

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Montelukast Teva 10 mg Film-coated Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 10.40 mg montelukast sodium, which is equivalent to 10 mg of montelukast.

Excipient with known effect:

Each film-coated tablet contains 122.2 mg of lactose (as lactose monohydrate).

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.

Beige, round, film coated tablet, debossed with "93" on one side and "7426" on the other side of the tablet

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Montelukast is indicated in the treatment of asthma as add-on therapy in those patients with mild to moderate persistent asthma who are inadequately controlled on inhaled corticosteroids and in whom 'as-needed' short-acting β -agonists provide inadequate clinical control of asthma. In those asthmatic patients in whom montelukast is indicated in asthma, montelukast can also provide symptomatic relief of seasonal allergic rhinitis.

Montelukast is also indicated in the prophylaxis of asthma, , in which the predominant component is exercise-induced bronchoconstriction.

4.2 Posology and method of administration

Posology

The recommended dose for adults and adolescents 15 years of age and older with asthma, or with asthma and concomitant seasonal allergic rhinitis, is one 10 mg tablet daily to be taken in the evening.

General recommendations

The therapeutic effect of Montelukast on parameters of asthma control occurs within one day. Montelukast may be taken with or without food. Patients should be advised to continue taking Montelukast even if their asthma is under control, as well as during periods of worsening asthma.

Montelukast should not be used concomitantly with other products containing the same active ingredient.

Therapy with Montelukast in relation to other treatments for asthma.

Montelukast can be added to a patient's existing treatment regimen.

Inhaled corticosteroids: Treatment with Montelukast can be used as add-on therapy in patients when other agents, such as inhaled corticosteroids plus "as needed" short acting β -agonists, provide inadequate clinical control. Montelukast should not be abruptly substituted for inhaled corticosteroids (see section 4.4).

Special populations

No dosage adjustment is necessary for the elderly, or for patients with renal insufficiency, or mild to moderate hepatic impairment. There are no data on patients with severe hepatic impairment. The dosage is the same for both male and female patients.

Paediatric population

Do not give Montelukast Teva 10 mg Film-coated Tablets to children less than 15 years of age. The safety and efficacy of Montelukast Teva 10mg Film-coated Tablets has not been established.

5 mg chewable tablets are available for paediatric patients 6 to 14 years of age.

4 mg chewable tablets are available for paediatric patients 2 to 5 years of age.

4 mg granules are available for paediatric patients 6 months to 5 years of age.

Method of administration

Oral use.

4.3 Contraindications

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

4.4 Special warnings and precautions for use

Patients should be advised never to use oral montelukast to treat acute asthma attacks and to keep their usual appropriate rescue medication for this purpose readily available. If an acute attack occurs, a short-acting inhaled β -agonist should be used. Patients should seek their doctor's advice as soon as possible if they need more inhalations of short-acting β -agonists than usual.

Montelukast should not be substituted abruptly for inhaled or oral corticosteroids.

There are no data demonstrating that oral corticosteroids can be reduced when montelukast is given concomitantly.

In rare cases, patients on therapy with anti-asthma agents including montelukast may present with systemic eosinophilia, sometimes presenting with clinical features of vasculitis consistent with Churg-Strauss syndrome, a condition which is often treated with systemic corticosteroid therapy. These cases, have been sometimes associated with the reduction or withdrawal of oral corticosteroid therapy. Although a causal relationship with leukotriene receptor antagonism has not been established, physicians should be alert to eosinophilia, vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in their patients. Patients who develop these symptoms should be reassessed and their treatment regimens evaluated.

Treatment with montelukast does not alter the need for patients with aspirin-sensitive asthma to avoid taking aspirin and other non-steroidal anti-inflammatory drugs.

