

ANNEX I

SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Clopidogrel dura 75 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 75 mg of clopidogrel (as hydrochloride).

Excipient with known effect:

Each film-coated tablet contains 13 mg hydrogenated castor oil.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet.

Pink, round and slightly convex film-coated tablets.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Prevention of atherothrombotic events

Clopidogrel is indicated in:

- Adults patients suffering from myocardial infarction (from a few days until less than 35 days), ischaemic stroke (from 7 days until less than 6 months) or established peripheral arterial disease.

For further information please refer to section 5.1.

4.2 Posology and method of administration

Posology

- Adults and elderly

Clopidogrel should be given as a single daily dose of 75 mg.

If a dose is missed:

- Within less than 12 hours after regular scheduled time: patients should take the dose immediately and then take the next dose at the regular scheduled time.
 - For more than 12 hours: patients should take the next dose at the regular scheduled time and should not double the dose.
- Paediatric population
Clopidogrel should not be used in children because of efficacy concerns (see section 5.1).
 - Renal impairment
Therapeutic experience is limited in patients with renal impairment (see section 4.4).
 - Hepatic impairment

Therapeutic experience is limited in patients with moderate hepatic disease who may have bleeding diatheses (see section 4.4).

Method of administration

For oral use

It may be given with or without food.

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Severe hepatic impairment.
- Active pathological bleeding such as peptic ulcer or intracranial haemorrhage.

4.4 Special warnings and precautions for use

Bleeding and haematological disorders

Due to the risk of bleeding and haematological adverse reactions, blood cell count determination and/or other appropriate testing should be promptly considered whenever clinical symptoms suggestive of bleeding arise during the course of treatment (see section 4.8). As with other antiplatelet agents, clopidogrel should be used with caution in patients who may be at risk of increased bleeding from trauma, surgery or other pathological conditions and in patients receiving treatment with ASA, heparin, glycoprotein IIb/IIIa inhibitors or non-steroidal anti-inflammatory drugs (NSAIDs) including Cox-2 inhibitors. Patients should be followed carefully for any signs of bleeding including occult bleeding, especially during the first weeks of treatment and/or after invasive cardiac procedures or surgery. The concomitant administration of clopidogrel with oral anticoagulants is not recommended since it may increase the intensity of bleedings (see section 4.5).

If a patient is to undergo elective surgery and antiplatelet effect is temporarily not desirable, clopidogrel should be discontinued 7 days prior to surgery. Patients should inform physicians and dentists that they are taking clopidogrel before any surgery is scheduled and before any new medicinal product is taken. Clopidogrel prolongs bleeding time and should be used with caution in patients who have lesions with a propensity to bleed (particularly gastrointestinal and intraocular).

Patients should be told that it might take longer than usual to stop bleeding when they take clopidogrel (alone or in combination with ASA), and that they should report any unusual bleeding (site or duration) to their physician.

Thrombotic Thrombocytopenic Purpura (TTP)

Thrombotic Thrombocytopenic Purpura (TTP) has been reported very rarely following the use of clopidogrel, sometimes after a short exposure. It is characterised by thrombocytopenia and microangiopathic haemolytic anaemia associated with either neurological findings, renal dysfunction or fever. TTP is a potentially fatal condition requiring prompt treatment including plasmapheresis.

Acquired haemophilia

Acquired haemophilia has been reported following use of clopidogrel. In cases of confirmed isolated activated Partial Thromboplastin Time (aPTT) prolongation with or without bleeding, acquired haemophilia should be considered. Patients with a confirmed diagnosis of acquired haemophilia should be managed and treated by specialists, and clopidogrel should be discontinued.

Recent ischaemic stroke

In view of the lack of data, clopidogrel cannot be recommended during the first 7 days after acute ischaemic stroke.

Cytochrome P450 2C19 (CYP2C19)

Pharmacogenetics: In patients who are poor CYP2C19 metabolisers, clopidogrel at recommended doses forms less of the active metabolite of clopidogrel and has a smaller effect on platelet function. Tests are available to identify a patient's CYP2C19 genotype.

Since clopidogrel is metabolised to its active metabolite partly by CYP2C19, use of medicinal products that inhibit the activity of this enzyme would be expected to result in reduced drug levels of the active metabolite of clopidogrel. The clinical relevance of this interaction is uncertain. As a precaution concomitant use of strong or moderate CYP2C19 inhibitors should be discouraged (see section 4.5 for a list of CYP2C19 inhibitors, see also section 5.2).

Cross-reactions among thienopyridines

Patients should be evaluated for history of hypersensitivity to thienopyridines (such as clopidogrel, ticlopidine, prasugrel) since cross-reactivity among thienopyridines has been reported (see section 4.8). Thienopyridines may cause mild to severe allergic reactions such as rash, angioedema, or haematological cross-reactions such as thrombocytopenia and neutropenia. Patients who had developed a previous allergic reaction and/or haematological reaction to one thienopyridine may have an increased risk of developing the same or another reaction to another thienopyridine. Monitoring for signs of hypersensitivity in patients with a known allergy to thienopyridines is advised.

Renal impairment

Therapeutic experience with clopidogrel is limited in patients with renal impairment. Therefore clopidogrel should be used with caution in these patients (see section 4.2).

Hepatic impairment

Experience is limited in patients with moderate hepatic disease who may have bleeding diatheses. Clopidogrel should therefore be used with caution in this population (see section 4.2).

Excipients

This medicinal product contains hydrogenated castor oil which may cause stomach upset and diarrhoea.

