

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Enalapril/Lercanidipine Krka 10mg/10mg film-coated tablets

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 10 mg enalapril maleate (equivalent to 7.64 mg enalapril) and 10 mg lercanidipine hydrochloride (equivalent to 9.44 mg lercanidipine).

Excipients with known effect: lactose monohydrate

Each film-coated tablet contains 317 mg lactose monohydrate.

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Film-coated tablet.

The film-coated tablets are white, round, slightly biconvex with bevelled edges, tablet diameter 10 mm.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic Indications

Treatment of essential hypertension in patients whose blood pressure is not adequately controlled by lercanidipine 10 mg alone.

Fixed combination Enalapril/Lercanidipine Krka 10 mg/10 mg should not be used for initial treatment of hypertension.

### 4.2 Posology and method of administration

#### Posology

Patients whose blood pressure is not adequately controlled by lercanidipine 10 mg alone could either be titrated up to lercanidipine 20 mg monotherapy or switched to fixed combination Enalapril/Lercanidipine Krka 10 mg/10 mg.

Individual dose titration with the components can be recommended. When clinically appropriate, direct switch from monotherapy to the fixed combination may be considered.

The recommended dose is one tablet once a day at least 15 minutes before meals.

#### Special populations

##### *Elderly*

The dose should depend on the patient's renal function (see section 4.4, "Renal impairment").

##### *Renal impairment*

Enalapril/Lercanidipine Krka is contraindicated in patients with severe renal dysfunction (creatinine clearance <30 ml/min) or in patients undergoing haemodialysis (see sections 4.3 and 4.4). Particular caution is needed when initiating treatment in patients with mild to moderate (creatinine clearance: 30-60 ml/min) renal dysfunction.

##### *Hepatic impairment*

Enalapril/Lercanidipine Krka is contraindicated in severe hepatic dysfunction. Particular caution is needed when initiating treatment in patients with mild to moderate hepatic dysfunction.

Pediatric population

There is no relevant use of Enalapril/Lercanidipine Krka in the paediatric population in the indication of hypertension.

Method of administration

Precautions to be taken before handling or administering the medicinal product:

- treatment should be preferably administered in the morning at least 15 minutes before breakfast.
- this product should not be administered with grapefruit juice (see sections 4.3 and 4.5).

**4.3 Contraindications**

Enalapril/Lercanidipine Krka must not be taken in:

- Hypersensitivity to the active substances (enalapril or lercanidipine) or to any of the excipients listed in section 6.1.
- Hypersensitivity to an ACE-inhibitor or dihydropyridine calcium channel blocker
- History of angioedema associated with ACE-inhibitor therapy
- Hereditary or idiopathic angioedema
- Second and third trimesters of pregnancy (see sections 4.4 and 4.6)
- Left ventricular outflow obstruction, including aortic stenosis
- Untreated congestive heart failure
- Unstable angina pectoris or recent (within 1 month) myocardial infarction
- Severe renal impairment (GFR < 30 ml/min), including patients undergoing dialysis
- Severe hepatic impairment
- Co-administration with:
  - strong CYP3A4 inhibitors (see section 4.5)
  - ciclosporin (see section 4.5)
  - grapefruit or grapefruit juice (see section 4.5)
- The concomitant use of Enalapril/Lercanidipine Krka with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60 ml/min/1.73 m<sup>2</sup>) (see sections 4.5 and 5.1).
- Concomitant use with sacubitril/valsartan therapy. Enalapril/Lercanidipine Krka must not be initiated earlier than 36 hours after the last dose of sacubitril/valsartan (see also sections 4.4 and 4.5).

**4.4 Special warnings and precautions for use**Symptomatic hypotension

Symptomatic hypotension is rarely seen in uncomplicated hypertensive patients. In hypertensive patients receiving enalapril, symptomatic hypotension is more likely to occur if the patient has been volume-depleted, e.g. by diuretic therapy, dietary salt restriction, dialysis, diarrhoea or vomiting (see section 4.5). In patients with heart failure, with or without associated renal insufficiency, symptomatic hypotension has been observed. This is most likely to occur in those patients with more severe degrees of heart failure, as reflected by the use of high doses of loop diuretics, hyponatremia or functional renal impairment. In these patients, therapy should be started under medical supervision and the patients should be followed closely whenever the dose of enalapril and/or diuretic is adjusted. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, should receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which can be given usually without difficulty once the blood pressure has increased after volume expansion.

In some patients with heart failure who have normal or low blood pressure, additional lowering of systemic blood pressure may occur with enalapril. This effect is anticipated and usually is not a reason to discontinue treatment. If hypotension becomes symptomatic, a reduction of dose and/or discontinuation of the diuretic and/or enalapril may be necessary.

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.

#### Sick-sinus syndrome

Particular caution is recommended in the use of lercanidipine in patients with sick-sinus syndrome (without a pacemaker).

#### Left ventricular dysfunction

Although haemodynamic controlled studies revealed no impairment of ventricular function, care is required in patients with left ventricular dysfunction.

#### Ischaemic heart disease

It has been suggested that patients with ischaemic heart disease show an elevated cardiovascular risk under treatment with some short-acting dihydropyridines. Although lercanidipine is long-acting, caution is advised in these patients.

In rare cases, some dihydropyridines can cause precordial pain or angina pectoris. Very rarely, patients with pre-existing angina pectoris may experience increased frequency, duration or severity of these attacks. Isolated cases of myocardial infarction may be observed (see section 4.8).

#### Renal impairment

Particular caution is required with enalapril when initiating treatment in patients with mild to moderate renal impairment. Routine monitoring of potassium and creatinine are part of normal medical practice for these patients.

Renal failure has been reported in association with enalapril and has been mainly in patients with severe heart failure or underlying renal disease, including renal artery stenosis. If recognised promptly and treated appropriately, renal failure when associated with therapy with enalapril is usually reversible.

Some hypertensive patients, with no apparent pre-existing renal disease have developed increases in blood urea and creatinine when enalapril has been given concurrently with a diuretic. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required. This situation should raise the possibility of underlying renal artery stenosis (see section 4.4, *Renovascular hypertension*).

#### Renovascular hypertension

There is an increased risk of hypotension and renal insufficiency when patients with bilateral renal artery stenosis or stenosis of the artery to a single functioning kidney are treated with ACE inhibitors. Loss of renal function may occur with only mild changes in serum creatinine. In these patients, therapy should be initiated under close medical supervision with low doses, careful titration, and monitoring of renal function.

#### Kidney transplantation

There is no experience regarding the administration of lercanidipine or enalapril in patients with recent kidney transplantation. Therefore treatment of these patients with Enalapril/Lercanidipine Krka is not recommended.

#### Peritoneal dialysis

Lercanidipine has been associated with the development of cloudy peritoneal effluent in patients on peritoneal dialysis. The turbidity is due to an increased triglyceride concentration in the peritoneal effluent. Whilst the mechanism is unknown, the turbidity tends to resolve soon after withdrawal of lercanidipine. This is an important association to recognise as cloudy peritoneal effluent can be mistaken for infective peritonitis with consequential unnecessary hospitalisation and empiric antibiotic administration.