Neuropsychiatric events have been reported in adults, adolescents, and children taking montelukast (see section 4.8). Patients and physicians should be alert for neuropsychiatric events. Patients and/or caregivers should be instructed to notify their physician if these changes occur. Prescribers should carefully evaluate the risks and benefits of continuing treatment with Montelukast Teva 10 mg Film-coated Tablets if such events occur.

Excipient(s)

Lactose

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 film-coated tablet, that is to say essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interactions

Montelukast may be administered with other therapies routinely used in the prophylaxis and chronic treatment of asthma. In drug-interactions studies, the recommended clinical dose of montelukast did not have clinically important effects on the pharmacokinetics of the following medicinal products: theophylline, prednisone, prednisolone, oral contraceptives (ethinyl oestradiol/norethindrone 35/1), terfenadine, digoxin and warfarin.

The area under the plasma concentration curve (AUC) for montelukast was decreased approximately 40% in subjects with co-administration of phenobarbital. Since montelukast is metabolised by CYP 3A4, 2C8, and 2C9, caution should be exercised, particularly in children, when montelukast is co-administered with inducers of CYP 3A4, 2C8, and 2C9, such as phenytoin, phenobarbital and rifampicin.

In vitro studies have shown that montelukast is a potent inhibitor of CYP 2C8. However, data from a clinical drug-drug interaction study involving montelukast and rosiglitazone (a probe substrate representative of medicinal products primarily metabolised by CYP 2C8) demonstrated that montelukast does not inhibit CYP 2C8 *in vivo*. Therefore, montelukast is not anticipated to markedly alter the metabolism of medicinal products metabolised by this enzyme (eg, paclitaxel, rosiglitazone, and repaglinide).

In vitro studies have shown that montelukast is a substrate of CYP 2C8, and to a less significant extent, of 2C9, and 3A4. In a clinical drug-drug interaction study involving montelukast and gemfibrozil (an inhibitor of both CYP 2C8 and 2C9) gemfibrozil increased the systemic exposure of montelukast by 4.4-fold. No routine dosage adjustment of montelukast is required upon co-administration with gemfibrozil or other potent inhibitors of CYP 2C8, but the physician should be aware of the potential for an increase in adverse reactions.

Based on *in vitro* data, clinically important drug interactions with less potent inhibitors of CYP 2C8 (e.g., trimethoprim) are not anticipated. Co-administration of montelukast with itraconazole, a strong inhibitor of CYP 3A4, resulted in no significant increase in the systemic exposure of montelukast.

4.6 Fertility, pregnancy and lactation

Pregnancy

Animal studies do not indicate harmful effects with respect to effects on pregnancy or embryonal/foetal development.

Available data from published prospective and retrospective cohort studies with montelukast use in pregnant women evaluating major birth defects have not established a drug-associated risk. Available studies have methodologic limitations, including small sample size, in some cases retrospective data collection, and inconsistent comparator groups.

Montelukast Teva may be used during pregnancy only if it is considered to be clearly essential.

Breast-feeding

Studies in rats have shown that montelukast is excreted in milk (see section 5.3). It is unknown whether montelukast/metabolites are excreted in human milk.

Montelukast Teva may be used in breast-feeding only if it is considered to be clearly essential.

4.7 Effects on ability to drive and use machines

Montelukast has no or negligible influence on the ability to drive and use machines. However, individuals have reported drowsiness or dizziness.

4.8 Undesirable effects

Montelukast has been evaluated in clinical studies as follows:

- 10 mg film-coated tablets in approximately 4,000 adult and adolescent asthmatic patients 15 years of age and older.
- 10 mg film-coated tablets in approximately 400 adult and adolescent asthmatic patients with seasonal allergic rhinitis 15 years of age and older.
- 5 mg chewable tablets in approximately 1750 paediatric asthmatic patients 6 to 14 years of age.
- 4 mg chewable tablets in 851 paediatric patients 2 to 5 years of age, and
- 4 mg granules in 175 paediatric patients 6 months to 2 years of age. Montelukast has been evaluated in a clinical study in patients with intermittent asthma as follows:
- 4 mg granules and chewable tablets in 1038 paediatric patients 6 months to 5 years of age. The following drug-related adverse reactions in clinical studies were reported commonly (>1/100, <1/10) in asthmatic patients treated with montelukast and at a greater incidence than in patients treated with placebo.

