

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Olmesartan/Hydrochlorothiazide Krka 20 mg/12.5 mg film-coated tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 20 mg olmesartanmedoxomil and 12.5 mg hydrochlorothiazide.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet

White to almost white, round, biconvex film-coated tablets, engraved with a mark C1 on one side of the tablet; diameter 9 mm.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Treatment of essential hypertension.

Olmesartan/Hydrochlorothiazide Krka 20 mg/12.5 mg and 20 mg/25 mg fixed dose combination is indicated in adult patients whose blood pressure is not adequately controlled on olmesartan medoxomil alone.

4.2 Posology and method of administration

Posology

Adults

Olmesartan/Hydrochlorothiazide Krka is not for use as initial therapy, but in patients whose blood pressure is not adequately controlled by 20 mg olmesartan medoxomil alone. Olmesartan/Hydrochlorothiazide Krka is administered once daily, with or without food.

When clinically appropriate, direct change from monotherapy with 20 mg olmesartan medoxomil to the fixed combination may be considered, taking into account that the antihypertensive effect of olmesartan medoxomil is maximal by about 8 weeks after initiating therapy (see section 5.1). Dose titration of the individual components is recommended:

20 mg olmesartan medoxomil/12.5 mg hydrochlorothiazide may be administered in patients whose blood pressure is not adequately controlled by the optimal monotherapy olmesartan medoxomil 20 mg alone.

20 mg olmesartan medoxomil/25 mg hydrochlorothiazide may be administered in patients whose blood pressure is not adequately controlled by 20 mg olmesartan medoxomil/12.5 mg hydrochlorothiazide.

Older people (age 65 years or over)

In older people the same dosage of the combination is recommended as for adults.

Renal impairment

When Olmesartan/Hydrochlorothiazide Krka is used in patients with mild to moderate renal impairment (creatinine clearance of 30 -60 ml/min) periodic monitoring of renal function is advised (see section 4.4). Olmesartan/Hydrochlorothiazide Krka is contraindicated in patients with severe renal impairment (creatinine clearance < 30 mL/min) (see section 4.3).

Hepatic impairment

Olmesartan/Hydrochlorothiazide Krka should be used with caution in patients with mild to moderate hepatic impairment (see sections 4.4, 5.2). In patients with moderate hepatic impairment, an initial dose of 10 mg olmesartan medoxomil once daily is

recommended and the maximum dose should not exceed 20 mg once daily. Close monitoring of blood pressure and renal function is advised in hepatically-impaired patients who are receiving diuretics and/or other antihypertensive agents. There is no experience of olmesartan medoxomil in patients with severe hepatic impairment.

Olmесartan/Hydrochlorothiazide Krka should not be used in patients with severe hepatic impairment (see sections 4.3, 5.2), cholestasis and biliary obstruction (see section 4.3).

Paediatric population

The safety and efficacy of Olmesartan/Hydrochlorothiazide Krka in children and adolescents below 18 years has not been established. No data are available.

Method of administration

The tablet should be swallowed with a sufficient amount of fluid (e.g. one glass of water). The tablet should not be chewed and should be taken at the same time each day.

4.3 Contraindications

Hypersensitivity to the active substances, to any of the excipients listed in section 6.1 or to other sulphonamide-derived substances (since hydrochlorothiazide is a sulphonamide-derived medicinal product).

Severe renal impairment (creatinine clearance < 30 ml/min).

Refractory hypokalaemia, hypercalcaemia, hyponatraemia and symptomatic hyperuricaemia.

Severe hepatic impairment, cholestasis and biliary obstructive disorders.

Second and third trimester of pregnancy (see sections 4.4 and 4.6).

The concomitant use of Olmesartan/Hydrochlorothiazide Krka with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60 ml/min/1.73 m²) (see sections 4.5 and 5.1).

4.4 Special warnings and precautions for use

Intravascular volume depletion

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

Other conditions with stimulation of the renin-angiotensin-aldosterone system

In patients whose vascular tone and renal function depend predominantly on the activity of the renin-angiotensin-aldosterone system (e.g. patients with severe congestive heart failure or underlying renal disease, including renal artery stenosis), treatment with medicinal products that affect this system has been associated with acute hypotension, azotaemia, oliguria or, rarely, acute renal failure.

Renovascular hypertension

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

Renal impairment and kidney transplantation

Olmесartan medoxomil/hydrochlorothiazide combination should not be used in patients with severe renal impairment (creatinine clearance < 30 ml/min) (see section 4.3). No dosage adjustment is necessary in patients with mild to moderate renal impairment (creatinine clearance is \geq 30 ml/min, < 60 ml/min). However, in such patients olmesartan medoxomil/hydrochlorothiazide combination should be administered with caution and periodic monitoring of serum potassium, creatinine and uric acid levels is recommended. Thiazide diuretic-associated azotaemia may occur in patients with impaired renal function. If progressive renal impairment becomes evident, careful reappraisal of therapy is necessary, with

consideration given to discontinuing diuretic therapy. There is no experience of the administration of olmesartan medoxomil/hydrochlorothiazide combination in patients with recent kidney transplantation.