4.5 Interaction with other medicinal products and other forms of interaction

Oral anticoagulants: the concomitant administration of clopidogrel with oral anticoagulants is not recommended since it may increase the intensity of bleedings (see section 4.4). Although the administration of clopidogrel 75 mg/day did not modify the pharmacokinetics of S-warfarin or International Normalised Ratio (INR) in patients receiving long-term warfarin therapy, coadministration of clopidogrel with warfarin increases the risk of bleeding because of independent effects on hemostasis.

Glycoprotein IIb/IIIa inhibitors: clopidogrel should be used with caution in patients who receive concomitant glycoprotein IIb/IIIa inhibitors (see section 4.4).

Acetylsalicylic acid (ASA): ASA did not modify the clopidogrel-mediated inhibition of ADP-induced platelet aggregation, but clopidogrel potentiated the effect of ASA on collagen-induced platelet aggregation. However, concomitant administration of 500 mg of ASA twice a day for one day did not significantly increase the prolongation of bleeding time induced by clopidogrel intake. A pharmacodynamic interaction between clopidogrel and acetylsalicylic acid is possible, leading to increased risk of bleeding. Therefore, concomitant use should be undertaken with caution (see section 4.4). However, clopidogrel and ASA have been administered together for up to one year (see section 5.1).

Heparin: in a clinical study conducted in healthy subjects, clopidogrel did not necessitate modification of the heparin dose or alter the effect of heparin on coagulation. Co-administration of heparin had no effect on the inhibition of platelet aggregation induced by clopidogrel. A pharmacodynamic

interaction between clopidogrel and heparin is possible, leading to increased risk of bleeding. Therefore, concomitant use should be undertaken with caution (see section 4.4).

Thrombolytics: the safety of the concomitant administration of clopidogrel, fibrin or non-fibrin specific thrombolytic agents and heparins was assessed in patients with acute myocardial infarction. The incidence of clinically significant bleeding was similar to that observed when thrombolytic agents and heparin are co-administered with ASA (see section 4.8).

NSAIDs: in a clinical study conducted in healthy volunteers, the concomitant administration of clopidogrel and naproxen increased occult gastrointestinal blood loss. However, due to the lack of interaction studies with other NSAIDs it is presently unclear whether there is an increased risk of gastrointestinal bleeding with all NSAIDs. Consequently, NSAIDs including Cox-2 inhibitors and clopidogrel should be co-administered with caution (see section 4.4).

Other concomitant therapy:

Since clopidogrel is metabolised to its active metabolite partly by CYP2C19, use of medicinal products that inhibit the activity of this enzyme would be expected to result in reduced drug levels of the active metabolite of clopidogrel. The clinical relevance of this interaction is uncertain. As a precaution concomitant use of strong or moderate CYP2C19 inhibitors should be discouraged (see sections 4.4 and 5.2).

Medicinal products that inhibit CYP2C19 include omeprazole and esomeprazole, fluvoxamine, fluoxetine, moclobemide, voriconazole, fluconazole, ticlopidine, ciprofloxacin, cimetidine, carbamazepine, oxcarbazepine and chloramphenicol.

Proton Pump Inhibitors (PPI):

Omeprazole 80 mg once daily administered either at the same time as clopidogrel or with 12 hours between the administrations of the two drugs decreased the exposure of the active metabolite by 45% (loading dose) and 40% (maintenance dose). The decrease was associated with a 39% (loading dose) and 21% (maintenance dose) reduction of inhibition of platelet aggregation. Esomeprazole is expected to give a similar interaction with clopidogrel.

Inconsistent data on the clinical implications of this pharmacokinetic (PK)/pharmacodynamic (PD) interaction in terms of major cardiovascular events have been reported from both observational and clinical studies. As a precaution, concomitant use of omeprazole or esomeprazole should be discouraged (see section 4.4).

Less pronounced reductions of metabolite exposure has been observed with pantoprazole or lansoprazole.

The plasma concentrations of the active metabolite was 20% reduced (loading dose) and 14% reduced (maintenance dose) during concomitant treatment with pantoprazole 80 mg once daily. This was associated with a reduction of the mean inhibition of platelet aggregation by 15% and 11%, respectively. These results indicate that clopidogrel can be administered with pantoprazole.

There is no evidence that other medicinal products that reduce stomach acid such as H₂ blockers (except cimetidine which is a CYP2C19 inhibitor) or antacids interfere with antiplatelet activity of clopidogrel.

Other medicinal products: A number of other clinical studies have been conducted with clopidogrel and other concomitant medicinal products to investigate the potential for pharmacodynamic and pharmacokinetic interactions. No clinically significant pharmacodynamic interactions were observed when clopidogrel was co-administered with atenolol, nifedipine, or both atenolol and nifedipine. Furthermore, the pharmacodynamic activity of clopidogrel was not significantly influenced by the co-administration of phenobarbital, or oestrogen.

The pharmacokinetics of digoxin or theophylline were not modified by the co-administration of clopidogrel. Antacids did not modify the extent of clopidogrel absorption.

Data from the CAPRIE study indicate that phenytoin and tolbutamide which are metabolised by CYP2C9 can be safely co-administered with clopidogrel.

Apart from the specific medicinal product interaction information described above, interaction studies with clopidogrel and some medicinal products commonly administered in patients with atherothrombotic disease have not been performed. However, patients entered into clinical trials with clopidogrel received a variety of concomitant medicinal products including diuretics, beta blockers, ACEI, calcium antagonists, cholesterol lowering agents, coronary vasodilators, antidiabetic agents (including insulin), antiepileptic agents, and GPIIb/IIIa antagonists without evidence of clinically significant adverse interactions.