#### Hepatic failure

The antihypertensive effect of lercanidipine can be potentiated in patients with hepatic dysfunction.

Rarely, ACE inhibitors have been associated with a syndrome that starts with cholestatic jaundice or hepatitis and progresses to fulminant hepatic necrosis and (sometimes) death. The mechanism of this syndrome is not understood. Patients receiving ACE

inhibitors who develop jaundice or marked elevations of hepatic enzymes should discontinue the ACE inhibitor and receive appropriate medical follow-up.

#### Neutropenia/agranulocytosis

Neutropenia/agranulocytosis, thrombocytopenia and anaemia have been reported in patients receiving ACE inhibitors. In patients with normal renal function and no other complicating factors, neutropenia occurs rarely. Enalapril should be used with extreme caution in patients with collagen vascular disease, immunosuppressant therapy, treatment with allopurinol or procainamide, or a combination of these complicating factors, especially if there is pre-existing impaired renal function. Some of these patients developed serious infections which in a few instances did not respond to intensive antibiotic therapy. If enalapril is used in such patients, periodic monitoring of white blood cell counts is advised and patients should be instructed to report any sign of infection.

#### Hypersensitivity/angioneurotic oedema

Angioneurotic edema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin-converting enzyme inhibitors, including enalapril. This may occur at any time during treatment. In such cases, enalapril should be discontinued promptly and appropriate monitoring should be instituted to ensure complete resolution of symptoms prior to dismissing the patient. Even in those instances where swelling of only tongue is involved, without respiratory distress, patients may require prolonged observation since treatment, with antihistamines and corticosteroids may not be sufficient.

Very rarely, fatalities have been reported due to angioedema associated with laryngeal edema or tongue edema. Patients with involvement of the tongue, glottis or larynx are likely to experience airway obstruction, especially those with a history of airway surgery. Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, which may include subcutaneous epinephrine solution 1:1000 (0.3 ml to 0.5 ml) and/or measures to ensure a patent airway, should be administered promptly.

Black patients receiving ACE inhibitors have been reported to have a higher incidence of angioedema compared to non-blacks.

Patients with a history of angioedema unrelated to ACE-inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see section 4.3).

Concomitant use of ACE inhibitors with sacubitril/valsartan is contraindicated due to the increased risk of angioedema. Treatment with sacubitril/valsartan must not be initiated earlier than 36 hours after the last dose of Enalapril/Lercanidipine Krka. Treatment with Enalapril/Lercanidipine Krka must not be initiated earlier than 36 hours after the last dose of sacubitril/valsartan (see sections 4.3 and 4.5).

Concomitant use of ACE inhibitors with racecadotril, mTOR inhibitors (e.g. sirolimus, everolimus, temsirolimus) and vildagliptin may lead to an increased risk of angioedema (e.g. swelling of the airways or tongue, with or without respiratory impairment) (see section 4.5). Caution should be used when starting racecadotril, mTOR inhibitors (e.g. sirolimus, everolimus, temsirolimus) and vildagliptin in a patient already taking an ACE inhibitor.

#### Anaphylactoid reactions during desensitisation with insect venoms

Rarely, patients receiving ACE inhibitors during desensitisation with hymenoptera venom have experienced life-threatening anaphylactoid reactions. These reactions were avoided by temporarily withholding ACE-inhibitor therapy prior to each desensitisation.

#### Anaphylactoid reactions during LDL-apheresis

Rarely, patients receiving ACE inhibitors during low density lipoprotein (LDL)-apheresis with dextran sulfate have experienced life-threatening anaphylactoid reactions. These reactions were avoided by temporarily withholding ACE-inhibitor therapy prior to each apheresis.

#### Hypoglycemia

Diabetic patients treated with oral antidiabetic agents or insulin starting an ACE inhibitor, should be told to closely monitor for hypoglycemia, especially during the first month of combined use (see section 4.5).

#### Cough

Cough has been reported with the use of ACE-inhibitors. Characteristically, the cough is non-productive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

#### Surgery/anaesthesia

In patients undergoing major surgery or anaesthesia with agents that produce hypotension, enalapril blocks angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Serum potassium

ACE inhibitors can cause hyperkalemia because they inhibit the release of aldosterone. The effect is usually not significant in patients with normal renal function. Risk factors for the development of hyperkalaemia include those with renal insufficiency, worsening of renal function, age (> 70 years), diabetes mellitus, intercurrent events, in particular dehydration, acute cardiac decompensation, metabolic acidosis and concomitant use of potassium-sparing diuretics, (e.g., spironolactone, eplerenone, triamterene, or amiloride), potassium supplements or potassium-containing salt substitutes; or those patients taking other drugs associated with increases in serum potassium, (e.g. heparin, trimethoprim or co-trimoxazole also known as trimethoprim/sulfamethoxazole) and especially aldosterone antagonists or angiotensin-receptor blockers. The use of potassium supplements, potassium-sparing diuretics, or potassium-containing salt substitutes particularly in patients with impaired renal function may lead to a significant increase in serum potassium. Hyperkalemia can cause serious, sometimes fatal arrhythmias. Potassium-sparing diuretics and angiotensin-receptor blockers should be used with caution in patients receiving ACE inhibitors, and serum potassium and renal function should be monitored. If concomitant use of enalapril and any of the above mentioned agents is deemed appropriate, they should be used with caution and with frequent monitoring of serum potassium (see section 4.5).

#### Lithium

The combination of lithium and enalapril is generally not recommended (see section 4.5).

#### Inducers of CYP3A4

CYP3A4 inducers such as anticonvulsants (e.g. phenytoin, carbamazepine) and rifampicin can reduce serum levels of lercanidipine so that the efficacy of the drug can be lower than expected (see section 4.5).

#### Ethnic differences

As with other ACE-inhibitors, enalapril is apparently less effective in lowering blood pressure in black people than in non-blacks, possibly because of a higher prevalence of low-renin states in the black hypertensive population.

#### Pregnancy

Enalapril/Lercanidipine Krka is not recommended during pregnancy.

ACE inhibitors, like enalapril, should not be initiated during pregnancy. Unless continued ACE inhibitor 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 ACE inhibitors should be stopped immediately, and, if appropriate, alternative therapy should be started (see sections 4.3 and 4.6).

The use of lercanidipine is also not recommended during pregnancy or in women planning to become pregnant (see section 4.6).

#### Lactation

The use of Enalapril/Lercanidipine Krka is not recommended during lactation (see section 4.6).

#### Pediatric population

The safety and efficacy of this association has not been demonstrated in children and adolescent below 18 age.

#### Alcohol

Alcohol should be avoided because it may potentiate the effect of vasodilator antihypertensives (see section 4.5).