Hepatic impairment

There is currently no experience of olmesartan medoxomil in patients with severe hepatic impairment. Furthermore, minor alterations of fluid and electrolyte balance during thiazide therapy may precipitate hepatic coma in patients with impaired hepatic function or progressive liver disease. Therefore care should be taken in patients with mild to moderate hepatic impairment (see section 4.2). Use of olmesartan medoxomil/hydrochlorothiazide combinations in patients with severe hepatic impairment, cholestasis and biliary obstruction is contraindicated (see sections 4.3, 5.2).

Aortic and mitral valve stenosis, obstructive hypertrophic cardiomyopathy

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

Primary aldosteronism

Patients with primary aldosteronism generally will not respond to anti-hypertensive medicinal products acting through inhibition of the renin-angiotensin system. Therefore, the use of olmesartan medoxomil/hydrochlorothiazide combination is not recommended in such patients.

Metabolic and endocrine effects

Thiazide therapy may impair glucose tolerance. In diabetic patients dosage adjustments of insulin or oral hypoglycaemic agents may be required (see section 4.5). Latent diabetes mellitus may become manifest during thiazide therapy.

Increases in cholesterol and triglyceride levels are undesirable effects known to be associated with thiazide diuretic therapy.

Hyperuricaemia may occur or frank gout may be precipitated in some patients receiving thiazide therapy.

Electrolyte imbalance

As for any patient receiving diuretic therapy, periodic determination of serum electrolytes should be performed at appropriate intervals.

Thiazides, including hydrochlorothiazide, can cause fluid or electrolyte imbalance (including hypokalaemia, hyponatraemia and hypochloroemic alkalosis). Warning signs of fluid or electrolyte imbalance are dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pain or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea or vomiting (see section 4.8).

The risk of hypokalaemia is greatest in patients with cirrhosis of the liver, in patients experiencing brisk diuresis, in patients who are receiving inadequate oral intake of electrolytes and in patients receiving concomitant therapy with corticosteroids or ACTH (see section 4.5).

Conversely, due to antagonism at the angiotensin-II receptors (AT₁) through the olmesartan medoxomil component of olmesartan medoxomil/hydrochlorothiazide combination hyperkalaemia may occur, especially in the presence of renal impairment and/or heart failure, and diabetes mellitus. Adequate monitoring of serum potassium in patients at risk is recommended. Potassium-sparing diuretics, potassium supplements or potassium-containing salt substitutes and other medicinal products that may increase serum potassium levels (e.g. heparin) should be co-administered cautiously with olmesartan medoxomil/hydrochlorothiazide combination (see section 4.5).

There is no evidence that olmesartan medoxomil would reduce or prevent diuretic-induced hyponatraemia. Chloride deficit is generally mild and usually does not require treatment.

Thiazides may decrease urinary calcium excretion and cause an intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Hypercalcaemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Thiazides have been shown to increase the urinary excretion of magnesium, which may result in hypomagnesaemia.

Dilutional hyponatraemia may occur in oedematous patients in hot weather.

Lithium

As with other medicinal products containing angiotensin II receptor antagonists and thiazide in combination, the co-administration of olmesartan medoxomil/hydrochlorothiazide combination and lithium is not recommended (see section 4.5).

Sprue-like enteropathy

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

Ethnic differences

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

Anti-doping test

Hydrochlorothiazide contained in this medicinal product could produce a positive analytic result in an anti-doping test.

Pregnancy

AllIRAs should not be initiated during pregnancy. Unless continued AllIRA 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 AllIRAs should be stopped immediately and, if appropriate, alternative therapy should be started (see sections 4.3 and 4.6).

Other

In general arteriosclerosis, in patients with ischaemic heart disease or ischaemic cerebrovascular disease, there is always a risk that excessive blood pressure decrease could result in a myocardial infarction or stroke.

Hypersensitivity reactions to hydrochlorothiazide may occur in patients with or without a history of allergy or bronchial asthma, but are more likely in patients with such a history.

Exacerbation or activation of systemic lupus erythematosus has been reported with the use of thiazide diuretics.

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.

Non-melanoma skin cancer

An increased risk of non-melanoma skin cancer (NMSC) [basal cell carcinoma (BCC) and squamous cell carcinoma (SCC)] with increasing cumulative dose of hydrochlorothiazide (HCTZ) exposure has been observed in two epidemiological studies based on the Danish National Cancer Registry. Photosensitizing actions of HCTZ could act as a possible mechanism for NMSC.

Patients taking HCTZ should be informed of the risk of NMSC and advised to regularly check their skin for any new lesions and promptly report any suspicious skin lesions. Possible preventive measures such as limited exposure to sunlight and UV rays and, in case of exposure, adequate protection should be advised to the patients in order to minimize the risk of skin cancer.

Suspicious skin lesions should be promptly examined potentially including histological examinations of biopsies. The use of HCTZ may also need to be reconsidered in patients who have experienced previous NMSC (see also section 4.8).

Choroidal effusion, acute myopia and secondary angle-closure glaucoma

Sulfonamide or sulfonamide derivative drugs can cause an idiosyncratic reaction resulting in choroidal effusion with visual field defect, transient myopia and acute angle-closure glaucoma. Symptoms include acute onset of decreased visual acuity or ocular pain and typically occur within hours to weeks of drug initiation. Untreated acute angle-closure glaucoma can lead to permanent vision loss. The primary treatment is to discontinue drug intake as rapidly as possible. Prompt medical or surgical treatments may need to be considered if the intraocular pressure remains uncontrolled. Risk factors for developing acute angle-closure glaucoma may include a history of sulfonamide or penicillin allergy.

