

Medicinal product no longer authorised

ANNEX I

SUMMARY OF PRODUCT CHARACTERISTICS

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 for how to report adverse reactions.

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 20 mg tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 20 mg of azilsartan medoxomil (as potassium).

For a full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Tablet.

White to nearly white round tablets, 6.0 mm in diameter, debossed "ASL" on one side and "20" on the other.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Ipreziv is indicated for the treatment of essential hypertension in adults.

4.2 Posology and method of administration

Posology

The recommended starting dose is 40 mg once daily. The dose may be increased to a maximum of 80 mg once daily for patients whose blood pressure is not adequately controlled at the lower dose.

Near-maximal antihypertensive effect is evident at 2 weeks, with maximal effects attained by 4 weeks.

If blood pressure is not adequately controlled with Ipreziv alone, additional blood pressure reduction can be achieved when Ipreziv is coadministered with other antihypertensive medicinal products, including diuretics (such as chlortalidone and hydrochlorothiazide) and calcium channel blockers (see sections 4.3, 4.4, 4.5 and 5.1).

Special populations

Older people (65 years and over)

No initial dose adjustment with Ipreziv is necessary in elderly patients (see section 5.2), although consideration can be given to 20 mg as a starting dose in the very elderly (≥ 75 years), who may be at risk of hypotension.

Renal impairment

Caution should be exercised in hypertensive patients with severe renal impairment and end stage renal disease as there is no experience of use of Ipreziv in these patients (see sections 4.4 and 5.2).

Hemodialysis does not remove azilsartan from the systemic circulation.

No dose adjustment is required in patients with mild or moderate renal impairment.

Hepatic impairment

Ipreziv has not been studied in patients with severe hepatic impairment and therefore its use is not recommended in this patient group (see sections 4.4 and 5.2).

As there is limited experience of use of Ipreziv in patients with mild to moderate hepatic impairment close monitoring is recommended and consideration should be given to 20 mg as a starting dose (see section 5.2).

Intravascular volume depletion

For patients with possible depletion of intravascular volume or salt depletion (e.g. patients with vomiting, diarrhoea or taking high doses of diuretics), Ipreziv should be initiated under close medical supervision and consideration can be given to 20 mg as a starting dose (see section 4.4).

Heart failure

Caution should be exercised in hypertensive patients with congestive heart failure as there is no experience of use of Ipreziv in these patients (see section 4.4).

Black population

No dose adjustment is required in the black population, although smaller reductions in blood pressure are observed compared with a non-black population (see section 5.1). This generally has been true for other angiotensin II receptor (AT₁) antagonists and angiotensin-converting enzyme inhibitors.

Consequently, up-titration of Ipreziv and concomitant therapy may be needed more frequently for blood pressure control in black patients.

Paediatric population

The safety and efficacy of Ipreziv in children and adolescents 0 to < 18 years have not yet been established.

No data are available.

Method of administration

Ipreziv is for oral use and may be taken with or without food (see section 5.2).

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients.
- Second and third trimester of pregnancy (see sections 4.4 and 4.6).
- The concomitant use of Ipreziv with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60 mL/min/1.73m²) (see sections 4.5 and 5.1).

4.4 Special warnings and precautions for use

Activated 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 congestive heart failure, severe renal impairment or renal artery stenosis), treatment with medicinal products that affect this system, such as angiotensin-converting enzyme inhibitors and angiotensin II receptor antagonists, has been associated with acute hypotension, azotaemia, oliguria or, rarely, acute renal failure. The possibility of similar effects cannot be excluded with Ipreziv.

Caution should be exercised in hypertensive patients with severe renal impairment, congestive heart failure or renal artery stenosis, as there is no experience of use of Ipreziv in these patients (see sections 4.2 and 5.2).

Excessive blood pressure decreases in patients with ischaemic cardiomyopathy or ischaemic cerebrovascular disease could result in a myocardial infarction or stroke.

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.

Kidney transplantation

There is currently no experience on the use of Ipreziv in patients who have recently undergone kidney transplantation.

Hepatic impairment

Ipreziv has not been studied in patients with severe hepatic impairment and therefore its use is not recommended in this patient group (see sections 4.2 and 5.2).

Hypotension in volume- and/or salt-depleted patients

In patients with marked volume- and/or salt-depletion (e.g. patients with vomiting, diarrhoea or taking high doses of diuretics) symptomatic hypotension could occur after initiation of treatment with Ipreziv. Hypovolemia should be corrected prior to administration of Ipreziv, or the treatment should start under close medical supervision, and consideration can be given to a starting dose of 20 mg.

Primary hyperaldosteronism

Patients with primary hyperaldosteronism generally will not respond to antihypertensive medicinal products acting through inhibition of the renin-angiotensin system. Therefore, the use of Ipreziv is not recommended in these patients.

Hyperkalaemia

Based on experience with the use of other medicinal products that affect the renin-angiotensin-aldosterone system, concomitant use of Ipreziv with potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium, or other medicinal products that may increase potassium levels (e.g. heparin) may lead to increases in serum potassium in hypertensive patients (see section 4.5). In the elderly, in patients with renal insufficiency, in diabetic patients and/or in patients with other co-morbidities, the risk of hyperkalaemia, which may be fatal, is increased. Monitoring of potassium should be undertaken as appropriate.

Aortic and mitral valve stenosis, obstructive hypertrophic cardiomyopathy

Special caution is indicated in patients suffering from aortic or mitral valve stenosis, or hypertrophic obstructive cardiomyopathy (HOCM).