4.6 Fertility, pregnancy and lactation

Pregnancy

As no clinical data on exposure to clopidogrel during pregnancy are available, it is preferable not to use clopidogrel during pregnancy as a precautionary measure.

Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/foetal development, parturition or postnatal development (see section 5.3).

Breast-feeding

It is unknown whether clopidogrel is excreted in human breast milk. Animal studies have shown excretion of clopidogrel in breast milk. As a precautionary measure, breast-feeding should not be continued during treatment with Clopidogrel dura.

Fertility

Clopidogrel was not shown to alter fertility in animal studies.

4.7 Effects on ability to drive and use machines

Clopidogrel has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

Summary of the safety profile

Clopidogrel has been evaluated for safety in more than 42,000 patients, who have participated in clinical studies, including over 9,000 patients treated for 1 year or more. The clinically relevant adverse reactions observed in the CAPRIE, CURE, CLARITY and COMMIT studies are discussed below. Overall, clopidogrel 75 mg/day was comparable to ASA 325 mg/day in CAPRIE regardless of age, gender and race. The clinically relevant adverse reactions observed in the CAPRIE, CURE, CLARITY, COMMIT studies are discussed below. In addition to clinical studies experience, adverse reactions have been spontaneously reported.

Bleeding is the most common reaction reported both in clinical studies as well as in post-marketing experience where it was mostly reported during the first month of treatment.

In CAPRIE, in patients treated with either clopidogrel or ASA, the overall incidence of any bleeding was 9.3%. The incidence of severe cases was similar for clopidogrel and ASA.

In CURE, there was no excess in major bleeds with clopidogrel plus ASA within 7 days after coronary bypass graft surgery in patients who stopped therapy more than five days prior to surgery. In patients who remained on therapy within five days of bypass graft surgery, the event rate was 9.6% for clopidogrel plus ASA, and 6.3% for placebo plus ASA.

In CLARITY, there was an overall increase in bleeding in the clopidogrel plus ASA group vs. the placebo plus ASA group. The incidence of major bleeding was similar between groups. This was consistent across subgroups of patients defined by baseline characteristics, and type of fibrinolytic or heparin therapy.

In COMMIT, the overall rate of noncerebral major bleeding or cerebral bleeding was low and similar in both groups

Tabulated list of adverse reactions

Adverse reactions that occurred either during clinical studies or that were spontaneously reported are presented in the table below. Their frequency is defined using the following conventions: 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). Within each system organ class, adverse reactions are presented in order of decreasing seriousness.

System Organ Class	Common	Uncommon	Rare	Very rare, not known*
Blood and the lymphatic system disorders		Thrombocytopenia, leucopenia, eosinophilia	Neutropenia, including severe neutropenia	Thrombotic thrombocytopenic purpura (TTP) (see section 4.4), aplastic anaemia, pancytopenia, agranulocytosis, severe thrombocytopenia, acquired haemophilia A, granulocytopenia, anaemia
Immune system disorders				Serum sickness, anaphylactoid reactions, cross reactive drug hypersensitivity among thienopyridines (such as ticlopidine, prasugrel) (see section 4.4)*
Psychiatric disorders				Hallucinations, confusion
Nervous system disorders		Intracranial bleeding (some cases were reported with fatal outcome), headache, paraesthesia, dizziness		Taste disturbances

Eye disorders		Eye bleeding (conjunctival, ocular, retinal)		
Ear and labyrinth disorders			Vertigo	
Vascular disorders	Haematoma			Serious haemorrhage, haemorrhage of operative wound, vasculitis, hypotension
Respiratory, thoracic and mediastinal disorders	Epistaxis			Respiratory tract bleeding (haemoptysis, pulmonary haemorrhage), bronchospasm, interstitial pneumonitis, eosinophilic pneumonia
Gastrointestinal disorders	Gastrointestinal haemorrhage, diarrhoea, abdominal pain, dyspepsia	Gastric ulcer and duodenal ulcer, gastritis, vomiting, nausea, constipation, flatulence	Retroperitoneal haemorrhage	Gastrointestinal and retroperitoneal haemorrhage with fatal outcome, pancreatitis, colitis (including ulcerative or lymphocytic colitis), stomatitis
Hepato-biliary disorders				Acute liver failure, hepatitis, abnormal liver function test
Skin and subcutaneous tissue disorders	Bruising	Rash, pruritus, skin bleeding (purpura)		Bullous dermatitis (toxic epidermal necrolysis, Stevens Johnson Syndrome, erythema multiforme), angioedema, drug induced hypersensitivity syndrome, drug rash with eosinophilia and systemic symptoms (DRESS), rash erythematous, urticaria, eczema, lichen planus
Musculoskeletal, connective tissue and bone disorders				Musculo-skeletal bleeding (haemarthrosis), arthritis, arthralgia, myalgia

Renal and urinary disorders		Haematuria		Glomerulonephritis, blood creatinine increased
General disorders and administration site conditions	Bleeding at puncture site			Fever
Investigations		Bleeding time prolonged, neutrophil count decreased, platelet count decreased		

* Information related to clopidogrel with frequency “not known”.

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 the national reporting system listed in [Appendix V](#).