4.5 Interaction with other medicinal products and other forms of interactions

Potential interactions related to both olmesartan medoxomil and hydrochlorothiazide:

Concomitant use not recommended

Lithium:

Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with angiotensin converting enzyme inhibitors and, rarely, with angiotensin II antagonists. In addition, renal clearance of lithium is reduced by thiazides and consequently the risk of lithium toxicity may be increased. Therefore use of olmesartan medoxomil/hydrochlorothiazide combination and lithium in combination is not recommended (see section 4.4). If use of the combination proves necessary, careful monitoring of serum lithium levels is recommended.

Concomitant use requiring caution

Baclofen:

Potential of antihypertensive effect may occur.

Non-steroidal anti-inflammatory medicinal products:

NSAIDs (i.e. acetylsalicylic acid > 3 g/day, COX-2 inhibitors and non-selective NSAIDs) may reduce the antihypertensive effect of thiazide diuretics and angiotensin II receptor antagonists.

In some patients with compromised renal function (e.g. dehydrated patients or older people with compromised renal function) the co-administration of angiotensin II antagonists and agents that inhibit cyclooxygenase may result in further deterioration of renal function, including possible acute renal failure, which is usually reversible. Therefore, the combination should be administered with caution, especially in older people. Patients should be adequately hydrated and consideration should be given to monitoring of renal function after initiation of concomitant therapy and periodically thereafter.

Concomitant use to be taken into account

Amifostine:

Potential of antihypertensive effect may occur.

Other antihypertensive agents:

The blood pressure lowering effect of olmesartan medoxomil/hydrochlorothiazide combination can be increased by concomitant use of other antihypertensive medicinal products.

Alcohol, barbiturates, narcotics or antidepressants:

Potential of orthostatic hypotension may occur.

Potential interactions related to olmesartan medoxomil:

Concomitant use not recommended

Medicinal products affecting potassium levels:

Based on experience with the use of other medicinal products that affect the renin-angiotensin system, concomitant use of potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium or other medicinal products that may increase serum potassium levels (e.g. heparin, ACE inhibitors) may lead to increases in serum potassium (see section 4.4). If medicinal product which affect potassium levels are to be prescribed in combination with olmesartan medoxomil/hydrochlorothiazide combination, monitoring of potassium plasma levels is advised.

Bile acid sequestering agent colesevelam:

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

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).

Additional information

After treatment with antacid (aluminium magnesium hydroxide), a modest reduction in bioavailability of olmesartan was observed.

Olmesartan medoxomil had no significant effect on the pharmacokinetics or pharmacodynamics of warfarin or the pharmacokinetics of digoxin.

Co-administration of olmesartan medoxomil with pravastatin had no clinically relevant effects on the pharmacokinetics of either component in healthy subjects.

Olmesartan had no clinically relevant inhibitory effects on human cytochrome P450 enzymes 1A1/2, 2A6, 2C8/9, 2C19, 2D6, 2E1 and 3A4 *in vitro*, and had no or minimal inducing effects on rat cytochrome P450 activities. No clinically relevant interactions between olmesartan and medicinal products metabolised by the above cytochrome P450 enzymes are expected.

Potential interactions related to hydrochlorothiazide:**Concomitant use not recommended**Medicinal products affecting potassium levels:

The potassium-depleting effect of hydrochlorothiazide (see section 4.4) may be potentiated by the co-administration of other medicinal products associated with potassium loss and hypokalaemia (e.g. other kaliuretic diuretics, laxatives, corticosteroids, ACTH, amphotericin, carbenoxolone, penicillin G sodium or salicylic acid derivatives). Such concomitant use is therefore not recommended.

Concomitant use requiring cautionCalcium salts:

Thiazide diuretics may increase serum calcium levels due to decreased excretion. If calcium supplements must be prescribed, serum calcium levels should be monitored and calcium dosage adjusted accordingly.

Cholestyramine and colestipol resins:

Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins.

Digitalis glycosides:

Thiazide-induced hypokalaemia or hypomagnesaemia may favour the onset of digitalis-induced cardiac arrhythmias.

Medicinal products affected by serum potassium disturbances:

Periodic monitoring of serum potassium and ECG is recommended when olmesartan medoxomil/hydrochlorothiazide combination is administered with medicinal products affected by serum potassium disturbances (e.g. digitalis glycosides and antiarrhythmics) and with the following torsades de pointes (ventricular tachycardia)-inducing medicinal products (including some antiarrhythmics), hypokalaemia being a predisposing factor to torsades de pointes (ventricular tachycardia):

- Class Ia antiarrhythmics (e.g. quinidine, hydroquinidine, disopyramide).

- Class III antiarrhythmics (e.g. amiodarone, sotalol, dofetilide, ibutilide).
- Some antipsychotics (e.g. thioridazine, chlorpromazine, levomepromazine, trifluoperazine, cyamemazine, sulphiride, sultopride, amisulpride, tiapride, pimozide, haloperidol, droperidol).
- Others (e.g. bepridil, cisapride, diphemanil, erythromycin IV, halofantrin, mizolastin, pentamidine, sparfloracin, terfenadine, vincamine IV).