Pregnancy

Angiotensin II receptor antagonists should not be initiated during pregnancy. Unless continued angiotensin II receptor antagonist 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 angiotensin II receptor antagonists should

be stopped immediately, and, if appropriate, alternative therapy should be started (see sections 4.3 and 4.6).

Lithium

As with other angiotensin II receptor antagonists the combination of lithium and Ipreziv is not recommended (see section 4.5).

4.5 Interaction with other medicinal products and other forms of interaction

Concomitant use not recommended

Lithium

Reversible increases in serum lithium concentrations and toxicity have been reported during concurrent use of lithium and angiotensin-converting enzyme inhibitors. A similar effect may occur with angiotensin II receptor antagonists. Due to the lack of experience with concomitant use of azilsartan medoxomil and lithium, this combination is not recommended. If the combination proves necessary, careful monitoring of serum lithium levels is recommended.

Caution required with concomitant use

Non-steroidal anti-inflammatory drugs (NSAIDs), including selective COX-2 inhibitors, acetylsalicylic acid > 3 g/day, and non-selective NSAIDs

When angiotensin II receptor antagonists are administered simultaneously with NSAIDs (i.e. selective COX-2 inhibitors, acetylsalicylic acid (> 3 g/day) and non-selective NSAIDs), attenuation of the antihypertensive effect may occur. Furthermore, concomitant use of angiotensin II receptor antagonists and NSAIDs may lead to an increased risk of worsening of renal function and an increase in serum potassium. Therefore, adequate hydration and monitoring of renal function at the beginning of the treatment are recommended.

Potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium and other substances that may increase potassium levels

Concomitant use of potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium, or other medicinal products (e.g. heparin) may increase potassium levels. Monitoring of serum potassium should be undertaken as appropriate (see section 4.4).

Additional information

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).

No clinically significant interactions have been reported in studies of azilsartan medoxomil or azilsartan given with amlodipine, antacids, chlortalidone, digoxin, fluconazole, glyburide, ketoconazole, metformin, and warfarin.

Azilsartan medoxomil is rapidly hydrolysed to the active moiety azilsartan by esterases in the gastrointestinal tract and/or during drug absorption (see section 5.2). *In vitro* studies indicated that interactions based on esterase inhibition are unlikely.

4.6 Fertility, pregnancy and lactation

Pregnancy

The use of angiotensin II receptor antagonists is not recommended during the first trimester of pregnancy (see section 4.4).

The use of angiotensin II receptor antagonists is contraindicated during the second and third trimester of pregnancy (see sections 4.3 and 4.4).

There are no data from the use of Ipreziv in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3).

Epidemiological evidence regarding the risk of teratogenicity following exposure to angiotensin converting enzyme inhibitors during the first trimester of pregnancy has not been conclusive; however, a small increase in risk cannot be excluded. Whilst there are no controlled epidemiological data on the risk with angiotensin II receptor antagonists, similar risks may exist for this class of medicinal products. Unless continued angiotensin II receptor antagonist 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 angiotensin II receptor antagonists should be stopped immediately and, if appropriate, alternative therapy should be started.

Exposure to angiotensin II receptor antagonist 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 angiotensin II receptor antagonists have occurred from the second trimester of pregnancy, ultrasound check of renal function and skull is recommended.

Infants whose mothers have taken Angiotensin II receptor antagonists should be closely observed for hypotension (see sections 4.3 and 4.4).

Breastfeeding

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

Fertility

No data are available on the effect of Ipreziv on human fertility. Nonclinical studies demonstrated that azilsartan did not appear to affect male or female fertility in the rat (see section 5.3).

4.7 Effects on ability to drive and use machines

Based on its pharmacodynamic properties it is expected that azilsartan medoxomil would have negligible influence on the ability to drive and use machines. However, when taking any antihypertensive it should be taken into account that occasionally dizziness or tiredness may occur.

4.8 Undesirable effects

Summary of the safety profile

Ipreziv at doses of 20, 40 or 80 mg has been evaluated for safety in clinical studies in patients treated for up to 56 weeks. In these clinical studies, adverse reactions associated with treatment with Ipreziv were mostly mild or moderate, with an overall incidence similar to placebo. The most common adverse reaction was dizziness. The incidence of adverse reactions with Ipreziv was not affected by gender, age, or race.

Tabulated list of adverse reactions

Adverse reactions based on pooled data (40 and 80 mg doses) are listed below according to system organ class and preferred terms. These are ranked by frequency, using the following convention: very common ($\geq 1/10$); common ($\geq 1/100$, $< 1/10$); uncommon ($\geq 1/1,000$, $< 1/100$); rare ($\geq 1/10,000$, $< 1/1,000$); very rare ($< 1/10,000$), including isolated reports. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Adverse reactions were reported at a similar frequency for the Ipreziv 20 mg dose as with the 40 and 80 mg doses in one placebo controlled study.

System organ class	Frequency	Adverse reaction
Nervous system disorders	Common	Dizziness
Vascular disorders	Uncommon	Hypotension
Gastrointestinal disorders	Common Uncommon	Diarrhoea Nausea
Skin and subcutaneous tissue disorders	Uncommon Rare	Rash, pruritus Angioedema
Musculoskeletal and connective tissue disorders	Uncommon	Muscle spasms
General disorders and administration site conditions	Uncommon	Fatigue Peripheral oedema
Investigations	Common Uncommon	Blood creatine phosphokinase increased Blood creatinine increased Blood uric acid increased / Hyperuricemia

Description of selected adverse reactions

When Ipreziv was coadministered with chlortalidone, the frequencies of blood creatinine increased and hypotension were increased from uncommon to common.