4.9 Overdose

Overdose following clopidogrel administration may lead to prolonged bleeding time and subsequent bleeding complications. Appropriate therapy should be considered if bleedings are observed. No antidote to the pharmacological activity of clopidogrel has been found. If prompt correction of prolonged bleeding time is required, platelet transfusion may reverse the effects of clopidogrel.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antithrombotic agents, platelet aggregation inhibitors excl. heparin, ATC code: B01AC04.

Mechanism of action

Clopidogrel is a prodrug, one of whose metabolites is an inhibitor of platelet aggregation. Clopidogrel must be metabolised by CYP450 enzymes to produce the active metabolite that inhibits platelet aggregation. The active metabolite of clopidogrel selectively inhibits the binding of adenosine diphosphate (ADP) to its platelet P2Y₁₂ receptor and the subsequent ADP-mediated activation of the glycoprotein GPIIb/IIIa complex, thereby inhibiting platelet aggregation. Due to the irreversible binding, platelets exposed are affected for the remainder of their lifespan (approximately 7-10 days) and recovery of normal platelet function occurs at a rate consistent with platelet turnover. Platelet aggregation induced by agonists other than ADP is also inhibited by blocking the amplification of platelet activation by released ADP.

Because the active metabolite is formed by CYP450 enzymes, some of which are polymorphic or subject to inhibition by medicinal products, not all patients will have adequate platelet inhibition.

Pharmacodynamic effects

Repeated doses of 75 mg per day produced substantial inhibition of ADP-induced platelet aggregation from the first day; this increased progressively and reached steady state between Day 3 and Day 7. At steady state, the average inhibition level observed with a dose of 75 mg per day was between 40% and

60%. Platelet aggregation and bleeding time gradually returned to baseline values, generally within 5 days after treatment was discontinued.

Clinical efficacy and safety

The safety and efficacy of clopidogrel have been evaluated in 4 double-blind studies involving over 80,000 patients: the CAPRIE study, a comparison of clopidogrel to ASA, and the CURE, CLARITY and COMMIT studies comparing clopidogrel to placebo, both medicinal products given in combination with ASA and other standard therapy.

Recent myocardial infarction (MI), recent stroke or established peripheral arterial disease

The CAPRIE study included 19,185 patients with atherothrombosis as manifested by recent myocardial infarction (<35 days), recent ischaemic stroke (between 7 days and 6 months) or established peripheral arterial disease (PAD). Patients were randomised to clopidogrel 75 mg/day or ASA 325 mg/day, and were followed for 1 to 3 years. In the myocardial infarction subgroup, most of the patients received ASA for the first few days following the acute myocardial infarction. Clopidogrel significantly reduced the incidence of new ischaemic events (combined end point of myocardial infarction, ischaemic stroke and vascular death) when compared to ASA. In the intention to treat analysis, 939 events were observed in the clopidogrel group and 1,020 events with ASA (relative risk reduction (RRR) 8.7%, [95% CI: 0.2 to 16.4]; $p = 0.045$), which corresponds, for every 1000 patients treated for 2 years, to 10 [CI: 0 to 20] additional patients being prevented from experiencing a new ischaemic event. Analysis of total mortality as a secondary endpoint did not show any significant difference between clopidogrel (5.8%) and ASA (6.0%).

In a subgroup analysis by qualifying condition (myocardial infarction, ischaemic stroke, and PAD) the benefit appeared to be strongest (achieving statistical significance at $p = 0.003$) in patients enrolled due to PAD (especially those who also had a history of myocardial infarction) (RRR = 23.7%; CI: 8.9 to 36.2) and weaker (not significantly different from ASA) in stroke patients (RRR = 7.3%; CI: -5.7 to 18.7 [$p=0.258$]). In patients who were enrolled in the trial on the sole basis of a recent myocardial infarction, clopidogrel was numerically inferior, but not statistically different from ASA (RRR = -4.0%; CI: -22.5 to 11.7 [$p=0.639$]). In addition, a subgroup analysis by age suggested that the benefit of clopidogrel in patients over 75 years was less than that observed in patients ≤ 75 years.

Since the CAPRIE trial was not powered to evaluate efficacy of individual subgroups, it is not clear whether the differences in relative risk reduction across qualifying conditions are real, or a result of chance.

Paediatric population

In a dose escalation study of 86 neonates or infants up to 24 months of age at risk for thrombosis (PICOLO), clopidogrel was evaluated at consecutive doses of 0.01, 0.1 and 0.2 mg/kg in neonates and infants and 0.15 mg/kg only in neonates. The dose of 0.2 mg/kg achieved the mean percent inhibition of 49.3% (5 μ M ADP-induced platelet aggregation) which was comparable to that of adults taking Clopidogrel 75 mg/day.

In a randomised, double-blind, parallel-group study (CLARINET), 906 paediatric patients (neonates and infants) with cyanotic congenital heart disease palliated with a systemic-to-pulmonary arterial shunt were randomised to receive clopidogrel 0.2 mg/kg ($n=467$) or placebo ($n=439$) along with concomitant background therapy up to the time of second stage surgery. The mean time between shunt palliation and first administration of study medicinal product was 20 days. Approximately 88% of patients received concomitant ASA (range of 1 to 23 mg/kg/day). There was no significant difference between groups in the primary composite endpoint of death, shunt thrombosis or cardiac-related intervention prior to 120 days of age following an event considered of thrombotic nature (89 [19.1%] for the clopidogrel group and 90 [20.5%] for the placebo group) (see section 4.2). Bleeding was the most frequently reported adverse reaction in both clopidogrel and placebo groups; however, there was no significant difference in the bleeding rate between groups. In the long-term safety follow-up of this study, 26 patients with the shunt still in place at one year of age received clopidogrel up to 18 months of age. No new safety concerns were noted during this long-term follow-up.