Non-depolarizing skeletal muscle relaxants (e.g. tubocurarine):

The effect of nondepolarizing skeletal muscle relaxants may be potentiated by hydrochlorothiazide.

Anticholinergic agents (e.g. atropine, biperiden):

Increase of the bioavailability of thiazide-type diuretics by decreasing gastrointestinal motility and stomach emptying rate.

Antidiabetic medicinal products (oral agents and insulin):

The treatment with a thiazide may influence the glucose tolerance. Dosage adjustment of the antidiabetic medicinal product may be required (see section 4.4).

Metformin:

Metformin should be used with caution because of the risk of lactic acidosis induced by possible functional renal failure linked to hydrochlorothiazide.

Beta-blockers and diazoxide:

The hyperglycaemic effect of beta-blockers and diazoxide may be enhanced by thiazides.

Pressor amines (e.g. noradrenaline):

The effect of pressor amines may be decreased.

Medicinal products used in the treatment of gout (probenecid, sulfinpyrazone and allopurinol):

Dosage adjustment of uricosuric medicinal products may be necessary since hydrochlorothiazide may raise the level of serum uric acid. Increase in dosage of probenecid or sulfinpyrazone may be necessary. Co-administration of a thiazide may increase the incidence of hypersensitivity reactions to allopurinol.

Amantadine:

Thiazides may increase the risk of adverse effects caused by amantadine.

Cytotoxic agents (e.g. cyclophosphamide, methotrexate):

Thiazides may reduce the renal excretion of cytotoxic medicinal products and potentiate their myelosuppressive effects.

Salicylates:

In case of high dosages of salicylates hydrochlorothiazide may enhance the toxic effect of the salicylates on the central nervous system.

Methyldopa:

There have been isolated reports of haemolytic anaemia occurring with concomitant use of hydrochlorothiazide and methyldopa.

Cyclosporine:

Concomitant treatment with cyclosporine may increase the risk of hyperuricaemia and gout-type complications.

Tetracyclines:

Concomitant administration of tetracyclines and thiazides increases the risk of tetracycline-induced increase in urea. This interaction is probably not applicable to doxycycline.

4.6 Fertility, pregnancy and lactation

Pregnancy (see section 4.3)

Given the effects of the individual components in this combination product on pregnancy, the use of Olmesartan medoxomil/hydrochlorothiazide combination is not recommended during the first trimester of pregnancy (see section 4.4). The use of olmesartan medoxomil/hydrochlorothiazide combination is contra-indicated during the 2nd and 3rd trimester of pregnancy (see sections 4.3 and 4.4).

Olmesartan medoxomil

The use of AIIIRAs is not recommended during the first trimester of pregnancy (see section 4.4). The use of AIIIRAs is contraindicated 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. Whilst there is no controlled epidemiological data on the risk with Angiotensin II Receptor Inhibitors (AIIIRAs), similar risks may exist for this class of drugs. Unless continued AIIIRA therapy is considered essential, patients planning pregnancy should be changed to alternative antihypertensive treatments which have an established safety profile for use in pregnancy. When pregnancy is diagnosed, treatment with AIIIRAs should be stopped immediately and, if appropriate, alternative therapy should be started. Exposure to AIIIRA therapy during the second and third trimesters is known to induce human fetotoxicity (decreased renal function, oligohydramnios, skull ossification retardation) and neonatal toxicity (renal failure, hypotension, hyperkalaemia). (See section 5.3.)

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

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

Hydrochlorothiazide

There is limited experience with hydrochlorothiazide during pregnancy, especially during the first trimester. Animal studies are insufficient.

Hydrochlorothiazide crosses the placenta. Based on the pharmacological mechanism of action of hydrochlorothiazide its use during the second and third trimester may compromise foeto-placental perfusion and may cause foetal and neonatal effects like icterus, disturbance of electrolyte balance and thrombocytopenia.

Hydrochlorothiazide should not be used for gestational oedema, gestational hypertension or preeclampsia due to the risk of decreased plasma volume and placental hypoperfusion, without a beneficial effect on the course of the disease.

Hydrochlorothiazide should not be used for essential hypertension in pregnant women except in rare situations where no other treatment could be used.

Breastfeeding

Olmesartan medoxomil

Because no information is available regarding the use of Olmesartan/Hydrochlorothiazide Krka during breastfeeding, Olmesartan/Hydrochlorothiazide Krka is not recommended and alternative treatments with better established safety profiles during breast-feeding are preferable, especially while nursing a newborn or preterm infant.

Hydrochlorothiazide

Hydrochlorothiazide is excreted in human milk in small amounts. Thiazides in high doses causing intense diuresis can inhibit the milk production.

The use of Olmesartan/Hydrochlorothiazide Krka during breast feeding is not recommended. If Olmesartan/Hydrochlorothiazide Krka is used during breast feeding, doses should be kept as low as possible.

4.7 Effects on ability to drive and use machines

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

4.8 Undesirable effects

The most commonly reported adverse reactions during treatment with olmesartan medoxomil/hydrochlorothiazide combination are headache (2.9%), dizziness (1.9%) and fatigue (1.0%).

Hydrochlorothiazide may cause or exacerbate volume depletion which may lead to electrolyte imbalance (see section 4.4).