#### Lactose

Enalapril/Lercanidipine Krka contains lactose monohydrate. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

#### Sodium

This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium-free'.

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

The antihypertensive effect of Enalapril/Lercanidipine Krka could be potentiated by other blood pressure-lowering drugs such as diuretics, beta-blockers, alpha-blockers and other substances.

In addition, the following interactions have been observed with one or other constituents of the combined product.

#### ***Enalapril maleate***

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

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-sparing diuretics, potassium supplements or potassium-containing salt substitutes:

ACE-inhibitors attenuate diuretic-induced potassium loss. Although serum potassium usually remains within normal limits, hyperkalaemia may occur in some patients treated with enalapril. Potassium-sparing diuretics (e.g. spironolactone, eplerenone, triamterene or amiloride), potassium supplements or potassium-containing salt substitutes may lead to significant increases in serum potassium. Care should also be taken when Enalapril/Lercanidipine Krka is co-administered with other agents that increase serum potassium, such as trimethoprim and co-trimoxazole (trimethoprim/sulfamethoxazole) as trimethoprim is known to act as a potassium-sparing diuretic like amiloride. Therefore, the combination of Enalapril/Lercanidipine Krka with the above-mentioned drugs is not recommended. If concomitant use is indicated because of demonstrated hypokalaemia, they should be used with caution and with frequent monitoring of serum potassium (see section 4.4).

##### Lithium

Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with ACE-inhibitors. Concomitant use of thiazide diuretics may further increase lithium levels and enhance the risk of lithium toxicity with ACE-inhibitors. Use of enalapril with lithium is not recommended, but if the combination proves necessary, careful monitoring of serum lithium levels should be performed (see section 4.4).

##### Antidiabetics

Epidemiological studies have suggested that concomitant administration of ACE-inhibitors and antidiabetic medicines (insulin, oral hypoglycaemic agents) may cause an increased blood glucose-lowering effect, with risk of hypoglycaemia. This phenomenon appeared to be more likely to occur during the first weeks of combined treatment and in patients with renal impairment (see sections 4.4 and 4.8).

##### Diuretics (thiazides or loop diuretics)

Prior treatment with high dose diuretics may result in volume depletion and a risk of hypotension when initiating therapy with enalapril (see section 4.4). The hypotensive effects can be reduced by discontinuation of the diuretic, by increasing volume or salt intake or by initiating therapy with a low dose of enalapril.

##### Other antihypertensive agents

Concomitant use of these agents may increase the hypotensive effects of enalapril. Concomitant use with nitroglycerine and other nitrates, or other vasodilators, may further reduce blood pressure.

##### Non-steroidal anti-inflammatory drugs (NSAIDs) including selective Cyclooxygenase-2 (COX-2) inhibitors

Non-steroidal anti-inflammatory drugs (NSAIDs) including selective cyclooxygenase-2 inhibitors (COX-2 inhibitors) may reduce the effect of diuretics and others antihypertensive drugs. Therefore, the antihypertensive effect of angiotensin II receptor antagonists or ACE-inhibitors may be attenuated by NSAIDs including selective COX-2 inhibitors.

The co-administration of NSAIDs (including COX-2 inhibitors) and angiotensin II receptor antagonists or ACE-inhibitors exert an additive effect on the increase in serum potassium and may result in a deterioration of renal function. These effects are

usually reversible. Rarely, acute renal failure may occur, especially in patients with compromised renal function (such as the elderly or dehydrated patients, including those on diuretic therapy). Therefore, the combination should be administered with caution in patients with compromised renal function. Patients should be adequately hydrated and consideration should be given to monitoring renal function after initiation of concomitant therapy, and periodically thereafter.

#### Alcohol

Alcohol enhances the hypotensive effect of ACE inhibitors.

#### Tricyclic antidepressants/Antipsychotics/Anaesthetics/Narcotics

Concomitant use of certain anaesthetic medicinal products, tricyclic antidepressants and antipsychotics with ACE inhibitors may result in further reduction in blood pressure (see section 4.4).

#### Sympathomimetics

Sympathomimetics may reduce the antihypertensive effects of ACE-inhibitors.

#### Acetylsalicylic acid, thrombolytics and beta-blockers

Enalapril can be administered without problems concomitantly with acetylsalicylic acid (in doses suitable for cardiovascular prophylaxis), thrombolytics and beta-blockers.

#### Sacubitril/valsartan

Concomitant use of ACE inhibitors with sacubitril/valsartan is contraindicated as this increases the risk of angioedema (see section 4.3 and 4.4).

#### mTOR inhibitors (e.g. sirolimus, everolimus, temsirolimus)

Concomitant use of ACE inhibitors with mTOR inhibitors (e.g. sirolimus, everolimus, temsirolimus) may lead to an increased risk for angioedema (see section 4.4).

#### Vildagliptin

Concomitant use of ACE inhibitors with vildagliptin may lead to an increased risk for angioedema (see section 4.4).

#### Racecadotril

ACE inhibitors (e.g. perindopril) are known to cause angioedema. Concomitant use of ACE inhibitors with racecadotril (a drug used against acute diarrhea) may lead to an increased risk for angioedema (see section 4.4).

#### Ciclosporin :

Hyperkalaemia may occur during concomitant use of ACE inhibitors with ciclosporin. Monitoring of serum potassium is recommended.

#### Heparin:

Hyperkalaemia may occur during concomitant use of ACE inhibitors with heparin. Monitoring of serum potassium is recommended.

#### Co-trimoxazole (trimethoprim/sulfamethoxazole)

Patients taking concomitant co-trimoxazole (trimethoprim/sulfamethoxazole) may be at increased risk for hyperkalaemia (see section 4.4).

#### Gold

Nitritoid reactions (symptoms include facial flushing, nausea, vomiting and hypotension) have been reported rarely in patients on therapy with injectable gold (sodium aurothiomalate) and concomitant ACE inhibitor therapy including enalapril.

### ***Lercanidipine***

#### **Contraindications of concomitant use**

#### Inhibitors of CYP3A4

Since lercanidipine is known to be metabolised by the enzyme CYP3A4, simultaneously administered inhibitors and inducers of CYP3A4 may interact with the metabolism and excretion of lercanidipine.

An interaction study with ketoconazole, a strong inhibitor of CYP3A4, showed a marked rise in plasma levels of lercanidipine (a 15-fold increase in area under the drug concentration-time curve, AUC, and an 8-fold increase in C<sub>max</sub> of the eutomer S-lercanidipine). Co-prescription of lercanidipine and strong inhibitors of CYP3A4 (e.g. ketoconazole, itraconazole, ritonavir, erythromycin, troleandomycin) should be avoided (see section 4.3).

#### Cyclosporin

Cyclosporin and lercanidipine should not be used together (see section 4.3).