The CLARINET and the PICOLO trials were conducted using a constituted solution of clopidogrel. In a relative bioavailability study in adults, the constituted solution of clopidogrel showed a similar extent and slightly higher rate of absorption of the main circulating (inactive) metabolite compared to the authorised tablet.

5.2 Pharmacokinetic properties

Absorption

After single and repeated oral doses of 75 mg per day, clopidogrel is rapidly absorbed. Mean peak plasma levels of unchanged clopidogrel (approximately 2.2-2.5 ng/ml after a single 75 mg oral dose) occurred approximately 45 minutes after dosing. Absorption is at least 50%, based on urinary excretion of clopidogrel metabolites.

Distribution

Clopidogrel and the main circulating (inactive) metabolite bind reversibly *in vitro* to human plasma proteins (98% and 94% respectively). The binding is non-saturable *in vitro* over a wide concentration range.

Biotransformation

Clopidogrel is extensively metabolised by the liver. *In vitro* and *in vivo*, clopidogrel is metabolised according to two main metabolic pathways: one mediated by esterases and leading to hydrolysis into its inactive carboxylic acid derivative (85% of circulating metabolites), and one mediated by multiple cytochromes P450. Clopidogrel is first metabolised to a 2-oxo-clopidogrel intermediate metabolite. Subsequent metabolism of the 2-oxo-clopidogrel intermediate metabolite results in formation of the active metabolite, a thiol derivative of clopidogrel. *In vitro*, this metabolic pathway is mediated by CYP3A4, CYP2C19, CYP1A2 and CYP2B6. The active thiol metabolite which has been isolated *in vitro*, binds rapidly and irreversibly to platelet receptors, thus inhibiting platelet aggregation.

The C_{max} of the active metabolite is twice as high following a single 300-mg clopidogrel loading dose as it is after four days of 75-mg maintenance dose. C_{max} occurs approximately 30 to 60 minutes after dosing.

Elimination

Following an oral dose of ¹⁴C-labelled clopidogrel in man, approximately 50% was excreted in the urine and approximately 46% in the faeces in the 120-hour interval after dosing. After a single oral dose of 75 mg, clopidogrel has a half-life of approximately 6 hours. The elimination half life of the main circulating (inactive) metabolite was 8 hours after single and repeated administration.

Pharmacogenetics

CYP2C19 is involved in the formation of both the active metabolite and the 2-oxo-clopidogrel intermediate metabolite. Clopidogrel active metabolite pharmacokinetics and antiplatelet effects, as measured by *ex vivo* platelet aggregation assays, differ according to CYP2C19 genotype.

The CYP2C19*1 allele corresponds to fully functional metabolism while the CYP2C19*2 and CYP2C19*3 alleles are nonfunctional. The CYP2C19*2 and CYP2C19*3 alleles account for the majority of reduced function alleles in Caucasian (85%) and Asian (99%) poor metabolisers. Other alleles associated with absent or reduced metabolism are less frequent and include CYP2C19*4, *5, *6, *7, and *8. A patient with poor metaboliser status will possess two loss-of-function alleles as defined above. Published frequencies for the poor CYP2C19 metaboliser genotypes are approximately 2% for Caucasians, 4% for Blacks and 14% for Chinese. Tests are available to determine a patient's CYP2C19 genotype.

A crossover study in 40 healthy subjects, 10 each in the four CYP2C19 metaboliser groups (ultrarapid, extensive, intermediate and poor), evaluated pharmacokinetic and antiplatelet responses using 300 mg followed by 75 mg/day and 600 mg followed by 150 mg/day, each for a total of 5 days (steady state).

No substantial differences in active metabolite exposure and mean inhibition of platelet aggregation (IPA) were observed between ultrarapid, extensive and intermediate metabolisers. In poor metabolisers, active metabolite exposure was decreased by 63-71% compared to extensive metabolisers. After the 300 mg/75 mg dose regimen, antiplatelet responses were decreased in the poor metabolisers with mean IPA (5 μ M ADP) of 24% (24 hours) and 37% (Day 5) as compared to IPA of 39% (24 hours) and 58% (Day 5) in the extensive metabolisers and 37% (24 hours) and 60% (Day 5) in the intermediate metabolisers. When poor metabolisers received the 600 mg/150 mg regimen, active metabolite exposure was greater than with the 300 mg/75 mg regimen. In addition, IPA was 32% (24 hours) and 61% (Day 5), which were greater than in the poor metabolisers receiving the 300 mg/75 mg regimen, and were similar to the other CYP2C19 metaboliser groups receiving the 300 mg/75 mg regimen. An appropriate dose regimen for this patient population has not been established in clinical outcome trials.

Consistent with the above results, in a meta-analysis including 6 studies of 335 clopidogrel-treated subjects at steady state, it was shown that active metabolite exposure was decreased by 28% for intermediate metabolisers, and 72% for poor metabolisers while platelet aggregation inhibition (5 μ M ADP) was decreased with differences in IPA of 5.9% and 21.4%, respectively, when compared to extensive metabolisers.

The influence of CYP2C19 genotype on clinical outcomes in patients treated with clopidogrel has not been evaluated in prospective, randomised, controlled trials. There have been a number of retrospective analyses, however, to evaluate this effect in patients treated with clopidogrel for whom there are genotyping results: CURE (n=2721), CHARISMA (n=2428), CLARITY-TIMI 28 (n=227), TRITON-TIMI 38 (n=1477), and ACTIVE-A (n=601), as well as a number of published cohort studies.