In clinical trials involving 1155 patients treated with olmesartan medoxomil/hydrochlorothiazide combinations at dosages of 20/12.5 mg or 20/25 mg and 466 patients treated with placebo for periods of up to 21 months, the overall frequency of adverse events on olmesartan medoxomil/hydrochlorothiazide combination therapy was similar to that on placebo.

Discontinuations due to adverse events were also similar for olmesartan medoxomil/hydrochlorothiazide 20/12.5 mg - 20/25 mg (2%) and placebo (3%). The frequency of adverse events on olmesartan medoxomil/hydrochlorothiazide overall relative to placebo appeared to be unrelated to age (< 65 years versus ≥65 years), gender or race although the frequency of dizziness was somewhat increased in patients aged ≥75 years.

In addition, the safety of olmesartan medoxomil/hydrochlorothiazide as a high dose combination was investigated in clinical trials in 3709 patients receiving olmesartan medoxomil in combination with hydrochlorothiazide in the dose strengths 40 mg/12.5 mg and 40 mg/25 mg.

Adverse reactions from medoxomil/hydrochlorothiazide combination in clinical trials, post-authorisation safety studies and spontaneous reporting are summarised in the below table as well as adverse reactions from the individual components olmesartan medoxomil and hydrochlorothiazide based on the known safety profile of these substances.

The following terminologies have been used in order to classify the occurrence of adverse reactions: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000); not known (cannot be estimated from the available data).

MedDRA System Organ Class	Adverse reactions	Frequency		
		Olmesartan medoxomil / hydrochlorothiazide combination	Olmesartan medoxomil	Hydrochlorothiazide
Infections and infestations	Sialadenitis			Rare
Neoplasms benign, malignant and unspecified (incl cysts and polyps)	Non-melanoma skin cancer (Basal cell carcinoma and Squamous cell carcinoma) ¹			Not known
Blood and lymphatic system disorders	Aplastic anaemia			Rare
	Bone marrow depression			Rare
	Haemolytic anaemia			Rare
	Leukopenia			Rare

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	Neutropenia/ Agranulocytosis			Rare
	Thrombocytopenia		Uncommon	Rare
Immune system disorders	Anaphylactic reactions		Uncommon	Uncommon
Metabolism and nutrition disorders	Anorexia			Uncommon
	Glykosuria			Common
	Hypercalcaemia			Common
	Hypercholesterolaemia	Uncommon		Very common
	Hyperglycaemia			Common
	Hyperkalaemia		Rare	
	Hypertriglyceridaemia	Uncommon	Common	Very common
	Hyperuricaemia	Uncommon	Common	Very common
	Hypochloraemia			Common
	Hypochloraemic alkalosis			Very rare
	Hypokaliaemia			Common
	Hypomagnesaemia			Common
	Hyponatraemia			Common
	Hyperamylasaemia			Common
Psychiatric disorders	Apathy			Rare
	Depression			Rare
	Restlessness			Rare
	Sleep disturbances			Rare
Nervous system disorders	Confusional state			Common
	Convulsions			Rare
	Disturbances in consciousness (such as loss of consciousness)	Rare		
	Dizziness/light-headedness	Common	Common	Common
	Headache	Common	Common	Rare
	Loss of appetite			Uncommon
	Paraesthesia			Rare
	Postural dizziness	Uncommon		
	Somnolence	Uncommon		
	Syncope	Uncommon		
Eye disorders	Lacrimation decreased			Rare
	Transient blurred vision			Rare
	Worsening of pre-existing myopia			Uncommon
	Xanthopsia			Rare
	Choroidal effusion,acutemyopia, acute angle-closure glaucoma			Not known
Ear and labyrinth disorders	Vertigo	Uncommon	Uncommon	Rare
Cardiac disorders	Angina pectoris		Uncommon	
	Cardiac arrhythmias			Rare
	Palpitations	Uncommon		
Vascular disorders	Embolism			Rare
	Hypotension	Uncommon	Rare	
	Necrotising angiitis (vasculitis, cutaneous vasculitis)			Rare
	Orthostatic hypotension	Uncommon		Uncommon
	Thrombosis			Rare

Respiratory, thoracic and mediastinal disorders	Bronchitis		Common	
	Cough	Uncommon	Common	
	Dyspnoea			Rare
	Interstitial pneumonia			Rare
	Pharyngitis		Common	
	Pulmonary oedema			Rare
	Respiratory distress			Uncommon
	Rhinitis		Common	
Gastrointestinal disorders	Abdominal pain	Uncommon	Common	Common
	Constipation			Common
	Diarrhoea	Uncommon	Common	Common
	Dyspepsia	Uncommon	Common	
	Gastric irritation			Common
	Gastroenteritis		Common	
	Meteorism			Common
	Nausea	Uncommon	Common	Common
	Pancreatitis			Rare
	Paralytic ileus			Very rare
	Vomiting	Uncommon	Uncommon	Common
	Sprue-like enteropathy (see section 4.4)		Very rare	
Hepato-biliary disorders	Acute cholecystitis			Rare
	Jaundice (intrahepatic cholestatic icterus)			Rare
Skin and subcutaneous tissue disorders	Allergic dermatitis		Uncommon	
	Anaphylactic skin reactions			Rare
	Angioneurotic oedema	Rare	Rare	
	Cutaneous lupus erythematoses-like reactions			Rare
	Eczema	Uncommon		
	Erythema			Uncommon
	Exanthem		Uncommon	
	Photosensitivity reactions			Uncommon
	Pruritus		Uncommon	Uncommon
	Purpura			Uncommon
	Rash	Uncommon	Uncommon	Uncommon
	Reactivation of cutaneous lupus erythematoses			Rare
	Toxic epidermal necrolysis			Rare
	Urticaria	Rare	Uncommon	Uncommon
Musculoskeletal and connective tissue disorders	Arthralgia	Uncommon		
	Arthritis		Common	
	Back pain	Uncommon	Common	
	Muscle spasm	Uncommon	Rare	
	Muscular weakness			Rare
	Myalgia	Uncommon	Uncommon	
	Pain in extremity	Uncommon		
	Paresis			Rare