Increased plasma concentrations of both drugs have been observed following concurrent administration. A study in healthy young volunteers showed no changes in plasma lercanidipine levels when cyclosporin was taken 3 hours after ingestion of lercanidipine, but the AUC of cyclosporin rose by 27%. Co-administration of lercanidipine with cyclosporin caused a 3-fold rise in plasma lercanidipine levels and a 21% increase in AUC of cyclosporin.

#### Grapefruit or grapefruit juice

Lercanidipine should not be taken with grapefruit or grapefruit juice (see section 4.3).

As for other dihydropyridines, the metabolism of lercanidipine can be inhibited by the ingestion of grapefruit or grapefruit juice, resulting in a rise in the systemic availability of lercanidipine and increased hypotensive effect.

### **Concomitant use not recommended**

#### Alcohol

Alcohol should be avoided since it may potentiate the effect of vasodilator antihypertensives (see section 4.4).

#### Inducers of CYP3A4

Concurrent use of lercanidipine with CYP3A4 inducers such as anticonvulsants (e.g. phenytoin, phenobarbital, carbamazepine) and rifampicin should be approached with caution, because the antihypertensive effect of lercanidipine can be reduced. Blood pressure must therefore be monitored more frequently than usual.

### **Precautions including dose adjustment**

#### Substrates of CYP3A4

Caution is required on the co-prescribing of lercanidipine with other substrates of CYP3A4 such as terfenadine, astemizole, Class III antiarrhythmics, e.g. amiodarone, quinidine.

#### Digoxin

Co-administration of 20 mg lercanidipine in patients chronically treated with beta-methyl digoxin showed no evidence of pharmacokinetic interaction. Healthy volunteers treated with digoxin after administration of 20 mg lercanidipine showed a mean increase in digoxin C<sub>max</sub> of 33%, whereas neither AUC nor renal clearance were significantly altered. Patients on concomitant digoxin should be closely monitored for clinical signs of digoxin toxicity.

#### Midazolam

In elderly volunteers the concurrent administration of oral midazolam 20 mg enhanced the absorption of lercanidipine (by about 40%) and decreased its rate of absorption (t<sub>max</sub> was delayed from 1.75 to 3 hours). No changes in midazolam concentrations occurred.

#### Metoprolol

When lercanidipine was co-administered with metoprolol - a beta-blocker predominantly eliminated by the liver - the bioavailability of metoprolol was unchanged, whereas the bioavailability of lercanidipine was reduced by 50%. This effect may be due to the reduction in hepatic blood flow caused by beta-blockers and hence might also occur with other preparations of this class of drug. Nevertheless, lercanidipine can be safely used at the same time as blockers of beta-adrenergic receptors.

### **Concomitant use with other drugs**

#### Cimetidine

Concomitant administration of cimetidine 800 mg daily does not cause significant modifications in plasma levels of lercanidipine, but caution is required at higher doses since the bioavailability of lercanidipine, and therefore its hypotensive effect, may be increased.

### Fluoxetine

An interaction study with fluoxetine (an inhibitor of CYP2D6 and CYP3A4), conducted in healthy volunteers aged 65 ± 7 years (mean ± s.d.), showed no clinically relevant modification of the pharmacokinetics of lercanidipine.

### Simvastatin

When a 20 mg dose of lercanidipine was repeatedly co-administered with 40 mg of simvastatin, the AUC of lercanidipine was not significantly modified, whereas the AUC of simvastatin increased by 56% and that of its principal active metabolite, beta-hydroxyacid by 28%. It is unlikely that such changes are of clinical relevance. No interaction is expected if lercanidipine is administered in the morning and simvastatin in the evening, as indicated for such a drug.

### Warfarin

Co-administration of 20 mg lercanidipine to fasted healthy volunteers did not alter the pharmacokinetics of warfarin.

### Diuretics and ACE inhibitors

Lercanidipine has been safely administered with diuretics and ACE-inhibitors.

### Other medications affecting blood pressure

As for all antihypertensive medications, an increased hypotensive effects may be observed when lercanidipine is administered with other medications affecting blood pressure, such as alpha-blockers for the treatment of urinary symptoms, tricyclic antidepressants, neuroleptics. On the contrary, a reduction of the hypotensive effect may be observed with a concomitant use with corticosteroids

### Paediatric population

Interaction studies have only been performed in adults.

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

### **Pregnancy**

#### *Enalapril*

**The use of ACE inhibitors (enalapril) is not recommended during the first trimester of pregnancy (see section 4.4). The use of ACE inhibitors (enalapril) is contra-indicated during the second and third trimesters 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. Unless continued ACE inhibitor 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 ACE inhibitors should be stopped immediately, and, if appropriate, alternative therapy should be started.

Exposure to ACE inhibitor therapy during the second and third trimesters is known to induce human foetotoxicity (decreased renal function, oligohydramnios, skull ossification retardation) and neonatal toxicity (renal failure, hypotension, hyperkalaemia) (see section 5.3). Maternal oligohydramnios, presumably representing decreased foetal renal function, has occurred and may result in limb contractures, craniofacial deformations and hypoplastic lung development.

Should exposure to ACE inhibitor have occurred from the second trimester of pregnancy, ultrasound check of renal function and skull is recommended.

Infants whose mothers have taken ACE inhibitors should be closely observed for hypotension (see also sections 4.3 and 4.4).

#### *Lercanidipine*

There are no data from the use of lercanidipine in pregnant women. Animal studies with lercanidipine have not shown teratogenic effects (see section 5.3), but these have been observed with other dihydropyridine compounds.

Lercanidipine is not recommended during pregnancy and in women of childbearing-potential not using contraception (see section 4.4).

*Enalapril and lercanidipine*

There are no or limited amount of data from the use of enalapril maleate and lercanidipine in pregnant women. Animal studies are insufficient with respect to reproductive toxicity (see section 5.3).

Enalapril/Lercanidipine Krka should not be used in the second and third trimester of pregnancy. It is not recommended in the first trimester of pregnancy and in women of childbearing potential not using contraception.

Breast-feeding*Enalapril*

Limited pharmacokinetic data demonstrate very low concentrations in breast milk (see section 5.2). Although these concentrations seem to be clinically irrelevant, the use of Enalapril/Lercanidipine Krka in breastfeeding is not recommended for preterm infants and for the first few weeks after delivery, because of the hypothetical risk of cardiovascular and renal effects and because there is not enough clinical experience. In the case of an older infant, the use of Enalapril/Lercanidipine Krka in a breast-feeding mother may be considered if this treatment is necessary for the mother and the child is observed for any adverse effect.

*Lercanidipine*

The excretion of lercanidipine/metabolite in human milk is unknown. A risk to the newborns/infants cannot be excluded. Lercanidipine should not be used during breast-feeding.

*Enalapril and lercanidipine*

Consequently, the use of Enalapril/Lercanidipine Krka should not be used during breast-feeding.

Fertility

No clinical data are available with lercanidipine. Reversible biochemical changes in the head of spermatozoa which can impair fecundation have been reported in some patients treated by channel blockers. In cases where repeated in-vitro fertilisation is unsuccessful and where another explanation cannot be found, the possibility of calcium channel blockers as the cause should be considered.