When Ipreziv was coadministered with amlodipine, the frequency of peripheral oedema was increased from uncommon to common, but was lower than amlodipine alone.

Investigations

Serum creatinine

The incidence of elevations in serum creatinine following treatment with Ipreziv was similar to placebo in the randomised placebo-controlled monotherapy studies. Coadministration of Ipreziv with diuretics, such as chlortalidone, resulted in a greater incidence of creatinine elevations, an observation consistent with that of other angiotensin II receptor antagonists and angiotensin converting enzyme inhibitors. The elevations in serum creatinine during coadministration of Ipreziv with diuretics were associated with larger blood pressure reductions compared with a single medicinal product. Many of these elevations were transient or nonprogressive while subjects continued to receive treatment. Following discontinuation of treatment, the majority of the elevations that had not resolved during treatment were reversible, with the creatinine levels of most subjects returning to Baseline or near-Baseline values.

Uric acid

Small mean increases of serum uric acid were observed with Ipreziv (10.8 $\mu\text{mol/l}$) compared with placebo (4.3 $\mu\text{mol/l}$).

Hemoglobin and hematocrit

Small decreases in hemoglobin and hematocrit (mean decreases of approximately 3 g/l and 1 volume percent, respectively) were observed in placebo-controlled monotherapy studies. This effect is also seen with other inhibitors of the renin-angiotensin-aldosterone system.

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

Symptoms

Based on pharmacological considerations, the main manifestation of an overdose is likely to be symptomatic hypotension and dizziness. During controlled clinical studies in healthy subjects, once daily doses up to 320 mg of Ipreziv were administered for 7 days and were well tolerated.

Management

If symptomatic hypotension should occur, supportive treatment should be instituted and vital signs monitored.

Azilsartan is not removed by dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Angiotensin II antagonists, plain
ATC Code: C09CA09

Mechanism of action and pharmacodynamic effect

Azilsartan medoxomil is an orally active prodrug that is rapidly converted to the active moiety, azilsartan, which selectively antagonises the effects of angiotensin II by blocking its binding to the AT₁ receptor in multiple tissues (see section 5.2). Angiotensin II is the principal pressor agent of the renin-angiotensin system, with effects that include vasoconstriction, stimulation of synthesis and release of aldosterone, cardiac stimulation, and renal reabsorption of sodium.

Blockade of the AT₁ receptor inhibits the negative regulatory feedback of angiotensin II on renin secretion, but the resulting increases in plasma renin activity and angiotensin II circulating levels do not overcome the antihypertensive effect of azilsartan.

Essential hypertension

In seven double blind controlled studies, a total of 5941 patients (3672 given Ipreziv, 801 given placebo, and 1468 given active comparator) were evaluated. Overall, 51% of patients were male and 26% were 65 years or older (5% ≥ 75 years); 67% were white and 19% were black.

Ipreziv was compared with placebo and active comparators in two 6-week randomized, double blind studies. Blood pressure reductions compared with placebo based on 24 hour mean blood pressure by ambulatory blood pressure monitoring (ABPM) and clinic blood pressure measurements at trough are shown in the table below for both studies. Additionally, Ipreziv 80 mg resulted in significantly greater reductions in SBP than the highest approved doses of olmesartan medoxomil and valsartan.

	Placebo	Ipreziv 20 mg	Ipreziv 40 mg#	Ipreziv 80 mg#	OLM-M 40 mg#	Valsartan 320 mg#
Primary End point:						
24-Hour Mean SBP: LS Mean Change from Baseline (BL) to Week 6 (mm Hg)						
Study 1						
Change from BL	-1.4	-12.2 *	-13.5 *	-14.6 *†	-12.6	-
Study 2						
Change from BL	-0.3	-	-13.4 *	-14.5 *†	-12.0	-10.2
Key Secondary End Point:						
Clinic SBP: LS Mean Change from Baseline (BL) to Week 6 (mm Hg) (LOCF)						
Study 1						
Change from BL	-2.1	-14.3 *	-14.5 *	-17.6 *	-14.9	-
Study 2						
Change from BL	-1.8	-	-16.4 *†	-16.7 *†	-13.2	-11.3

OLM-M = olmesartan medoxomil, LS = least squares, LOCF = last observation carried forward

* Significant difference vs. Placebo at 0.05 level within the framework of the step-wise analysis

† Significant difference vs. Comparator(s) at 0.05 level within the framework of the step-wise analysis

Maximum dose achieved in study 2. Doses were force-titrated at Week 2 from 20 to 40 mg and 40 to 80 mg for Ipreziv, and 20 to 40 mg and 160 to 320 mg, respectively, for olmesartan medoxomil and valsartan

In these two studies, clinically important and most common adverse events included dizziness, headache and dyslipidemia. For Ipreziv, olmesartan medoxomil and valsartan, respectively dizziness was observed at an incidence of 3.0%, 3.3% and 1.8%; headache at 4.8%, 5.5% and 7.6% and dyslipidemia at 3.5%, 2.4% and 1.1%.

In active-comparator studies with either valsartan or ramipril, the blood-pressure-lowering effect with Ipreziv was sustained during long-term treatment. Ipreziv had a lower incidence of cough (1.2%) compared with ramipril (8.2%).