	Skeletal pain		Common	
Renal and urinary disorders	Acute renal failure	Rare	Rare	
	Haematuria	Uncommon	Common	
	Interstitial nephritis			Rare
	Renal insufficiency		Rare	
	Renal dysfunction			Rare
	Urinary tract infection		Common	
Reproductive system and breast disorders	Erectile dysfunction	Uncommon		Uncommon
General disorders and administration site conditions	Asthenia	Common	Uncommon	
	Chest pain	Common	Common	
	Face oedema		Uncommon	
	Fatigue	Common	Common	
	Fever			Rare
	Influenza-like symptoms		Common	
	Lethargy		Rare	
	Malaise	Rare	Uncommon	
	Pain		Common	
	Peripheral oedema	Common	Common	
	Weakness	Uncommon		
Investigations	Alanine aminotransferase increased	Uncommon		
	Aspartate aminotransferase increased	Uncommon		
	Blood calcium increased	Uncommon		
	Blood creatinine increased	Uncommon	Rare	Common
	Blood creatine phosphokinase increased		Common	
	Blood glucose increased	Uncommon		
	Blood haematocrit decreased	Rare		
	Blood haemoglobin decreased	Rare		
	Blood lipids increased	Uncommon		
	Blood potassium decreased	Uncommon		
	Blood potassium increased	Uncommon		
	Blood urea increased	Uncommon	Common	Common
	Blood urea nitrogen increased	Rare		
	Blood uric acid increased	Rare		
	Gamma glutamyl transferase increased	Uncommon		
	Hepatic enzymes increased		Common	

¹Non-melanoma skin cancer: Based on available data from epidemiological studies, cumulative dosedependent association between HCTZ and NMSC has been observed (see also sections 4.4 and 5.1)

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

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.

4.9 Overdose

No specific information is available on the effects or treatment of olmesartan medoxomil/hydrochlorothiazide combination overdose. The patient should be closely monitored, and the treatment should be symptomatic and supportive. Management depends upon the time since ingestion and the severity of the symptoms. Suggested measures include induction of emesis and/or gastric lavage. Activated charcoal may be useful in the treatment of overdose. Serum electrolytes and creatinine should be monitored frequently. If hypotension occurs, the patient should be placed in a supine position, with salt and volume replacements given quickly.

The most likely manifestations of olmesartan medoxomil overdose are expected to be hypotension and tachycardia; bradycardia might also occur. Overdose with hydrochlorothiazide is associated with electrolyte depletion (hypokalaemia, hypochloraemia) and dehydration resulting from excessive diuresis. The most common signs and symptoms of overdose are nausea and somnolence. Hypokalaemia may result in muscle spasm and/or accentuate cardiac arrhythmias associated with the concomitant use of digitalis glycosides or certain anti-arrhythmic medicinal products.

No information is available regarding the dialysability of olmesartan or hydrochlorothiazide.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Angiotensin II antagonists and diuretics, ATC code: C09DA08.

Mechanism of action / Pharmacodynamic effects

Olmесartan/Hydrochlorothiazide Krka is a combination of an angiotensin II receptor antagonist, olmesartan medoxomil, and a thiazide diuretic, hydrochlorothiazide. The combination of these ingredients has an additive antihypertensive effect, reducing blood pressure to a greater degree than either component alone.

Once daily dosing with Olmesartan/Hydrochlorothiazide Krka provides an effective and smooth reduction in blood pressure over the 24 hour dose interval.

Olmесartan medoxomil is an orally active, selective angiotensin II receptor (type AT₁) antagonist. Angiotensin II is the primary vasoactive hormone of the renin-angiotensin-aldosterone system and plays a significant role in the pathophysiology of hypertension. The effects of angiotensin II include vasoconstriction, stimulation of the synthesis and release of aldosterone, cardiac stimulation and renal reabsorption of sodium. Olmesartan blocks the vasoconstrictor and aldosterone-secreting effects of angiotensin II by blocking its binding to the AT₁ receptor in tissues including vascular smooth muscle and the adrenal gland. The action of olmesartan is independent of the source or route of synthesis of angiotensin II. The selective antagonism of the angiotensin II (AT₁) receptors by olmesartan results in increases in plasma renin levels and angiotensin I and II concentrations, and some decrease in plasma aldosterone concentrations.

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

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

With continuous treatment, maximum reductions in blood pressure are achieved by 8 weeks after the initiation of therapy, although a substantial proportion of the blood pressure lowering effect is already observed after 2 weeks of treatment.