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

Enalapril/Lercanidipine Krka has minor influence on the ability to drive and use machines. However, caution is advised because dizziness, asthenia, fatigue and in rare cases somnolence may occur (see section 4.8).

**4.8 Undesirable effects**Summary of the safety profile

The safety of lercanidipine has been evaluated in five double-blind controlled clinical studies and in two long term open-label extension phases. In total, 1,141 patients have received enalapril and lercanidipine. The undesirable effects observed with combination therapy have been similar to those already observed with one or the other of the constituents given alone. The most commonly reported adverse reactions during treatment with lercanidipine were cough (4.03%), dizziness (1.67%) and headache (1.67%).

Tabulated summary of adverse reactions

In the table below, adverse reactions reported in clinical studies with enalapril and lercanidipine and for which a reasonable causal relationship exists are listed by MedDRA system organ class and frequency: 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).

<b>Frequency</b>	<b>Common</b>	<b>Uncommon</b>	<b>Rare</b>
<b>System organ</b>	<b>(<math>\geq 1/100</math> to <math>&lt; 1/10</math>)</b>	<b>(<math>\geq 1/1000</math> to <math>&lt; 1/100</math>)</b>	<b>(<math>\geq 1/10,000</math> to <math>&lt; 1/1,000</math>)</b>

<b>class</b>		<b>&lt;1/100)</b>	
<i>Blood and lymphatic system disorders</i>		Thrombocytopenia	Haemoglobin decreased
<i>Immune system disorders</i>			Hypersensitivity
<i>Metabolism and nutrition disorders</i>		Hyperkalaemia	
<i>Psychiatric disorders</i>		Anxiety	
<i>Nervous system disorders</i>	Dizziness, headache	Dizziness postural	
<i>Ear and labyrinth disorders</i>		Vertigo	Tinnitus
<i>Cardiac disorders</i>		Palpitations, tachycardia	
<i>Vascular disorders</i>		Flushing, hypotension	Circulatory collapse
<i>Respiratory, thoracic and mediastinal disorders</i>	Cough		Dry throat, oropharyngeal pain
<i>Gastrointestinal disorders</i>		Abdominal pain, constipation, nausea	Dyspepsia, lip oedema, tongue disorder, diarrhea, dry mouth, gingivitis
<i>Hepatobiliary disorders</i>		ALT increased, AST increased	
<i>Skin and subcutaneous tissue disorders</i>		Erythema	Angioedema, swelling face, dermatitis, rash, urticaria
<i>Musculoskeletal and connective tissue disorders</i>		Arthralgia	
<i>Renal and urinary disorders</i>		Pollakiuria	Nocturia, polyuria
<i>Reproductive system and breast disorders</i>			Erectile dysfunction
<i>General disorders and administration site conditions</i>		Fatigue, asthenia, feeling hot, oedema peripheral	

*Undesirable effects occurring in one patient only are reported under the frequency rare.*

Additional information on the individual components.

Adverse reactions reported with one of the individual components (enalapril or lercanidipine) may be potential undesirable effect with enalapril/lercanidipine as well, even if not observed in clinical trials or during the post-marketing period.

### **Enalapril alone**

Among the adverse drug reactions reported for enalapril are:

*Blood and lymphatic system disorders:*

Uncommon: anaemia (including aplastic and haemolytic forms)

Rare: neutropenia, decreases in haemoglobin, decreases in haematocrit, thrombocytopenia, agranulocytosis, bone marrow depression, pancytopenia, lymphadenopathy, autoimmune diseases

*Endocrine disorders:*

Not known: syndrome of inappropriate antidiuretic hormone secretion (SIADH)

*Metabolism and nutrition disorders:*

Uncommon: hypoglycaemia (see section 4.4)

*Psychiatric disorders:*

Common: depression

Uncommon: confusion, insomnia, nervousness

Rare: dream abnormality, sleep disorders

*Nervous system disorders:*

Very common: dizziness

Common: headache, syncope, taste alteration

Uncommon: somnolence, paraesthesia, vertigo

*Eye disorders:*

Very common: vision blurred

*Ear and labyrinth disorders:*

Uncommon: Tinnitus

*Cardiac disorders:*

Common: chest pain, rhythm disturbance, angina pectoris, tachycardia

Uncommon: palpitations, myocardial infarction or cerebrovascular accident\*, possibly secondary to excessive hypotension in high-risk patients (see section 4.4)

\* Incidence rates were comparable to those in the placebo and active control groups in the clinical trials.

*Vascular disorders:*

Common: hypotension (including orthostatic hypotension)

Uncommon: flushing, orthostatic hypotension

Rare: Raynaud's phenomenon

*Respiratory, thoracic and mediastinal disorders:*

Very common: cough

Common: dyspnoea

Uncommon: rhinorrhoea, sore throat and hoarseness, bronchospasm/asthma

Rare: lung infiltration, rhinitis, allergic alveolitis /eosinophilic pneumonia

*Gastrointestinal disorders:*

Very common: nausea

Common: diarrhoea, abdominal pain, dysgeusia

Uncommon: ileus, pancreatitis, vomiting, dyspepsia, constipation, anorexia, gastric irritations, dry mouth, peptic ulcer

Rare: stomatitis, aphthous stomatitis, glossitis

Very rare: intestinal angioedema

*Hepatobiliary disorders:*

Rare: hepatic failure, hepatitis – either hepatocellular or cholestatic, hepatitis including necrosis, cholestasis (including jaundice)

*Skin and subcutaneous tissue disorders:*

Common: rash, hypersensitivity/angioneurotic oedema: angioneurotic oedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported (see section 4.4)

Uncommon: hyperhidrosis, pruritus, urticaria, alopecia

Rare: erythema multiforme, Stevens-Johnson syndrome, dermatitis exfoliative, toxic epidermal necrolysis, pemphigus, erythroderma

A symptom complex has been reported which may include some or all of the following symptoms: fever, serositis, vasculitis, myalgia/myositis, arthralgia/arthritis, positive antinuclear antibodies (ANA), elevated erythrocyte sedimentation rate (ESR), eosinophilia and leucocytosis. Rash, photosensitivity or other dermatological manifestations may occur.

*Musculoskeletal, connective tissue, bone disorders:*

Uncommon: muscle cramps

*Renal and urinary disorders:*

Uncommon: renal impairment, renal failure, proteinuria

Rare: oliguria

*Reproductive system and breast disorders:*

Uncommon: impotence

Rare: gynaecomastia

*General disorders and administration site conditions:*

Very common: asthenia

Common: fatigue

Uncommon: malaise, fever

*Investigations:*

Common: hyperkalaemia, increases in serum creatinine

Uncommon: increases in blood urea, hyponatremia

Rare: elevation of liver enzymes, elevation of serum bilirubin.