The antihypertensive effect of Ipreziv occurred within the first 2 weeks of dosing with the full effect achieved by 4 weeks. The blood pressure lowering effect of Ipreziv was also maintained throughout the 24-hour dosing interval. The placebo-corrected trough-to-peak ratios for SBP and DBP were approximately 80% or higher.

Rebound hypertension was not observed following abrupt cessation of Ipreziv therapy after 6 months of treatment.

No overall differences in safety and effectiveness were observed between elderly patients and younger patients, but greater sensitivity to blood pressure lowering effects in some elderly individuals cannot be ruled out (see section 4.2). As with other angiotensin II receptor antagonists and angiotensin converting enzyme inhibitors the antihypertensive effect was lower in black patients (usually a low-renin population).

Coadministration of Ipreziv 40 and 80 mg with a calcium channel blocker (amlodipine) or a thiazide-type diuretic (chlortalidone) resulted in additional blood pressure reductions compared with the other antihypertensive alone. Dose dependent adverse events including dizziness, hypotension and serum creatinine elevations were more frequent with diuretic coadministration compared with Ipreziv alone, while hypokalemia was less frequent compared with diuretic alone.

Beneficial effects of Ipreziv on mortality and cardiovascular morbidity and target organ damage are currently unknown.

Effect on cardiac repolarisation

A thorough QT/QTc study was conducted to assess the potential of Ipreziv to prolong the QT/QTc interval in healthy subjects. There was no evidence of QT/QTc prolongation at a dose of 320 mg of Ipreziv.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with Ipreziv in one or more subsets of the paediatric population in hypertension (see section 4.2 for information on paediatric use).

Additional information

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.

5.2 Pharmacokinetic properties

Following oral administration, azilsartan medoxomil is rapidly hydrolyzed to the active moiety azilsartan in the gastrointestinal tract and/or during absorption. Based on *in vitro* studies, carboxymethylenbutenolidase is involved in the hydrolysis in the intestine and liver. In addition, plasma esterases are involved in the hydrolysis of azilsartan medoxomil to azilsartan.

Absorption

The estimated absolute oral bioavailability of azilsartan medoxomil based on plasma levels of azilsartan is approximately 60%. After oral administration of azilsartan medoxomil, peak plasma concentrations (C_{max}) of azilsartan are reached within 1.5 to 3 hours. Food does not affect the bioavailability of azilsartan (see section 4.2).

Distribution

The volume of distribution of azilsartan is approximately 16 litres. Azilsartan is highly bound to plasma proteins (> 99%), mainly serum albumin. Protein binding is constant at azilsartan plasma concentrations well above the range achieved with recommended doses.

Biotransformation

Azilsartan is metabolised to two primary metabolites. The major metabolite in plasma is formed by *O*-dealkylation, referred to as metabolite M-II, and the minor metabolite is formed by decarboxylation, referred to as metabolite M-I. Systemic exposures to the major and minor metabolites in humans were approximately 50% and less than 1% that of azilsartan, respectively. M-I and M-II do not contribute to the pharmacologic activity of Ipreziv. The major enzyme responsible for azilsartan metabolism is CYP2C9.

Elimination

Following an oral dose of ¹⁴C-labelled azilsartan medoxomil, approximately 55% of radioactivity was recovered in feces and approximately 42% in urine, with 15% of the dose excreted in urine as azilsartan. The elimination half-life of azilsartan is approximately 11 hours and renal clearance is approximately 2.3 ml/min. Steady-state levels of azilsartan are achieved within 5 days and no accumulation in plasma occurs with repeated once-daily dosing.

Linearity/non-linearity

Dose proportionality in exposure was established for azilsartan in the azilsartan medoxomil dose range of 20 mg to 320 mg after single or multiple dosing.

Characteristics in specific groups of patients

Paediatric population

The pharmacokinetics of azilsartan have not been studied in children under 18 years of age.

Older people

Pharmacokinetics of azilsartan do not differ significantly between young (age range 18-45 years) and elderly (age range 65-85 years) patients.

Renal impairment

In patients with mild, moderate, and severe renal impairment azilsartan total exposure (AUC) was +30%, +25% and +95% increased. No increase (+5%) was observed in end-stage renal disease patients who were dialysed. However, there is no clinical experience in patients with severe renal impairment or end stage renal disease (see section 4.2). Hemodialysis does not remove azilsartan from the systemic circulation.

Hepatic impairment

Administration of Ipreziv for up to 5 days in subjects with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment resulted in slight increase in azilsartan exposure (AUC increased by 1.3 to 1.6 fold, see section 4.2). Ipreziv has not been studied in patients with severe hepatic impairment.

Gender

Pharmacokinetics of azilsartan do not differ significantly between males and females. No dose adjustment is necessary based on gender.

Race

Pharmacokinetics of azilsartan do not differ significantly between black and white populations. No dose adjustment is necessary based on race.

5.3 Preclinical safety data

In preclinical safety studies, azilsartan medoxomil and M-II, the major human metabolite, were examined for repeated-dose toxicity, reproduction toxicity, mutagenicity and carcinogenicity.

In the repeated-dose toxicity studies, doses producing exposure comparable to that in the clinical therapeutic range caused reduced red cell parameters, changes in the kidney and renal haemodynamics, as well as increased serum potassium in normotensive animals. These effects, which

were prevented by oral saline supplementation, do not have clinical significance in treatment of hypertension.