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

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

For the primary endpoint, the study demonstrated a significant risk reduction in the time to onset of microalbuminuria, in favour of olmesartan. After adjustment for BP differences this risk reduction was no longer statistically significant. 8.2% (178 of 2160) of the patients in the olmesartan group and 9.8% (210 of 2139) in the placebo group developed microalbuminuria. For the secondary endpoints, cardiovascular events occurred in 96 patients (4.3%) with olmesartan and in 94 patients (4.2%) with placebo. The incidence of cardiovascular mortality was higher with olmesartan compared to placebo treatment (15 patients (0.7%) vs. 3 patients (0.1%)), despite similar rates for non-fatal stroke (14 patients (0.6%) vs. 8 patients (0.4%)), non-fatal myocardial infarction (17 patients (0.8%) vs. 26 patients (1.2%)) and non-cardiovascular mortality (11 patients (0.5%) vs. 12 patients (0.5%)). Overall mortality with olmesartan was numerically increased (26 patients (1.2%) vs. 15 patients (0.7%)), which was mainly driven by a higher number of fatal cardiovascular events.

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

The primary composite endpoint (time to first event of the doubling of serum creatinine, end-stage renal disease, all-cause death) occurred in 116 patients in the olmesartan group (41.1%) and 129 patients in the placebo group (45.4%) (HR 0.97 (95% CI 0.75 to 1.24); $p=0.791$). The composite secondary cardiovascular endpoint occurred in 40 olmesartan-treated patients (14.2%) and 53 placebo-treated patients (18.7%). This composite cardiovascular endpoint included cardiovascular death in 10 (3.5%) patients receiving olmesartan versus 3 (1.1%) receiving placebo, overall mortality 19 (6.7%) versus 20 (7.0%), non-fatal stroke 8 (2.8%) versus 11 (3.9%) and non-fatal myocardial infarction 3 (1.1%) versus 7 (2.5%), respectively.

Hydrochlorothiazide is a thiazide diuretic. The mechanism of the antihypertensive effect of thiazide diuretics is not fully known. Thiazides affect the renal tubular mechanisms of electrolyte reabsorption, directly increasing excretion of sodium and chloride in approximately equivalent amounts. The diuretic action of hydrochlorothiazide reduces plasma volume, increases plasma renin activity and increases aldosterone secretion, with consequent increases in urinary potassium and bicarbonate loss, and decreases in serum potassium. The renin-aldosterone link is mediated by angiotensin II and therefore co-administration of an angiotensin II receptor antagonist tends to reverse the potassium loss associated with thiazide diuretics. With hydrochlorothiazide, onset of diuresis occurs at about 2 hours and peak effect occurs at about 4 hours post-dose, whilst the action persists for approximately 6-12 hours.

Epidemiological studies have shown that long-term treatment with hydrochlorothiazide monotherapy reduces the risk of cardiovascular mortality and morbidity.

Clinical efficacy and safety

The combination of olmesartan medoxomil and hydrochlorothiazide produces additive reductions in blood pressure which generally increase with the dose of each component.

In pooled placebo-controlled studies, administration of the 20 mg/12.5 mg and 20 mg/25 mg combinations of olmesartan medoxomil/hydrochlorothiazide resulted in mean placebo-subtracted systolic/diastolic blood pressure reductions at trough of 12/7 mmHg and 16/9 mmHg, respectively.

Age and gender had no clinically relevant effect on response to treatment with olmesartan medoxomil/hydrochlorothiazide combination therapy.

Administration of 12.5 mg and 25 mg hydrochlorothiazide in patients insufficiently controlled by olmesartan medoxomil 20 mg monotherapy gave additional reductions in 24-hour systolic/diastolic blood pressures measured by ambulatory blood pressure monitoring of 7/5 mmHg and 12/7 mmHg, respectively, compared with olmesartan medoxomil monotherapy baseline. The additional mean systolic/diastolic blood pressure reductions at trough compared with baseline, measured conventionally, were 11/10 mmHg and 16/11 mmHg, respectively.

The effectiveness of olmesartan medoxomil/hydrochlorothiazide combination therapy was maintained over long-term (one-year) treatment. Withdrawal of olmesartan medoxomil therapy, with or without concomitant hydrochlorothiazide therapy, did not result in rebound hypertension.

The effects of fixed dose combination of olmesartan medoxomil/hydrochlorothiazide on mortality and cardiovascular morbidity are currently unknown.

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

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.

Non-melanoma skin cancer

Based on available data from epidemiological studies, cumulative dose-dependent association between HCTZ and NMSC has been observed. One study included a population comprised of 71,533 cases of BCC and of 8,629 cases of SCC matched to 1,430,833 and 172,462 population controls, respectively. High HCTZ use ($\geq 50,000$ mg cumulative) was associated with an adjusted OR of 1.29 (95% CI: 1.23-1.35) for BCC and 3.98 (95% CI: 3.68-4.31) for SCC. A clear cumulative dose response relationship was observed for both BCC and SCC. Another study showed a possible association between lip cancer (SCC) and exposure to HCTZ: 633 cases of lip-cancer were matched with 63,067 population controls, using a risk-set sampling strategy. A cumulative dose-response relationship was demonstrated with an adjusted OR 2.1 (95% CI: 1.7-2.6) increasing to OR 3.9 (3.0-4.9) for high use ($\sim 25,000$ mg) and OR 7.7 (5.7-10.5) for the highest cumulative dose ($\sim 100,000$ mg) (see also section 4.4).