***Lercanidipine alone***

The adverse drug reactions most commonly reported in controlled clinical trials and in the post- marketing experience are headache, oedema peripheral, tachycardia, palpitations and flushing.

*Immune system disorders:*

Rare: hypersensitivity

*Nervous system disorders:*

Common: headache

Uncommon: dizziness

Rare: somnolence, syncope

*Cardiac disorders:*

Common: tachycardia, palpitations

Rare: angina pectoris

*Vascular disorders:*

Common: flushing

Uncommon: hypotension

*Gastrointestinal disorders:*

Uncommon: nausea, dyspepsia, abdominal pain upper

Rare: vomiting, diarrhoea

Not known: gingival hypertrophy<sup>1</sup>, peritoneal cloudy effluent<sup>1</sup>

*Hepatobiliary disorders:*

Not known: serum transaminase increased<sup>1</sup>

*Skin and subcutaneous tissue disorders:*

Uncommon: rash , pruritus

Rare: urticaria

Not known: angioedema<sup>1</sup>*Musculoskeletal and connective tissue disorders:*

Uncommon: myalgia

*Renal and urinary disorders:*

Uncommon: polyuria

Rare: pollakiuria

*General disorders and administration site conditions:*

Common: oedema peripheral

Uncommon: asthenia, fatigue

Rare: chest pain

<sup>1</sup>adverse reactions from spontaneous reporting in the worldwide post-marketing experience

Some dihydropyridines may rarely lead to precordial localised pain or angina pectoris. Very rarely, patients with pre-existing angina pectoris may experience increased frequency, duration or severity of these attacks. Isolated cases of myocardial infarction may occur.

Lercanidipine does not appear to have any adverse effect on blood sugar or serum lipid levels.

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. Website: [www.hpra.ie](http://www.hpra.ie).

**4.9 Overdose**

In the post-marketing experience, some cases of intentional overdose requiring hospitalization were reported with administration of enalapril/lercanidipine at doses from 100 up to 1000 mg each. The reported symptoms (blood pressure systolic decreased, bradycardia, restlessness, somnolence and flank pain) could also be due to the concomitant administration of high doses of other drugs (e.g. beta-blockers).

Symptoms of overdose with enalapril and lercanidipine alone:

The most prominent features of overdose reported with enalapril to date are marked hypotension (beginning some six hours after ingestion of the tablets), concomitant with blockade of the renin-angiotensin system, and stupor.

Symptoms associated with overdose of ACE-inhibitors may include circulatory shock, electrolyte disturbances, renal failure, hyperventilation, tachycardia, palpitations, bradycardia, dizziness, anxiety and cough. Serum enalaprilat levels 100- and 200-fold higher than usually seen after therapeutic doses have been reported after ingestion of 300 mg and 440 mg of enalapril respectively.

As with other dihydropyridines, overdose with lercanidipine might be expected to cause excessive peripheral vasodilatation with marked hypotension and reflex tachycardia. However, at very high doses, the peripheral selectivity may be lost, causing bradycardia and a negative inotropic effect. The most common ADRs associated to cases of overdose have been hypotension, dizziness, headache and palpitations.

Treatment of cases of overdose with enalapril and lercanidipine alone:

The recommended treatment of overdosage with enalapril is intravenous infusion of saline solution. If hypotension occurs, the patients should be placed in the shock position. If available, treatment with angiotensin II infusion and/or intravenous catecholamines may also be considered. If the tablets were ingested recently, measures to eliminate enalapril maleate should be taken (e.g. vomiting, gastric lavage, administration of absorbents or sodium sulfate). Enalaprilat can be removed from the

circulation by haemodialysis (see section 4.4). Pacemaker therapy is indicated for therapy-resistant bradycardia. Vital signs, serum electrolytes and creatinine should be continuously monitored.

With lercanidipine, clinically significant hypotension requires active cardiovascular support including frequent monitoring of cardiac and respiratory function, elevation of extremities and attention to circulating fluid volume and urine output.

In view of the prolonged pharmacological effect of lercanidipine, the cardiovascular status of patients who have taken an overdose must be monitored for at least 24 hours. Since the product has a high protein binding, dialysis is not likely to be effective. Patients in whom a moderate to severe intoxication is anticipated should be observed in a high-care setting.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: ACE inhibitors and calcium channel blockers: enalapril and lercanidipine, ATC code: C09BB02.

Enalapril/Lercanidipine Krka is a fixed combination of an ACE-inhibitor (enalapril) and a calcium channel blocker (lercanidipine), two antihypertensive compounds with complementary mechanism of action to control blood pressure in patients with essential hypertension.

#### ***Enalapril***

Enalapril maleate is the maleate salt of enalapril, a derivative of two aminoacids, L-alanine and L-proline. Angiotensin-converting enzyme (ACE) is a peptidyl dipeptidase which catalyses the conversion of angiotensin I to the vasopressor agent angiotensin II. After absorption, enalapril is hydrolysed to enalaprilat, which inhibits ACE. Inhibition of ACE results in decreased plasma angiotensin II, which leads to increased plasma renin activity (due to the removal of negative feedback of renin release) and decreased aldosterone secretion.

Since ACE is identical to kininase II, enalapril may also inhibit the degradation of bradykinin, a potent vasodepressor peptide. However the role of this mechanism in the therapeutic effects of enalapril is still not understood.

Although the mechanism by which enalapril reduces blood pressure is primarily attributed to suppression of the renin-angiotensin-aldosterone system, enalapril is antihypertensive even in patients with low renin levels.

Administration of enalapril to hypertensive patients reduces both supine and standing blood pressure, without a significant increase in heart rate.

Symptomatic postural hypotension is rare. In some patients it may take a few weeks of treatment before optimal blood pressure control is achieved. Abrupt withdrawal of enalapril is not associated with a rapid increase in blood pressure.

Effective inhibition of ACE activity normally occurs 2 to 4 hours after oral administration of a single dose of enalapril. Onset of the antihypertensive action was usually seen after one hour with maximum reduction of blood pressure observed 4 to 6 hours after administration. The duration of action is dose-related, but with recommended doses, antihypertensive and haemodynamic effects have been shown to persist for at least 24 hours.

Haemodynamic studies in patients with essential hypertension showed that the blood pressure reduction was associated with a decrease in peripheral arterial resistance and an increase in cardiac output; there was little or no change in heart rate. Following administration of enalapril, renal blood flow increased whilst glomerular filtration rate remained unchanged. There were no signs of sodium or water retention. However in patients with a low glomerular filtration rate prior to treatment, this rate was usually increased.

In short-term clinical studies in diabetic and non-diabetic patients with renal diseases, decreases in albuminuria and urinary excretion of IgG and total urinary protein were seen after the administration of enalapril.

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.