System Organ Class	Adult and	Paediatric	Paediatric	
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	Adolescent Patients 15 years and older (two 12-week studies; n=795)	Patients 6 to 14 years old (one 8-week study; n=201) (two 56-week studies; n=615)	Patients 2 to 5 years old (one 12-week study; n=461) (one 48-week study; n=278)	Paediatric Patients 6 months up to 2 years old (one 6-week study; n=175)
Nervous system disorders	headache	headache		hyperkinesia
Respiratory, thoracic, and mediastinal disorders				asthma
Gastrointestinal disorders	abdominal pain		abdominal pain	diarrhoea
Skin and subcutaneous tissue disorders				eczematous dermatitis, rash
General disorders and administration site conditions			thirst	

With prolonged treatment in clinical trials with a limited number of patients for up to 2 years for adults, and up to 12 months for paediatric patients 6 to 14 years of age, the safety profile did not change.

Cumulatively, 502 paediatric patients 2 to 5 years of age were treated with montelukast for at least 3 months, 338 for 6 months or longer, and 534 patients for 12 months or longer. With prolonged treatment, the safety profile did not change in these patients either.

The safety profile in paediatric patients 6 months to 2 years of age did not change with treatment up to 3 months.

The following adverse reactions have been reported in post-marketing use:

The frequencies of adverse events are ranked according to the following: 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).

Infections and infestations

Very common: upper respiratory infection¹

Blood and lymphatic system disorders

Rare: increased bleeding tendency

Very rare: thrombocytopenia

Immune system disorders

Uncommon: hypersensitivity reactions including anaphylaxis

Very rare: hepatic eosinophilic infiltration

Psychiatric disorders

Uncommon: dream abnormalities including nightmares, insomnia, somnambulism, anxiety, agitation including aggressive behaviour or hostility, depression, psychomotor hyperactivity (including irritability, restlessness, tremor⁵)

Rare: disturbance in attention, memory impairment, tic

Very rare: hallucinations, disorientation, suicidal thinking and behaviour (suicidality), obsessive-compulsive symptoms, dysphemia

Nervous system disorders

Uncommon: dizziness, drowsiness, paraesthesia/hypoesthesia, seizure

Cardiac disorders

Rare: palpitations

Respiratory, thoracic and mediastinal disorders

Uncommon: epistaxis

Very rare: Churg-Strauss syndrome (CSS) (see section 4.4), pulmonary eosinophilia

Gastrointestinal disorders

Common: diarrhoea², nausea², vomiting²

Uncommon: dry mouth, dyspepsia

Hepatobiliary disorders

Common: elevated levels of serum transaminases (ALT, AST)

Very rare: hepatitis (including cholestatic, hepatocellular, and mixed-pattern liver injury)

Skin and subcutaneous tissue disorders

Common: rash²

Uncommon: bruising, urticaria, pruritus

Rare: angioedema

Very rare: erythema nodosum, erythema multiforme

Musculoskeletal and connective tissue disorders

Uncommon: arthralgia, myalgia including muscle cramps

Renal and urinary disorders

Uncommon: enuresis in children

General disorders and administration site conditions

Common: pyrexia²

Uncommon: asthenia/fatigue, malaise, oedema

¹ This adverse experience, reported as very common in the patients who received montelukast, was also reported as very common in the patients who received placebo in clinical trials.

² This adverse experience, reported as common in the patients who received montelukast, was also reported as common in the patients who received placebo in clinical trials.

⁵ Frequency Category: Rare

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 HPRC Pharmacovigilance. Website: www.hpra.ie.