In TRITON-TIMI 38 and 3 of the cohort studies (Collet, Sibbing, Giusti) the combined group of patients with either intermediate or poor metaboliser status had a higher rate of cardiovascular events (death, myocardial infarction, and stroke) or stent thrombosis compared to extensive metabolisers.

In CHARISMA and one cohort study (Simon), an increased event rate was observed only in poor metabolisers when compared to extensive metabolisers.

In CURE, CLARITY and one of the cohort studies (Trenk), no increased event rate was observed based on metaboliser status.

None of these analyses were adequately sized to detect differences in outcome in poor metabolisers.

Special populations

The pharmacokinetics of the active metabolite of clopidogrel is not known in these special populations.

Renal impairment

After repeated doses of 75 mg clopidogrel per day in subjects with severe renal disease (creatinine clearance from 5 to 15 ml/min) inhibition of ADP-induced platelet aggregation was lower (25%) than that observed in healthy subjects, however, the prolongation of bleeding time was similar to that seen in healthy subjects receiving 75 mg of clopidogrel per day. In addition, clinical tolerance was good in all patients.

Hepatic impairment

After repeated doses of 75 mg clopidogrel per day for 10 days in patients with severe hepatic impairment, inhibition of ADP-induced platelet aggregation was similar to that observed in healthy subjects. The mean bleeding time prolongation was also similar in the two groups.

Race

The prevalence of CYP2C19 alleles that result in intermediate and poor CYP2C19 metabolism differs according to race/ethnicity (see Pharmacogenetics). From literature, limited data in Asian populations are available to assess the clinical implication of genotyping of this CYP on clinical outcome events.

5.3 Preclinical safety data

During non clinical studies in rat and baboon, the most frequently observed effects were liver changes. These occurred at doses representing at least 25 times the exposure seen in humans receiving the clinical dose of 75 mg/day and were a consequence of an effect on hepatic metabolising enzymes. No effect on hepatic metabolising enzymes was observed in humans receiving clopidogrel at the therapeutic dose.

At very high doses, a poor gastric tolerability (gastritis, gastric erosions and/or vomiting) of clopidogrel was also reported in rat and baboon.

There was no evidence of carcinogenic effect when clopidogrel was administered for 78 weeks to mice and 104 weeks to rats when given at doses up to 77 mg/kg per day (representing at least 25 times the exposure seen in humans receiving the clinical dose of 75 mg/day).

Clopidogrel has been tested in a range of *in vitro* and *in vivo* genotoxicity studies, and showed no genotoxic activity.

Clopidogrel was found to have no effect on the fertility of male and female rats and was not teratogenic in either rats or rabbits. When given to lactating rats, clopidogrel caused a slight delay in the development of the offspring. Specific pharmacokinetic studies performed with radiolabelled clopidogrel have shown that the parent compound or its metabolites are excreted in the milk. Consequently, a direct effect (slight toxicity), or an indirect effect (low palatability) cannot be excluded.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core:

Cellulose, microcrystalline
Colloidal anhydrous silica
Crospovidone (type A)
Macrogol 6000
Hydrogenated castor oil

Film coating:

Polyvinyl alcohol
Titanium dioxide (E171)
Red iron oxide (E172)
Yellow iron oxide (E172)
Talc
Macrogol 3000 (Polyethyleneglycol)

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 and light.

6.5 Nature and contents of container

Blister of OPA/Al/PVC-Al containing 7, 14, 28, 30, 50, 56, 84, 90 and 100 film-coated tablets in the box.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

7. MARKETING AUTHORISATION HOLDER

Mylan dura GmbH, Wittichstraße 6, D-64295 Darmstadt, Germany

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/09/560/001-009

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 21 September 2009

Date of latest renewal:

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines Agency <http://www.ema.europa.eu/>.

ANNEX II

- A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE**
- B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE**
- C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION**
- D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT**

A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE

Name and address of the manufacturer(s) responsible for batch release

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

TAD Pharma GmbH
Heinz-Lohmann-Straße 5
27472 Cuxhaven
Germany

The printed package leaflet of the medicinal product must state the name and address of the manufacturer responsible for the release of the concerned batch.

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

Medicinal product subject to medical prescription.

C. AND REQUIREMENTS OF THE MARKETING AUTHORISATION

- **Periodic Safety Update Reports**

The marketing authorisation holder shall submit periodic safety update reports for this product in accordance with the requirements set out in the list of Union reference dates (EURD list)) provided for under Article 107c(7) of Directive 2001/83/EC and published on the European medicines web-portal.

D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT

- **Risk Management Plan (RMP)**

Not applicable

ANNEX III

LABELLING AND PACKAGE LEAFLET

Medicinal product no longer authorised

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING**OUTER CARTON****1. NAME OF THE MEDICINAL PRODUCT**

Clopidogrel dura 75 mg film-coated tablets

clopidogrel

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each film-coated tablet contains 75 mg of clopidogrel (as hydrochloride).

3. LIST OF EXCIPIENTS

It also contains hydrogenated castor oil.
See leaflet for further information.

4. PHARMACEUTICAL FORM AND CONTENTS

7 film-coated tablets
14 film-coated tablets
28 film-coated tablets
30 film-coated tablets
50 film-coated tablets
56 film-coated tablets
84 film-coated tablets
90 film-coated tablets
100 film-coated tablets

5. METHOD AND ROUTE(S) OF ADMINISTRATION

Read the package leaflet before use.
Oral use

6. SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN

Keep out of the sight and reach of children.