In rats and dogs, increased plasma renin activity and hypertrophy/hyperplasia of the renal juxtaglomerular cells were observed. These changes, also a class effect of angiotensin converting enzyme inhibitors and other angiotensin II receptor antagonists, do not appear to have clinical significance.

Azilsartan and M-II crossed the placenta and were found in the fetuses of pregnant rats and were excreted into the milk of lactating rats. In the reproduction toxicity studies, there were no effects on male or female fertility. There is no evidence of a teratogenic effect, but animal studies indicated some hazardous potential to the postnatal development of the offspring such as lower body weight, a slight delay in physical development (delayed incisor eruption, pinna detachment, eye opening), and higher mortality.

Azilsartan and M-II showed no evidence of mutagenicity and relevant clastogenic activity in *in vitro* studies and no evidence of carcinogenicity in rats and mice.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Mannitol (E 421)
Fumaric acid (E 297)
Sodium hydroxide
Hydroxypropylcellulose (E 463)
Croscarmellose sodium
Cellulose, microcrystalline (E 460)
Magnesium stearate (E 572)

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 light and moisture.
This medicinal product does not require any special temperature storage conditions.

6.5 Nature and contents of container

Cartons containing aluminum blisters packs integrated with desiccant.

Pack sizes:

One blister pack contains either 14 tablets or 15 tablets.

14, 28, 30, 56, 90 or 98 tablets.

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

Takeda Pharma A/S
Dybendal Alle 10
2630 Taastrup
Denmark

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/11/735/001 14 tablets
EU/1/11/735/002 28 tablets
EU/1/11/735/012 30 tablets
EU/1/11/735/003 56 tablets
EU/1/11/735/013 90 tablets
EU/1/11/735/004 98 tablets

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

7 December 2011

10. DATE OF REVISION OF THE TEXT

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

Medicinal product no longer authorised

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 for how to report adverse reactions.

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 40 mg tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 40 mg of azilsartan medoxomil (as potassium).

For a full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Tablet.

White to nearly white round tablets, 7.6 mm in diameter, debossed "ASL" on one side and "40" on the other.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Ipreziv is indicated for the treatment of essential hypertension in adults.

4.2 Posology and method of administration

Posology

The recommended starting dose is 40 mg once daily. The dose may be increased to a maximum of 80 mg once daily for patients whose blood pressure is not adequately controlled at the lower dose.

Near-maximal antihypertensive effect is evident at 2 weeks, with maximal effects attained by 4 weeks.

If blood pressure is not adequately controlled with Ipreziv alone, additional blood pressure reduction can be achieved when Ipreziv is coadministered with other antihypertensive medicinal products, including diuretics (such as chlortalidone and hydrochlorothiazide) and calcium channel blockers (see sections 4.3, 4.4, 4.5 and 5.1).

Special populations

Older people (65 years and over)

No initial dose adjustment with Ipreziv is necessary in elderly patients (see section 5.2), although consideration can be given to 20 mg as a starting dose in the very elderly (≥ 75 years), who may be at risk of hypotension.

Renal impairment

Caution should be exercised in hypertensive patients with severe renal impairment and end stage renal disease as there is no experience of use of Ipreziv in these patients (see sections 4.4 and 5.2).

Hemodialysis does not remove azilsartan from the systemic circulation.

No dose adjustment is required in patients with mild or moderate renal impairment.

Hepatic impairment

Ipreziv has not been studied in patients with severe hepatic impairment and therefore its use is not recommended in this patient group (see sections 4.4 and 5.2).

As there is limited experience of use of Ipreziv in patients with mild to moderate hepatic impairment close monitoring is recommended and consideration should be given to 20 mg as a starting dose (see section 5.2).

Intravascular volume depletion

For patients with possible depletion of intravascular volume or salt depletion (e.g. patients with vomiting, diarrhoea or taking high doses of diuretics), Ipreziv should be initiated under close medical supervision and consideration can be given to 20 mg as a starting dose (see section 4.4).

Heart failure

Caution should be exercised in hypertensive patients with congestive heart failure as there is no experience of use of Ipreziv in these patients (see section 4.4).

Black population

No dose adjustment is required in the black population, although smaller reductions in blood pressure are observed compared with a non-black population (see section 5.1). This generally has been true for other angiotensin II receptor (AT₁) antagonists and angiotensin-converting enzyme inhibitors.

Consequently, up-titration of Ipreziv and concomitant therapy may be needed more frequently for blood pressure control in black patients.

Paediatric population

The safety and efficacy of Ipreziv in children and adolescents 0 to < 18 years have not yet been established.

No data are available.

Method of administration

Ipreziv is for oral use and may be taken with or without food (see section 5.2).

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients.
- Second and third trimester of pregnancy (see sections 4.4 and 4.6).
- The concomitant use of Ipreziv with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60 mL/min/1.73m²) (see sections 4.5 and 5.1).

4.4 Special warnings and precautions for use

Activated 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 congestive heart failure, severe renal impairment or renal artery stenosis), treatment with medicinal products that affect this system, such as angiotensin-converting enzyme inhibitors and angiotensin II receptor antagonists, has been associated with acute hypotension, azotaemia, oliguria or, rarely, acute renal failure. The possibility of similar effects cannot be excluded with Ipreziv.

Caution should be exercised in hypertensive patients with severe renal impairment, congestive heart failure or renal artery stenosis, as there is no experience of use of Ipreziv in these patients (see sections 4.2 and 5.2).