4.9 Overdose

In chronic asthma studies, montelukast has been administered at doses up to 200 mg/day to adult patients for 22 weeks and in short-term studies, up to 900 mg/day to patients for approximately one week without clinically important adverse experiences.

There have been reports of acute overdose in post-marketing experience and clinical studies with montelukast. These include reports in adults and children with a dose as high as 1000 mg (approximately 61 mg/kg in a 42 month old child). The clinical and laboratory findings observed were consistent with the safety profile in adults and paediatric patients. There were no adverse experiences in the majority of overdose reports.

Symptoms of overdose

The most frequently occurring adverse experiences were consistent with the safety profile of montelukast and included abdominal pain, somnolence, thirst, headache, vomiting, and psychomotor hyperactivity.

Management of overdose

No specific information is available on the treatment of overdose with montelukast. It is not known whether montelukast is dialysable by peritoneal- or haemo-dialysis.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Leukotriene receptor antagonist, ATC code: R03D CO3

Mechanism of action

The cysteinyl leukotrienes (LTC₄, LTD₄, LTE₄) are potent inflammatory eicosanoids released from various cells including mast cells and eosinophils. These important pro-asthmatic mediators bind to cysteinyl leukotriene (CysLT) receptors. The CysLT type-1 (CysLT₁) receptor is found in the human airway (including airway smooth muscle cells and airway macrophages) and on other pro-inflammatory cells (including eosinophils and certain myeloid stem cells). CysLTs have been correlated with the pathophysiology of asthma and allergic rhinitis. In asthma, leukotriene-mediated effects include bronchoconstriction, mucous secretion, vascular permeability, and eosinophil recruitment. In allergic rhinitis, CysLTs are released from the nasal mucosa after allergen exposure during both early- and late-phase reactions and are associated with symptoms of allergic rhinitis. Intranasal challenge with CysLTs has been shown to increase nasal airway resistance and symptoms of nasal obstruction.

Pharmacodynamic effects

Montelukast is an orally active compound which binds with high affinity and selectivity to the CysLT₁ receptor. In clinical studies, montelukast inhibits bronchoconstriction due to inhaled LTD₄ at doses as low as 5 mg. Bronchodilation was observed within two hours of oral administration. The bronchodilation effect caused by a β -agonist was additive to that caused by montelukast. Treatment with montelukast inhibited both early- and late-phase bronchoconstriction due to antigen challenge. Montelukast, compared with placebo, decreased peripheral blood eosinophils in adult and paediatric patients. In a separate study, treatment with montelukast significantly decreased eosinophils in the airways (as measured in sputum) and in peripheral blood while improving clinical asthma control.

Clinical efficacy and safety

In studies in adults, montelukast 10 mg once daily, compared with placebo, demonstrated significant improvements in morning FEV₁ (10.4% vs 2.7% change from baseline), AM peak expiratory flow rate (PEFR) (24.5 L/min vs 3.3 L/min change from baseline), and significant decrease in total β -agonist use (-26.1% vs -4.6% change from baseline). Improvement in patient-reported daytime and night-time asthma symptoms scores was significantly better than placebo.

Studies in adults demonstrated the ability of montelukast to add to the clinical effect of inhaled corticosteroid (% change from baseline for inhaled beclomethasone plus montelukast vs beclomethasone, respectively for FEV₁: 5.43% vs 1.04%; β -agonist use: -8.70% vs 2.64%). Compared with inhaled beclomethasone (200 microgram twice daily with a spacer device), montelukast demonstrated a more rapid initial response, although over the 12-week study, beclomethasone provided a greater average treatment effect (% change from baseline for montelukast vs beclomethasone, respectively for FEV₁: 7.49% vs 13.3%; β -agonist use: -28.28% vs -43.89%). However, compared with beclomethasone, a high percentage of patients treated with montelukast achieved similar clinical responses (e.g. 50% of patients treated with beclomethasone achieved an improvement in FEV₁ of approximately 11% or more over baseline while approximately 42% of patients treated with montelukast achieved the same response).

