPase enzyme, i.e. the final stage in the production of hydrochloric acid in the stomach. The inhibition is dose-dependent and affects both basal and stimulated acid secretion. In most patients, freedom from symptoms is achieved within 2 weeks. As with other proton pump inhibitors and H<sub>2</sub> receptor inhibitors, treatment with pantoprazole reduces acidity in the stomach and thereby increases gastrin in proportion to the reduction in acidity. The increase in gastrin is reversible.

Since pantoprazole binds to the enzyme distal to the cell receptor level, it can inhibit hydrochloric acid secretion independently of stimulation by other substances (acetylcholine, histamine, gastrin). The effect is the same whether the product is given orally or intravenously.

#### Clinical efficacy and safety

The fasting gastrin values increase under pantoprazole. On short-term use, in most cases they do not exceed the upper limit of normal. During long-term treatment, gastrin levels double in most cases. An excessive increase, however, occurs only in isolated cases. As a result, a mild to moderate increase in the number of specific endocrine (ECL) cells in the stomach is observed in a minority of cases during long-term treatment (simple to adenomatoid hyperplasia). However, according to the studies conducted so far, the formation of carcinoid precursors (atypical hyperplasia) or gastric carcinoids as were found in animal experiments (see section 5.3) have not been observed in humans.

During treatment with antisecretory medicinal products, serum gastrin increases in response to the decreased acid secretion. Also CgA increases due to decreased gastric acidity. The increased CgA level may interfere with investigations for neuroendocrine tumours.

Available published evidence suggests that proton pump inhibitors should be discontinued between 5 days and 2 weeks prior to CgA measurements. This is to allow CgA levels that might be spuriously elevated following PPI treatment to return to reference range.

An influence of a long term treatment with pantoprazole exceeding one year cannot be completely ruled out on endocrine parameters of the thyroid according to results in animal studies.

## **5.2 Pharmacokinetic properties**

#### Absorption

Pantoprazole is rapidly absorbed and the maximal plasma concentration is achieved even after one single 20 mg oral dose. On average at about 2.0 h - 2.5 h p.a. the maximum serum concentrations of about 1-1.5 micrograms/ml are achieved, and these values remain constant after multiple administration.

Pharmacokinetics do not vary after single or repeated administration. In the dose range of 10 to 80 mg, the plasma kinetics of pantoprazole are linear after both oral and intravenous administration.

The absolute bioavailability from the tablet was found to be about 77%. Concomitant intake of food had no influence on AUC, maximum serum concentration and thus bioavailability. Only the variability of the lag-time will be increased by concomitant food intake.

#### Distribution

Pantoprazole's serum protein binding is about 98%. Volume of distribution is about 0.15 l/kg.

#### Biotransformation

The substance is almost exclusively metabolized in the liver. The main metabolic pathway is demethylation by CYP2C19 with subsequent sulphate conjugation, other metabolic pathway include oxidation by CYP3A4.

#### Elimination

Terminal half-life is about 1 hour and clearance is about 0.1 l/h/kg. There were a few cases of subjects with delayed elimination. Because of the specific binding of pantoprazole to the proton pumps of the parietal cell the elimination half-life does not correlate with the much longer duration of action (inhibition of acid secretion).

Renal elimination represents the major route of excretion (about 80%) for the metabolites of pantoprazole, the rest is excreted with the faeces. The main metabolite in both the serum and urine is desmethylpantoprazole which is conjugated with sulphate. The half-life of the main metabolite (about 1.5 hours) is not much longer than that of pantoprazole.

#### Special populations

#### *Poor metabolisers*

Approximately 3% of the European population lack a functional CYP2C19 enzyme and are called poor metabolisers. In these individuals the metabolism of pantoprazole is probably mainly catalysed by CYP3A4. After a single-dose administration of 40 mg pantoprazole, the mean area under the plasma concentration-time curve was approximately 6 times higher in poor metabolisers than in subjects having a functional CYP2C19 enzyme (extensive metabolisers). Mean peak plasma concentrations were increased by about 60 %. These findings have no implications for the posology of pantoprazole.

#### *Renal impairment*

No dose reduction is recommended when pantoprazole is administered to patients with impaired renal function (including dialysis patients). As with healthy subjects, pantoprazole's half-life is short. Only very small amounts of pantoprazole are dialyzed. Although the main metabolite has a moderately delayed half-life (2 - 3h), excretion is still rapid and thus accumulation does not occur.