Excessive blood pressure decreases in patients with ischaemic cardiomyopathy or ischaemic cerebrovascular disease could result in a myocardial infarction or stroke.

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.

Kidney transplantation

There is currently no experience on the use of Ipreziv in patients who have recently undergone kidney transplantation.

Hepatic impairment

Ipreziv has not been studied in patients with severe hepatic impairment and therefore its use is not recommended in this patient group (see sections 4.2 and 5.2).

Hypotension in volume- and /or salt-depleted patients

In patients with marked volume- and/or salt-depletion (e.g. patients with vomiting, diarrhoea or taking high doses of diuretics) symptomatic hypotension could occur after initiation of treatment with Ipreziv. Hypovolemia should be corrected prior to administration of Ipreziv, or the treatment should start under close medical supervision, and consideration can be given to a starting dose of 20 mg.

Primary hyperaldosteronism

Patients with primary hyperaldosteronism generally will not respond to antihypertensive medicinal products acting through inhibition of the renin-angiotensin system. Therefore, the use of Ipreziv is not recommended in these patients.

Hyperkalaemia

Based on experience with the use of other medicinal products that affect the renin-angiotensin-aldosterone system, concomitant use of Ipreziv with potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium, or other medicinal products that may increase potassium levels (e.g. heparin) may lead to increases in serum potassium in hypertensive patients (see section 4.5). In the elderly, in patients with renal insufficiency, in diabetic patients and/or in patients with other co-morbidities, the risk of hyperkalaemia, which may be fatal, is increased. Monitoring of potassium should be undertaken as appropriate.

Aortic and mitral valve stenosis, obstructive hypertrophic cardiomyopathy

Special caution is indicated in patients suffering from aortic or mitral valve stenosis, or hypertrophic obstructive cardiomyopathy (HOCM).

Pregnancy

Angiotensin II receptor antagonists should not be initiated during pregnancy. Unless continued angiotensin II receptor antagonist 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 angiotensin II receptor antagonists should

be stopped immediately, and, if appropriate, alternative therapy should be started (see sections 4.3 and 4.6).

Lithium

As with other angiotensin II receptor antagonists the combination of lithium and Ipreziv is not recommended (see section 4.5).

4.5 Interaction with other medicinal products and other forms of interaction

Concomitant use not recommended

Lithium

Reversible increases in serum lithium concentrations and toxicity have been reported during concurrent use of lithium and angiotensin-converting enzyme inhibitors. A similar effect may occur with angiotensin II receptor antagonists. Due to the lack of experience with concomitant use of azilsartan medoxomil and lithium, this combination is not recommended. If the combination proves necessary, careful monitoring of serum lithium levels is recommended.

Caution required with concomitant use

Non-steroidal anti-inflammatory drugs (NSAIDs), including selective COX-2 inhibitors, acetylsalicylic acid > 3 g/day, and non-selective NSAIDs

When angiotensin II receptor antagonists are administered simultaneously with NSAIDs (i.e. selective COX-2 inhibitors, acetylsalicylic acid (> 3 g/day) and non-selective NSAIDs), attenuation of the antihypertensive effect may occur. Furthermore, concomitant use of angiotensin II receptor antagonists and NSAIDs may lead to an increased risk of worsening of renal function and an increase in serum potassium. Therefore, adequate hydration and monitoring of renal function at the beginning of the treatment are recommended.

Potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium and other substances that may increase potassium levels

Concomitant use of potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium, or other medicinal products (e.g. heparin) may increase potassium levels. Monitoring of serum potassium should be undertaken as appropriate (see section 4.4).

Additional information

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).

No clinically significant interactions have been reported in studies of azilsartan medoxomil or azilsartan given with amlodipine, antacids, chlortalidone, digoxin, fluconazole, glyburide, ketoconazole, metformin, and warfarin.

Azilsartan medoxomil is rapidly hydrolysed to the active moiety azilsartan by esterases in the gastro intestinal tract and/or during drug absorption (see section 5.2). *In vitro* studies indicated that interactions based on esterase inhibition are unlikely.

4.6 Fertility, pregnancy and lactation

Pregnancy

The use of angiotensin II receptor antagonists is not recommended during the first trimester of pregnancy (see section 4.4).

The use of angiotensin II receptor antagonists is contraindicated during the second and third trimester of pregnancy (see sections 4.3 and 4.4).

There are no data from the use of Ipreziv in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3).

Epidemiological evidence regarding the risk of teratogenicity following exposure to angiotensin converting enzyme inhibitors during the first trimester of pregnancy has not been conclusive; however, a small increase in risk cannot be excluded. Whilst there are no controlled epidemiological data on the risk with angiotensin II receptor antagonists, similar risks may exist for this class of medicinal products. Unless continued angiotensin II receptor antagonist 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 angiotensin II receptor antagonists should be stopped immediately and, if appropriate, alternative therapy should be started.

Exposure to angiotensin II receptor antagonist 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 angiotensin II receptor antagonists have occurred from the second trimester of pregnancy, ultrasound check of renal function and skull is recommended.

Infants whose mothers have taken Angiotensin II receptor antagonists should be closely observed for hypotension (see sections 4.3 and 4.4).

Breastfeeding

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

Fertility

No data are available on the effect of Ipreziv on human fertility. Nonclinical studies demonstrated that azilsartan did not appear to affect male or female fertility in the rat (see section 5.3).