A clinical study was conducted to evaluate montelukast for the symptomatic treatment of seasonal allergic rhinitis in adult and adolescent asthmatic patients 15 years of age and older with concomitant seasonal allergic rhinitis. In this study montelukast 10 mg tablets administered once daily demonstrated a statistically significant improvement in the Daily Rhinitis Symptoms score, compared with placebo. The Daily Rhinitis Symptoms score is the average of the Daytime Nasal Symptoms score (mean of nasal congestion, rhinorrhea, sneezing, nasal itching) and the Night-time Symptoms score (mean of nasal congestion upon awakening, difficulty going to sleep, and night-time awakenings scores). Global evaluations of allergic rhinitis by patients and physicians were significantly improved, compared with placebo. The evaluation of asthma efficacy was not a primary objective of this study.

In an 8-week study in paediatric patients 6 to 14 years of age, montelukast 5 mg once daily, compared with placebo, significantly improved respiratory function (FEV₁ 8.71% vs 4.16% change from baseline; AM PEFR 27.9 L/min vs 17.8 L/min change from baseline) and decreased 'as-needed' β -agonist use (-11.7% vs +8.2% change from baseline).

Significant reduction of exercise-induced bronchoconstriction (EIB) was demonstrated in a 12-week study in adults (maximal fall in FEV₁ 22.33% for montelukast vs 32.40% for placebo; time to recovery to within 5% of baseline FEV₁ 44.22 min vs 60.64 min). This effect was consistent throughout the 12-week study period. Reduction in EIB was also demonstrated in a short term study in paediatric patients 6 to 14 years of age (maximal fall in FEV₁ 18.27% vs 26.11%; time to recovery to within 5% of baseline FEV₁ 17.76 min vs 27.98 min). The effect in both studies was demonstrated at the end of the once-daily dosing interval.

In aspirin-sensitive asthmatic patients receiving concomitant inhaled and/or oral corticosteroids, treatment with montelukast, compared with placebo, resulted in significant improvement in asthma control (FEV₁ 8.55% vs -1.74% change from baseline and decrease in total β -agonist use -27.78% vs 2.09% change from baseline).

5.2 Pharmacokinetic properties

Absorption

Montelukast is rapidly absorbed following oral administration. For the 10 mg film-coated tablet, the mean peak plasma concentration (C_{max}) is achieved three hours (T_{max}) after administration in adults in the fasted state. The mean oral bioavailability is 64%. The oral bioavailability and C_{max} are not influenced by a standard meal. Safety and efficacy were demonstrated in clinical trials where the 10 mg film-coated tablet was administered without regard to the timing of food ingestion.

For the 5 mg chewable tablet, the C_{max} is achieved in two hours after administration in adults in the fasted state. The mean oral bioavailability is 73% and is decreased to 63% by a standard meal.

Distribution

Montelukast is more than 99% bound to plasma proteins. The steady-state volume of distribution of montelukast averages 8-11 litres. Studies in rats with radiolabelled montelukast indicate minimal distribution across the blood-brain barrier. In addition, concentrations of radiolabelled material at 24 hours post-dose were minimal in all other tissues.

Biotransformation:

Montelukast is extensively metabolised. In studies with therapeutic doses, plasma concentrations of metabolites of montelukast are undetectable at steady state in adults and children.

Cytochrome P450 2C8 is the major enzyme in the metabolism of montelukast. Additionally CYP 3A4 and 2C9 may have a minor contribution, although itraconazole, an inhibitor of CYP 3A4, was shown not to change pharmacokinetic variables of montelukast in healthy subjects that received 10 mg montelukast daily.

Based on *in vitro* results in human liver microsomes, therapeutic plasma concentrations of montelukast do not inhibit cytochromes P450 3A4, 2C9, 1A2, 2A6, 2C19, or 2D6. The contribution of metabolites to the therapeutic effect of montelukast is minimal.