#### *Hepatic impairment*

Although for patients with liver cirrhosis (classes A and B according to Child) the half-life values increased to between 3 and 6 h and the AUC values increased by a factor of 3 - 5, the maximum serum concentration only increased slightly by a factor of 1.3 compared with healthy subjects.

#### *Elderly*

A slight increase in AUC and  $C_{max}$  in elderly volunteers compared with younger counterparts is also not clinically relevant.

#### *Paediatric population*

Following administration of single oral doses of 20 or 40 mg pantoprazole to children aged 5 – 16 years AUC and  $C_{max}$  were in the range of corresponding values in adults.

Following administration of single *i.v.* doses of 0.8 or 1.6 mg/kg pantoprazole to children aged 2 – 16 years there was no significant association between pantoprazole clearance and age or weight. AUC and volume of distribution were in accordance with data from adults.

### **5.3 Preclinical safety data**

Non-clinical data reveal no special hazard to humans based on conventional studies of safety pharmacology, repeated dose toxicity and genotoxicity.

In the two-year carcinogenicity studies in rats neuroendocrine neoplasms were found. In addition, squamous cell papillomas were found in the forestomach of rats. The mechanism leading to the formation of gastric carcinoids by substituted benzimidazoles has been carefully investigated and allows the conclusion that it is a secondary reaction to the massively elevated serum gastrin levels occurring in the rat during chronic high-dose treatment. In the two-year rodent studies an increased number of liver tumors was observed in rats and in female mice and was interpreted as being due to pantoprazole's high metabolic rate in the liver.

A slight increase of neoplastic changes of the thyroid was observed in the group of rats receiving the highest dose (200 mg/kg). The occurrence of these neoplasms is associated with the pantoprazole-induced changes in the breakdown of thyroxine in the rat liver. As the therapeutic dose in man is low, no harmful effects on the thyroid glands are expected.

In animal reproduction studies, signs of slight fetotoxicity were observed at doses above 5 mg/kg. Investigations revealed no evidence of impaired fertility or teratogenic effects.

Penetration of the placenta was investigated in the rat and was found to increase with advanced gestation. As a result, concentration of pantoprazole in the foetus is increased shortly before birth.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

#### *Tablet core*

Sodium carbonate anhydrous (E500)

Mannitol (E421)

09 October 2019

CRN0099LY

Page 8 of 10



Crospovidone  
Povidone (K-90)  
Calcium stearate

*Gastro-resistant coating*

Methacrylic acid-ethyl acrylate copolymer (1:1)  
Sodium laurilsulfate  
Polysorbate 80 (E433)  
Triethyl citrate (E1505)

*Film coating*

Hypromellose (E464)  
Titanium dioxide (E171)  
Macrogol 400  
Iron oxide yellow (E172)

**6.2 Incompatibilities**

Not applicable.

**6.3 Shelf life**

3 years  
HDPE Bottles: In-use shelf life after first opening: 100 days

**6.4 Special precautions for storage**

Blister Pack: This medicinal product does not require any special storage conditions.

HDPE Bottles: Keep the container tightly closed in order to protect from moisture.

**6.5 Nature and contents of container**

HDPE bottle pack comprises of white round mouth HDPE bottle with white opaque, polypropylene (PP) screw cap with induction sealing liner. The bottle also contains desiccant canister (silica gel) or a desiccant '2 in 1' sachet (silica gel and activated carbon).

Blister pack comprising of Aluminium blisters with or without a desiccant layerpacked in cardboard cartons.

Bottles: 14, 28, 30, 50, 56, 60, 90, 98, 100, 250 tablet pack sizes.  
Blisters: 7, 14, 14 x 1, 28, 28 x 1, 30, 56, 70, 70 x 1, 96, 98 tablet pack sizes.

Not all pack sizes may be marketed.

**6.6 Special precautions for disposal**

No special requirements.

**7 MARKETING AUTHORISATION HOLDER**

McDermott Laboratories Ltd t/a Gerard Laboratories  
35/36 Baldoyle Industrial Estate  
Grange Road  
Dublin 13  
Ireland

**8 MARKETING AUTHORISATION NUMBER**

PA0577/146/001

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

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

Date of last renewal: 30<sup>th</sup> August 2014

**10 DATE OF REVISION OF THE TEXT**

October 2019