4.7 Effects on ability to drive and use machines

Based on its pharmacodynamic properties it is expected that azilsartan medoxomil would have negligible influence on the ability to drive and use machines. However, when taking any antihypertensive it should be taken into account that occasionally dizziness or tiredness may occur.

4.8 Undesirable effects

Summary of the safety profile

Ipreziv at doses of 20, 40 or 80 mg has been evaluated for safety in clinical studies in patients treated for up to 56 weeks. In these clinical studies, adverse reactions associated with treatment with Ipreziv were mostly mild or moderate, with an overall incidence similar to placebo. The most common adverse reaction was dizziness. The incidence of adverse reactions with Ipreziv was not affected by gender, age, or race.

Tabulated list of adverse reactions

Adverse reactions based on pooled data (40 and 80 mg doses) are listed below according to system organ class and preferred terms. These are ranked by frequency, using the following convention: very common ($\geq 1/10$); common ($\geq 1/100, < 1/10$); uncommon ($\geq 1/1,000, < 1/100$); rare ($\geq 1/10,000, < 1/1,000$); very rare ($< 1/10,000$), including isolated reports. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Adverse reactions were reported at a similar frequency for the Ipreziv 20 mg dose as with the 40 and 80 mg doses in one placebo controlled study.

System organ class	Frequency	Adverse reaction
Nervous system disorders	Common	Dizziness
Vascular disorders	Uncommon	Hypotension
Gastrointestinal disorders	Common Uncommon	Diarrhoea Nausea
Skin and subcutaneous tissue disorders	Uncommon Rare	Rash, pruritus Angioedema
Musculoskeletal and connective tissue disorders	Uncommon	Muscle spasms
General disorders and administration site conditions	Uncommon	Fatigue Peripheral oedema
Investigations	Common Uncommon	Blood creatine phosphokinase increased Blood creatinine increased Blood uric acid increased / Hyperuricemia

Description of selected adverse reactions

When Ipreziv was coadministered with chlortalidone, the frequencies of blood creatinine increased and hypotension were increased from uncommon to common.

When Ipreziv was coadministered with amlodipine, the frequency of peripheral oedema was increased from uncommon to common, but was lower than amlodipine alone.

Investigations

Serum creatinine

The incidence of elevations in serum creatinine following treatment with Ipreziv was similar to placebo in the randomised placebo-controlled monotherapy studies. Coadministration of Ipreziv with diuretics, such as chlortalidone, resulted in a greater incidence of creatinine elevations, an observation consistent with that of other angiotensin II receptor antagonists and angiotensin converting enzyme inhibitors. The elevations in serum creatinine during coadministration of Ipreziv with diuretics were associated with larger blood pressure reductions compared with a single medicinal product. Many of these elevations were transient or nonprogressive while subjects continued to receive treatment. Following discontinuation of treatment, the majority of the elevations that had not resolved during treatment were reversible, with the creatinine levels of most subjects returning to Baseline or near-Baseline values.

Uric acid

Small mean increases of serum uric acid were observed with Ipreziv (10.8 $\mu\text{mol/l}$) compared with placebo (4.3 $\mu\text{mol/l}$).

Hemoglobin and hematocrit

Small decreases in hemoglobin and hematocrit (mean decreases of approximately 3 g/l and 1 volume percent, respectively) were observed in placebo-controlled monotherapy studies. This effect is also seen with other inhibitors of the renin-angiotensin-aldosterone system.

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

Symptoms

Based on pharmacological considerations, the main manifestation of an overdose is likely to be symptomatic hypotension and dizziness. During controlled clinical studies in healthy subjects, once daily doses up to 320 mg of Ipreziv were administered for 7 days and were well tolerated.

Management

If symptomatic hypotension should occur, supportive treatment should be instituted and vital signs monitored.

Azilsartan is not removed by dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Angiotensin II antagonists, plain
ATC Code: C09CA09

Mechanism of action and pharmacodynamic effect

Azilsartan medoxomil is an orally active prodrug that is rapidly converted to the active moiety, azilsartan, which selectively antagonises the effects of angiotensin II by blocking its binding to the AT₁ receptor in multiple tissues (see section 5.2). Angiotensin II is the principal pressor agent of the renin-angiotensin system, with effects that include vasoconstriction, stimulation of synthesis and release of aldosterone, cardiac stimulation, and renal reabsorption of sodium.

Blockade of the AT₁ receptor inhibits the negative regulatory feedback of angiotensin II on renin secretion, but the resulting increases in plasma renin activity and angiotensin II circulating levels do not overcome the antihypertensive effect of azilsartan.

Essential hypertension

In seven double blind controlled studies, a total of 5941 patients (3672 given Ipreziv, 801 given placebo, and 1468 given active comparator) were evaluated. Overall, 51% of patients were male and 26% were 65 years or older (5% ≥ 75 years); 67% were white and 19% were black.

Ipreziv was compared with placebo and active comparators in two 6-week randomized, double blind studies. Blood pressure reductions compared with placebo based on 24 hour mean blood pressure by ambulatory blood pressure monitoring (ABPM) and clinic blood pressure measurements at trough are shown in the table below for both studies. Additionally, Ipreziv 80 mg resulted in significantly greater reductions in SBP than the highest approved doses of olmesartan medoxomil and valsartan.