7. OTHER SPECIAL WARNING(S), IF NECESSARY**8. EXPIRY DATE**

EXP

9. SPECIAL STORAGE CONDITIONS

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

10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Mylan dura GmbH, Wittichstraße 6, D-64295 Darmstadt, Germany

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/09/560/001-009

13. BATCH NUMBER

Batch

14. GENERAL CLASSIFICATION FOR SUPPLY

Medicinal product subject to medical prescription.

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Clopidogrel dura 75 mg

MINIMUM PARTICULARS TO APPEAR ON BLISTERS OR STRIPS
--

BLISTER

1. NAME OF THE MEDICINAL PRODUCT

Clopidogrel dura 75 mg film-coated tablets

clopidogrel

2. NAME OF THE MARKETING AUTHORISATION HOLDER
--

Mylan dura GmbH

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Batch

5. OTHER

B. PACKAGE LEAFLET

Medicinal product no longer authorised

Package leaflet: Information for the user

Clopidogrel dura 75 mg film-coated tablets clopidogrel

Read all of this leaflet carefully before you start taking this medicine because it contains important information for you.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you have any side effects, including any side effects not listed in this leaflet, please talk to your doctor or pharmacist. See section 4.

What is in this leaflet

1. What Clopidogrel dura is and what it is used for
2. What you need to know before you take Clopidogrel dura
3. How to take Clopidogrel dura
4. Possible side effects
5. How to store Clopidogrel dura
6. Contents of the pack and other information

1. What Clopidogrel Dura is and what it is used for

Clopidogrel dura contains clopidogrel and belongs to a group of medicines called antiplatelet medicinal products. Platelets are very small structures in the blood, which clump together during blood clotting. By preventing this clumping, antiplatelet medicinal products reduce the chances of blood clots forming (a process called thrombosis).

Clopidogrel dura is taken by adults to prevent blood clots (thrombi) forming in hardened blood vessels (arteries), a process known as atherothrombosis, which can lead to atherothrombotic events (such as stroke, heart attack, or death).

You have been prescribed Clopidogrel dura to help prevent blood clots and reduce the risk of these severe events because:

- You have a condition of hardening of arteries (also known as atherosclerosis), and
- You have previously experienced a heart attack, stroke or have a condition known as peripheral arterial disease.

2. What you need to know before you take Clopidogrel Dura

Do not take Clopidogrel dura

- if you are allergic to clopidogrel or any of the other ingredients of this medicine (listed in section 6)
- if you have a medical condition that is currently causing bleeding such as a stomach ulcer or bleeding within the brain;
- if you suffer from severe liver disease;

If you think any of these apply to you, or if you are in any doubt at all, consult your doctor before taking Clopidogrel dura.

Warnings and precautions

If any of the situations mentioned below apply to you, you should tell your doctor before taking Clopidogrel dura:

- if you have a risk of bleeding such as
 - a medical condition that puts you at risk of internal bleeding (such as a stomach ulcer)
 - a blood disorder that makes you prone to internal bleeding (bleeding inside any tissues, organs or joints of your body).
 - a recent serious injury
 - a recent surgery (including dental)
 - a planned surgery (including dental) in the next seven days
- if you have had a clot in an artery of your brain (ischaemic stroke) which occurred within the last seven days
- if you have kidney or liver disease.
- if you have had an allergy or reaction to any medicine used to treat your disease.

While you are taking Clopidogrel dura:

- You should tell your doctor if a surgery (including dental) is planned.
- You should also tell your doctor immediately if you develop a medical condition (also known as Thrombotic Thrombocytopenic Purpura or TTP) that includes fever and bruising under the skin that may appear as red pinpoint dots, with or without unexplained extreme tiredness, confusion, yellowing of the skin or eyes (jaundice) (see section 4 'Possible side effects').
- If you cut or injure yourself, it may take longer than usual for bleeding to stop. This is linked to the way your medicine works as it prevents the ability of blood clots to form. For minor cuts and injuries e.g., cutting yourself, shaving, this is usually of no concern. However, if you are concerned by your bleeding, you should contact your doctor straightaway (see section 4 'Possible side effects').
- Your doctor may order blood tests.

Children and adolescents

Do not give this medicine to children because it does not work.

Other medicines and Clopidogrel Dura

Tell your doctor or pharmacist if you are taking or have recently taken or might take any other medicines, including medicines obtained without a prescription.

Some other medicines may influence the use of Clopidogrel dura or vice versa.

You should specifically tell your doctor if you take

- oral anticoagulants, medicines used to reduce blood clotting,
- a non-steroidal anti-inflammatory medicine, usually used to treat painful and/or inflammatory conditions of muscle or joints,
- heparin, or any other injectable medicine used to reduce blood clotting,
- omeprazole, esomeprazole or cimetidine, medicines to treat for upset stomach,
- fluconazole, voriconazole, ciprofloxacin, or chloramphenicol, medicines to treat bacterial and fungal infections,
- fluoxetine, fluvoxamine, or moclobemide, medicines to treat depression,
- carbamazepine, or oxcarbazepine, medicines to treat some forms of epilepsy,
- ticlopidine, other antiplatelet agent.

An occasional use of acetylsalicylic acid (no more than 1000 mg in any 24 hour period), a substance present in many medicines used to relieve pain and lower fever, should generally not cause a problem, but prolonged use in other circumstances should be discussed with your doctor.