5.2 Pharmacokinetic properties**Absorption and distribution**Olmesartan medoxomil:

Olmesartan medoxomil is a prodrug. It is rapidly converted to the pharmacologically active metabolite, olmesartan, by esterases in the gut mucosa and in portal blood during absorption from the gastrointestinal tract. No intact olmesartan medoxomil or intact side chain medoxomil moiety have been detected in plasma or excreta. The mean absolute bioavailability of olmesartan from a tablet formulation was 25.6%.

The mean peak plasma concentration (C_{max}) of olmesartan is reached within about 2 hours after oral dosing with olmesartan medoxomil, and olmesartan plasma concentrations increase approximately linearly with increasing single oral doses up to about 80 mg.

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

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

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

Hydrochlorothiazide:

Following oral administration of olmesartan medoxomil and hydrochlorothiazide in combination, the median time to peak concentrations of hydrochlorothiazide was 1.5 to 2 hours after dosing. Hydrochlorothiazide is 68% protein bound in the plasma and its apparent volume of distribution is 0.83 – 1.14 l/kg.

Biotransformation and elimination

Olmesartan medoxomil:

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

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

Hydrochlorothiazide:

Hydrochlorothiazide is not metabolised in man and is excreted almost entirely as unchanged active substance in urine. About 60% of the oral dose is eliminated as unchanged active substance within 48 hours. Renal clearance is about 250 – 300 ml/min. The terminal elimination half-life of hydrochlorothiazide is 10 – 15 hours.

The combination of olmesartan medoxomil and hydrochlorothiazide

The systemic availability of hydrochlorothiazide is reduced by about 20% when co-administered with olmesartan medoxomil, but this modest decrease is not of any clinical relevance. The kinetics of olmesartan are unaffected by the co-administration of hydrochlorothiazide.

Pharmacokinetics in special populations

Older people (age 65 years or over):

In hypertensive patients, the olmesartan AUC at steady state was increased by ca 35% in older people (65 – 75 years old) and by ca 44% in very old people (≥ 75 years old) compared with the younger age group (see section 4.2).

Limited data suggest that the systemic clearance of hydrochlorothiazide is reduced in both healthy and hypertensive older people compared to young healthy volunteers.

Renal impairment:

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

The half-life of hydrochlorothiazide is prolonged in patients with impaired renal function.

Hepatic impairment:

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

Hepatic impairment does not significantly influence the pharmacokinetics of hydrochlorothiazide.

Drug interactions

Bile acid sequestering agent colesevelam:

Concomitant administration of 40 mg olmesartan medoxomil and 3750 mg colesevelam hydrochloride in healthy subjects resulted in 28% reduction in C_{max} and 39% reduction in AUC of olmesartan. Lesser effects, 4% and 15% reduction in C_{max} and AUC respectively, were observed when olmesartan medoxomil was administered 4 hours prior to colesevelam hydrochloride. Elimination half life of olmesartan was reduced by 50 – 52% irrespectively of whether administered concomitantly or 4 hours prior to colesevelam hydrochloride (see section 4.5).

5.3 Preclinical safety data

The toxic potential of olmesartan medoxomil/hydrochlorothiazide combinations was evaluated in repeated dose oral toxicity studies for up to six months in rats and dogs.

As for each of the individual substances and other medicinal products in this class, the main toxicological target organ of the combination was the kidney. The combination of olmesartan medoxomil/hydrochlorothiazide induced functional renal changes (increases in serum urea nitrogen and in serum creatinine). High dosages caused tubular degeneration and regeneration in the kidneys of rats and dogs, probably via a change in renal haemodynamics (reduced renal perfusion resulting from hypotension with tubular hypoxia and tubular cell degeneration). In addition the olmesartan medoxomil/ hydrochlorothiazide combination caused a decrease in red blood cell parameters (erythrocytes, haemoglobin and haematocrit) and a reduction in heart weight in rats.

These effects have also been observed for other AT¹ receptor antagonists and for ACE inhibitors and they seem to have been induced by the pharmacological action of high dosages of olmesartan medoxomil and seem to be not relevant to humans at the recommended therapeutic doses.

Genotoxicity studies using combined olmesartan medoxomil and hydrochlorothiazide as well as the individual components have not shown any signs of a clinically relevant genotoxic activity.

The carcinogenic potential of a combination of olmesartan medoxomil and hydrochlorothiazide was not investigated as there was no evidence of relevant carcinogenic effects for the two individual components under conditions of clinical use.

There was no evidence of teratogenicity in mice or rats treated with olmesartan medoxomil/hydrochlorothiazide combinations. As expected from this class of medicinal product, fetal toxicity was observed in rats, as evidenced by significantly reduced fetal body weights, when treated with olmesartan medoxomil/ hydrochlorothiazide combinations during gestation (see sections 4.3, 4.6).

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Cellulose microcrystalline
Magnesium stearate
Low-substituted hydroxypropylcellulose

Film coating

Titanium dioxide
Talc
Poly(vinyl alcohol)
Macrogol 3000

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

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

6.5 Nature and contents of container

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

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

Any unused product or waste material should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

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

8 MARKETING AUTHORISATION NUMBER

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9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

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Date of last renewal: 14th February 2021

10 DATE OF REVISION OF THE TEXT

March 2021