Elimination

The plasma clearance of montelukast averages 45 ml/min in healthy adults. Following an oral dose of radiolabelled montelukast, 86% of the radioactivity was recovered in 5-day faecal collections and <0.2% was recovered in urine. Coupled with estimates of montelukast oral bioavailability, this indicates that montelukast and its metabolites are excreted almost exclusively *via* the bile.

Characteristics in patients

No dosage adjustment is necessary for the elderly or mild to moderate hepatic insufficiency. Studies in patients with renal impairment have not been undertaken. Because montelukast and its metabolites are eliminated by the biliary route, no dose adjustment is anticipated to be necessary in patients with renal impairment. There are no data on the pharmacokinetics of montelukast in patients with severe hepatic insufficiency (Child-Pugh score >9).

With high doses of montelukast (20- and 60-fold the recommended adult dose), a decrease in plasma theophylline concentration was observed. This effect was not seen at the recommended dose of 10 mg once daily.

5.3 Preclinical safety data

In animal toxicity studies, minor serum biochemical alterations in ALT, glucose, phosphorus and triglycerides were observed which were transient in nature. The signs of toxicity in animals were increased excretion of saliva, gastrointestinal symptoms, loose stools and ion imbalance. These occurred at dosages which provided >17-fold the systemic exposure seen at the clinical dosage. In monkeys, the adverse effects appeared at doses from 150 mg/kg/day (>232-fold the systemic exposure seen at the clinical dose). In animal studies, montelukast did not affect fertility or reproductive performance at systemic exposure

exceeding the clinical systemic exposure by greater than 24-fold. A slight decrease in pup body weight was noted in the female fertility study in rats at 200 mg/kg/day (>69-fold the clinical systemic exposure). In studies in rabbits, a higher incidence of incomplete ossification, compared with concurrent control animals, was seen at systemic exposure >24-fold the clinical systemic exposure seen at the clinical dose. No abnormalities were seen in rats. Montelukast has been shown to cross the placental barrier and is excreted in breast milk of animals.

No deaths occurred following a single oral administration of montelukast sodium at doses up to 5000 mg/kg in mice and rats (15,000 mg/m² and 30,000 mg/m² in mice and rats, respectively) the maximum dose tested. This dose is equivalent to 25,000 times the recommended daily adult human dose (based on an adult patient weight of 50 kg).

Montelukast was determined not to be phototoxic in mice for UVA, UVB or visible light spectra at doses up to 500 mg/kg/day (approximately >200-fold based on systemic exposure).

Montelukast was neither mutagenic in *in vitro* and *in vivo* tests nor tumorigenic in rodent species.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Core

Sodium laurilsulfate

Lactose monohydrate

Hydroxypropyl cellulose

Starch, pregelatinised (maize)

Sodium starch glycolate (maize) (Type A)

Magnesium stearate

Coating

Opadry 20A23676 Yellow containing

Hydroxypropyl cellulose

Hypromellose

Titanium dioxide (E171)

Iron oxide yellow (E172)

Iron oxide red (E172)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 months

6.4 Special precautions for storage

This medicinal product does not require any special temperature storage conditions. Store in the original package in order to protect from light.

6.5 Nature and contents of container

Aluminium – Aluminium blister packs:

Montelukast Teva 10mg Film-coated Tablets are available in packs of 7, 14, 15, 20, 28, 30, 50, 56, 60, 90, 98 and 100 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

7 MARKETING AUTHORISATION HOLDER

Teva Pharma B.V.
Swansweg 5
2031GA Haarlem
Netherlands

8 MARKETING AUTHORISATION NUMBER

PA0749/048/003

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of First Authorisation: 9th June 2008.

Date of Last Renewal: 7th May 2013.

10 DATE OF REVISION OF THE TEXT

January 2022