### ***Lercanidipine***

Lercanidipine is a calcium antagonist of the dihydropyridine group and inhibits the transmembrane influx of calcium into cardiac and smooth muscle. The mechanism of the antihypertensive action is based on a direct relaxant effect on vascular smooth muscle, thus lowering total peripheral resistance. Due to its high membrane partition coefficient, lercanidipine has a prolonged antihypertensive action, and is devoid of negative inotropic effects because of its high vascular selectivity.

Since the vasodilatation produced by lercanidipine has a gradual onset, acute hypotension with reflex tachycardia has only been rarely observed in hypertensive patients.

As with other asymmetric 1,4-dihydropyridines, the antihypertensive activity of lercanidipine is mainly due to its (S)-enantiomer.

### ***Enalapril/Lercanidipine***

The combination of these substances has an additive antihypertensive effect, reducing blood pressure to a greater degree than either component alone.

In a pivotal phase III, double blind, add-on clinical trial conducted in 342 non responders to lercanidipine 10 mg (defined as SDBP 95-114 and SSBP 140-189 mmHg), the reduction in trough SSBP was 5.4 mmHg greater with the combination enalapril 10 mg/lercanidipine 10 mg than with lercanidipine 10 mg alone after 12 weeks of double-blind treatment (-7.7 mmHg vs -2.3 mmHg,  $p < 0.001$ ). Also the reduction in trough SDBP was 2.8 mmHg greater with the combination as compared to the monotherapy (-7.1 mmHg vs -4.3 mmHg,  $p < 0.001$ ). Responder rates resulted significantly higher with combination therapy than with monotherapy: 41% vs 24% ( $p < 0.001$ ) for SSBP and 35% vs 24% ( $p = 0.032$ ) for SDBP. A significantly higher percentage of patients on combination treatment experienced normalisation of SSBP (39% vs 22%,  $p < 0.001$ ) and of SDBP (29% vs 19%,  $p = 0.023$ ) compared with patients on monotherapy. In the open-label long term follow-up phase of this study a titration to the combination enalapril 20 mg/lercanidipine 10 mg was allowed if BP remained  $> 140/90$  mmHg: titration occurred in 133/221 patients and SDBP normalized after titration in 1/3 of these cases.

In a pivotal phase III, double blind, add-on clinical trial conducted in 327 non responders to enalapril 20 mg (defined as SDBP 95-114 and SSBP 140-189 mmHg), patients on enalapril 20 mg/lercanidipine 10 mg achieved a significantly greater reduction in trough SSBP compared with those on monotherapy (-9.8 vs -6.7 mmHg,  $p = 0.013$ ) and in trough SDBP (-9.2 vs -7.5 mmHg,  $p = 0.015$ ). Responder rates were not significantly higher with combination therapy than with monotherapy (53% vs 43%,  $p = 0.076$  for SDBP and 41% vs 33%,  $p = 0.116$  for SSBP) and a not significantly higher percentage of patients on combination therapy experienced normalisation of SDBP (48% vs. 37%,  $p = 0.055$ ) and of SSBP (33% vs 28%,  $p = 0.325$ ) compared with patients on monotherapy.

In a placebo and active-controlled randomized double blind study with a factorial design conducted on 1,039 patients with moderate hypertension (defined as office SDBP 100-109 mmHg, SSBP < 180 mmHg and home DBP  $\geq$  85 mmHg), patients on enalapril 20 mg/lercanidipine 20 mg had significantly greater reductions in office and home SDBP and SSBP compared with placebo ( $p < 0.001$ ). Clinically relevant differences in the change from baseline in office SDBP at trough were observed between combination therapy 20 mg/20 mg (-15.2 mmHg,  $n = 113$ ) in comparison with enalapril 20 mg (-11.3 mmHg,  $p = 0.004$ ,  $n = 113$ ) or lercanidipine 20 mg alone (-13.0 mmHg,  $p = 0.092$ ,  $n = 113$ ). Similarly, clinically relevant differences were observed in the change from baseline in office SSBP at trough between combination therapy 20 mg/20 mg (-19.2 mmHg) compared with lercanidipine 20 mg (-13.0 mmHg,  $p = 0.002$ ) or enalapril 20 mg alone (-15.3 mmHg,  $p = 0.055$ ). Clinically relevant differences were also observed in home SBP and DBP. A significant increase in the responder rates for SDBP (75%) and SSBP (71%) was observed with combination therapy 20 mg/20 mg over placebo ( $p < 0.001$ ) and both monotherapies ( $p < 0.01$ ). Normalisation of blood pressure was achieved by a higher percentage of patients treated with combination therapy 20 mg/20 mg (42%) than with placebo (22%).

## 5.2 Pharmacokinetic properties

No pharmacokinetic interactions have been observed on concurrent administration of enalapril and lercanidipine.

### Pharmacokinetics of enalapril

#### Absorption

Oral enalapril is rapidly absorbed, with peak serum concentrations of enalapril occurring within one hour. Based on urinary recovery, the extent of absorption of enalapril from oral enalapril maleate is approximately 60%. The absorption of oral enalapril is not affected by the presence of food in the gastrointestinal tract.

#### Distribution

Following absorption, oral enalapril is rapidly and extensively hydrolysed to enalaprilat, a potent angiotensin-converting enzyme inhibitor. Peak serum concentrations of enalaprilat occur 3 to 4 hours after an oral dose of enalapril maleate. The effective half-life for accumulation of enalaprilat following multiple doses of oral enalapril is 11 hours. In subjects with normal renal function, steady-state serum concentrations of enalaprilat was reached after four days of treatment.

Over the range of concentrations which are therapeutically relevant, enalapril binding to human plasma proteins does not exceed 60%.

#### Biotransformation

Apart from the conversion to enalaprilat, there is no evidence for significant metabolism of enalapril.

#### Elimination

Excretion of enalaprilat is primarily renal. The principal components in urine are enalaprilat, accounting for about 40% of the dose, and unchanged enalapril (about 20%).

#### Renal impairment

The exposure of enalapril and enalaprilat is increased in patients with renal insufficiency. In patients with mild to moderate renal insufficiency (creatinine clearance 40-60 ml/min), the steady state AUC of enalaprilat was approximately two-fold higher than in patients with normal renal function after administration of 5 mg once daily. In severe renal impairment (creatinine clearance  $\leq$  30 ml/min), the AUC was increased approximately 8-fold. The effective half-life of enalaprilat following multiple doses of enalapril maleate is prolonged at this level of renal insufficiency and time to steady state is delayed (see section 4.2).

Enalaprilate may be removed from the general circulation by haemodialysis. The dialysis clearance is 62 ml/min.