Pregnancy and breast-feeding

It is preferable not to take this medicine during pregnancy .

If you are pregnant or suspect that you are pregnant, you should tell your doctor or your pharmacist before taking Clopidogrel dura. If you become pregnant while taking Clopidogrel dura, consult your doctor immediately as it is recommended not to take clopidogrel while you are pregnant.

You should not breast-feed while taking this medicine.
If you are breast-feeding or planning to breastfeed, talk to your doctor before taking this medicine.

Ask your doctor or pharmacist for advice before taking any medicine.

Driving and using machines

Clopidogrel dura is unlikely to affect your ability to drive or to use machines.

Clopidogrel dura contains hydrogenated castor oil

This may cause stomach upset and diarrhoea.

3. How to take Clopidogrel Dura

Always take this medicine exactly as your doctor or pharmacist has told you. You should check with your doctor or pharmacist if you are not sure.

The usual dose is one 75 mg tablet of Clopidogrel dura per day to be taken orally with or without food, and at the same time each day.

You should take Clopidogrel dura for as long as your doctor continues to prescribe it.

If you take more Clopidogrel dura than you should:

Contact your doctor or the nearest hospital emergency department because of the increased risk of bleeding.

If you forget to take Clopidogrel dura:

If you forget to take a dose of Clopidogrel dura, but remember within 12 hours of your usual time, take your tablet straightaway and then take your next tablet at the usual time.

If you forget for more than 12 hours, simply take the next single dose at the usual time. Do not take a double dose to make up for a forgotten tablet.

If you stop taking Clopidogrel dura:

Do not stop the treatment unless your doctor tells you so. Contact your doctor or pharmacist before stopping.

If you have any further questions on the use of this medicine, ask your doctor or pharmacist.

4. Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them.

Contact your doctor immediately if you experience:

- fever, signs of infection or extreme tiredness. These may be due to rare decrease of some blood cells.
- signs of liver problems such as yellowing of the skin and/or the eyes (jaundice), whether or not associated with bleeding which appears under the skin as red pinpoint dots and/or confusion (see section 2 'Warnings and precautions').
- swelling in the mouth or skin disorders such as rashes and itching, blisters of the skin. These may be the signs of an allergic reaction.

The most common side effect reported is bleeding.

Bleeding may occur as bleeding in the stomach or bowels, bruising, haematoma (unusual bleeding or bruising under the skin), nose bleed, blood in the urine. In a small number of cases, bleeding in the eye, inside the head, the lung or the joints has also been reported.

If you experience prolonged bleeding when taking Clopidogrel dura

If you cut or injure yourself, it may take longer than usual for bleeding to stop. This is linked to the way your medicine works as it prevents the ability of blood clots to form. For minor cuts and injuries e.g., cutting yourself, shaving, this is of no concern. However, if you are concerned by your bleeding, you should contact your doctor straightaway (see section 2 'Warnings and precautions').

Other side effects include:

Common side effects (may affect up to 1 in 10 people) :
Diarrhoea, abdominal pain, indigestion or heartburn.

Uncommon side effects (may affect up to 1 in 100 people):

Headache, stomach ulcer, vomiting, nausea, constipation, excessive gas in stomach or intestines, rashes, itching, dizziness, sensation of tingling and numbness.

Rare side effect (may affect up to 1 in 1000 people):
Vertigo.

Very rare side effects (may affect up to 1 in 10,000 people):

Jaundice; severe abdominal pain with or without back pain; fever, breathing difficulties sometimes associated with cough; generalised allergic reactions (for example, overall sensation of heat with sudden general discomfort until fainting); swelling in the mouth; blisters of the skin; skin allergy; sore mouth (stomatitis); decrease in blood pressure; confusion; hallucinations; joint pain; muscular pain; changes in taste of food.

In addition, your doctor may identify changes in your blood or urine test results.

Reporting of side effects

If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via [the national reporting system](#) listed in [Appendix V](#). By reporting side effects you can help provide more information on the safety of this medicine.

5. How to store Clopidogrel Dura

Keep this medicine out of the sight and reach of children.

Do not use this medicine after the expiry date which is stated on the carton and blister after EXP. The expiry date refers to the last day of that month.

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

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help to protect the environment.

6. Contents of the pack and other information

What Clopidogrel dura contains

The active substance is clopidogrel. Each film-coated tablet contains 75 mg of clopidogrel (as hydrochloride).

The other ingredients are:

- Tablet core: microcrystalline cellulose, colloidal anhydrous silica, crospovidone (type A), macrogol 6000, hydrogenated castor oil (see section 2 'Clopidogrel Dura contains hydrogenated castor oil')
- Tablet coating: Polyvinyl alcohol, titanium dioxide (E171), red iron oxide (E172), yellow iron oxide (E172), talc and macrogol 3000.

What Clopidogrel dura looks like and contents of the pack

The film-coated tablets are pink, round and slightly convex.

Boxes of 7, 14, 28, 30, 50, 56, 84, 90 and 100 film-coated tablets in blisters are available.

Not all pack sizes may be marketed.

Marketing Authorisation Holder

Mylan dura GmbH, Wittichstraße 6, D-64295 Darmstadt, Germany

Manufacturer

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

TAD Pharma GmbH, Heinz-Lohmann-Straße 5, 27472 Cuxhaven, Germany

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This leaflet was last revised in MM/YYYY.

Detailed information is available on the European Medicines Agency website:

<http://www.ema.europa.eu>.