#### Lactation

After a single 20 mg oral dose in five postpartum women, the average peak enalapril milk level was 1.7  $\mu\text{g/L}$  (range 0.54 to 5.9  $\mu\text{g/L}$ ) at 4 to 6 hours after the dose. The average peak enalaprilat level was 1.7  $\mu\text{g/L}$  (range 1.2 to 2.3  $\mu\text{g/L}$ ); peaks occurred at various times over the 24-hour period. Using the peak milk level data, the estimated maximum intake of an exclusively breastfed infant would be about 0.16% of the maternal weight-adjusted dosage. A woman who had been taking oral enalapril 10 mg daily for 11 months had peak enalapril milk levels of 2  $\mu\text{g/L}$  4 hours after a dose and peak enalaprilat levels of 0.75  $\mu\text{g/L}$  about 9 hours after the dose. The total amount of enalapril and enalaprilat measured in milk during the 24 hour period was 1.44  $\mu\text{g/L}$  and 0.63  $\mu\text{g/L}$  of milk respectively. Enalaprilat milk levels were undetectable ( $< 0.2 \mu\text{g/L}$ ) 4 hours after a single dose of enalapril 5 mg in one mother and 10 mg in two mothers; enalapril levels were not determined.

## Pharmacokinetics of lercanidipine

### Absorption

Lercanidipine is completely absorbed after oral administration and peak plasma levels are reached after approximately 1.5 - 3 hours.

The two enantiomers of lercanidipine show a similar plasma level profile: the time to peak plasma concentration is the same and the peak plasma concentration and AUC are, on average 1.2 times higher for the (S)-enantiomer. The elimination half-lives of the two enantiomers are essentially the same. No interconversion of the two enantiomers is observed in vivo.

Due to the high first-pass metabolism, the absolute bioavailability of oral lercanidipine in non-fasted conditions is about 10%. However, the bioavailability on ingestion by healthy volunteers under fasting conditions is reduced to 1/3.

Oral availability of lercanidipine increases 4-fold when it is ingested up to 2 hours after a high-fat meal. Hence the drug should be taken before meals.

### Distribution

Distribution from plasma into tissues and organs is rapid and extensive.

The degree of plasma protein binding of lercanidipine exceeds 98%. Since plasma protein levels are reduced in patients with severe renal or hepatic dysfunction, the free fraction of the drug may be higher.

### Biotransformation

Lercanidipine is extensively metabolised by CYP3A4; no parent substance is found either in urine or faeces. It is predominantly converted into inactive metabolites and approximately 50% of the dose is excreted in the urine.

*In vitro* experiments with human liver microsomes have demonstrated that lercanidipine shows slight inhibition of the two enzymes CYP3A4 and CYP2D6 at concentrations 160- and 40-times higher than the peak plasma levels achieved after administration of the 20 mg dose.

Furthermore, interaction studies in humans have shown that lercanidipine does not modify the plasma levels of midazolam, a typical substrate of CYP3A4, or of metoprolol, a typical substrate of CYP2D6. Therefore, at therapeutic doses, lercanidipine is not expected to inhibit the biotransformation of drugs metabolised by CYP3A4 or CYP2D6.

### Elimination

Elimination essentially occurs through biotransformation.

A mean terminal elimination half-life of 8-10 hours was calculated, and due to the high binding to lipid membranes, therapeutic activity lasts for 24 hours. No accumulation was shown after repeated administration.

### Linearity/non-linearity

Oral administration of lercanidipine results in plasma levels that are not directly proportional to the dose (non-linear kinetics). After 10, 20 or 40 mg, peak plasma concentrations were in the ratio of 1:3:8 and areas under the plasma concentration-time curves in the ratio of 1:4:18, suggesting a progressive saturation of first pass metabolism. Accordingly, availability increases with dosage elevation.

### Special populations

It has been shown that the pharmacokinetic behaviour of lercanidipine in elderly patients and in patients with mild to moderate renal dysfunction or mild to moderate hepatic impairment is similar to that observed in the general patient population. Patients with severe renal dysfunction or dialysis-dependent patients showed higher concentrations of the drug (approximately 70%). In patients with moderate to severe hepatic impairment, systemic bioavailability of lercanidipine is probably increased because the drug is normally extensively metabolised in the liver.

## 5.3 Preclinical safety data

### Enalapril/Lercanidipine combination

Potential toxicity of the fixed combination of enalapril and lercanidipine was studied in rats after oral administration for up to 3 months and in two genotoxicity tests. The combination did not alter the toxicological profile of the two individual components.

The following data exist for the two individual components, enalapril and lercanidipine.

### **Enalapril**

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

Reproductive toxicity studies suggest that enalapril has no effects on fertility and reproductive performance in rats, and is not teratogenic. In a study in which female rats were dosed prior to mating through gestation, an increased incidence of rat pup deaths occurred during lactation. The compound has been shown to cross the placenta and is excreted in milk. Angiotensin converting enzyme inhibitors, as a class, have been shown to induce adverse effects on the late foetal development, resulting in foetal death and congenital effects, in particular affecting the skull. Foetotoxicity, intrauterine growth retardation and patent ductus arteriosus have also been reported. These developmental anomalies are thought to be partly due to a direct action of ACE inhibitors on the foetal renin angiotensin system and partly due to ischaemia resulting from maternal hypotension and decreases in foetal-placental blood flow and oxygen/nutrients delivery to the fetus.

### **Lercanidipine**

Non clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, toxicity to reproduction.

The relevant effects which have been observed in long term studies in rats and dogs were related, directly or indirectly, to the known effects of high doses of Ca-antagonist, predominantly reflecting exaggerated pharmacodynamic activity.

Treatment with lercanidipine had no effect on fertility or general reproductive performance in rats, but at high doses induced pre- and post- implantation losses and delay in foetal development. There was no evidence of any teratogenicity effect in rats and rabbits, but other dihydropyridines have been found to be teratogenic in animals. Lercanidipine induced dystocia when administered at high dose (12 mg/kg/day) during labour.

The distribution of lercanidipine and/or its metabolites in pregnant animals and their excretion in breast milk have not been investigated.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

*Tablet core:*

povidone K30  
maleic acid  
sodium starch glycolate type A  
lactose monohydrate  
sodium stearyl fumarate

*Film coating:*

hypromellose  
titanium dioxide (E171)  
talc  
macrogol 6000

### **6.2 Incompatibilities**

Not applicable.

### **6.3 Shelf life**

3 years

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

Do not store above 30 °C.

Store in the original package in order to protect from moisture.

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

Blisters (OPA/Alu/PVC-Alu foil): 10, 14, 15, 28, 30, 50, 56, 60, 84, 90, 98 or 100 film-coated tablets in a box.

Blisters (OPA/Alu/PVC-Alu foil), calendar packs: 14, 28, 56 or 98 film-coated tablets in a box.

Not all pack sizes may be marketed.

### **6.6 Special precautions for disposal**

No special requirements for disposal.

## **7 MARKETING AUTHORISATION HOLDER**

KRKA, d.d., Novo mesto  
Šmarješka cesta 6  
8501 Novo mesto  
Slovenia

## **8 MARKETING AUTHORISATION NUMBER**

PA1347/029/001

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

Date of first authorisation: 9<sup>th</sup> August 2013

Date of last renewal: 28<sup>th</sup> July 2018

## **10 DATE OF REVISION OF THE TEXT**

March 2022