	Placebo	Ipreziv 20 mg	Ipreziv 40 mg#	Ipreziv 80 mg#	OLM-M 40 mg#	Valsartan 320 mg#
Primary End point:						
24-Hour Mean SBP: LS Mean Change from Baseline (BL) to Week 6 (mm Hg)						
Study 1						
Change from BL	-1.4	-12.2 *	-13.5 *	-14.6 *†	-12.6	-
Study 2						
Change from BL	-0.3	-	-13.4 *	-14.5 *†	-12.0	-10.2
Key Secondary End Point:						
Clinic SBP: LS Mean Change from Baseline (BL) to Week 6 (mm Hg) (LOCF)						
Study 1						
Change from BL	-2.1	-14.3 *	-14.5 *	-17.6 *	-14.9	-
Study 2						
Change from BL	-1.8	-	-16.4 *†	-16.7 *†	-13.2	-11.3

OLM-M = olmesartan medoxomil, LS = least squares, LOCF = last observation carried forward

* Significant difference vs. Placebo at 0.05 level within the framework of the step-wise analysis

† Significant difference vs. Comparator(s) at 0.05 level within the framework of the step-wise analysis

Maximum dose achieved in study 2. Doses were force-titrated at Week 2 from 20 to 40 mg and 40 to 80 mg for Ipreziv, and 20 to 40 mg and 160 to 320 mg, respectively, for olmesartan medoxomil and valsartan

In these two studies, clinically important and most common adverse events included dizziness, headache and dyslipidemia. For Ipreziv, olmesartan medoxomil and valsartan, respectively dizziness was observed at an incidence of 3.0%, 3.3% and 1.8%; headache at 4.8%, 5.5% and 7.6% and dyslipidemia at 3.5%, 2.4% and 1.1%.

In active-comparator studies with either valsartan or ramipril, the blood-pressure-lowering effect with Ipreziv was sustained during long-term treatment. Ipreziv had a lower incidence of cough (1.2%) compared with ramipril (8.2%).

The antihypertensive effect of Ipreziv occurred within the first 2 weeks of dosing with the full effect achieved by 4 weeks. The blood pressure lowering effect of Ipreziv was also maintained throughout the 24-hour dosing interval. The placebo-corrected trough-to-peak ratios for SBP and DBP were approximately 80% or higher.

Rebound hypertension was not observed following abrupt cessation of Ipreziv therapy after 6 months of treatment.

No overall differences in safety and effectiveness were observed between elderly patients and younger patients, but greater sensitivity to blood pressure lowering effects in some elderly individuals cannot be ruled out (see section 4.2). As with other angiotensin II receptor antagonists and angiotensin converting enzyme inhibitors the antihypertensive effect was lower in black patients (usually a low-renin population).

Coadministration of Ipreziv 40 and 80 mg with a calcium channel blocker (amlodipine) or a thiazide-type diuretic (chlortalidone) resulted in additional blood pressure reductions compared with the other antihypertensive alone. Dose dependent adverse events including dizziness, hypotension and serum creatinine elevations were more frequent with diuretic coadministration compared with Ipreziv alone, while hypokalemia was less frequent compared with diuretic alone.

Beneficial effects of Ipreziv on mortality and cardiovascular morbidity and target organ damage are currently unknown.

Effect on cardiac repolarisation

A thorough QT/QTc study was conducted to assess the potential of Ipreziv to prolong the QT/QTc interval in healthy subjects. There was no evidence of QT/QTc prolongation at a dose of 320 mg of Ipreziv.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with Ipreziv in one or more subsets of the paediatric population in hypertension (see section 4.2 for information on paediatric use).

Additional information

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.

5.2 Pharmacokinetic properties

Following oral administration, azilsartan medoxomil is rapidly hydrolyzed to the active moiety azilsartan in the gastrointestinal tract and/or during absorption. Based on *in vitro* studies, carboxymethylenbutenolidase is involved in the hydrolysis in the intestine and liver. In addition, plasma esterases are involved in the hydrolysis of azilsartan medoxomil to azilsartan.

Absorption

The estimated absolute oral bioavailability of azilsartan medoxomil based on plasma levels of azilsartan is approximately 60%. After oral administration of azilsartan medoxomil, peak plasma concentrations (C_{max}) of azilsartan are reached within 1.5 to 3 hours. Food does not affect the bioavailability of azilsartan (see section 4.2).

Distribution

The volume of distribution of azilsartan is approximately 16 litres. Azilsartan is highly bound to plasma proteins (> 99%), mainly serum albumin. Protein binding is constant at azilsartan plasma concentrations well above the range achieved with recommended doses.

Biotransformation

Azilsartan is metabolised to two primary metabolites. The major metabolite in plasma is formed by *O*-dealkylation, referred to as metabolite M-II, and the minor metabolite is formed by decarboxylation, referred to as metabolite M-I. Systemic exposures to the major and minor metabolites in humans were approximately 50% and less than 1% that of azilsartan, respectively. M-I and M-II do not contribute to the pharmacologic activity of Ipreziv. The major enzyme responsible for azilsartan metabolism is CYP2C9.

Elimination

Following an oral dose of ¹⁴C-labelled azilsartan medoxomil, approximately 55% of radioactivity was recovered in feces and approximately 42% in urine, with 15% of the dose excreted in urine as azilsartan. The elimination half-life of azilsartan is approximately 11 hours and renal clearance is approximately 2.3 ml/min. Steady-state levels of azilsartan are achieved within 5 days and no accumulation in plasma occurs with repeated once-daily dosing.

Linearity/non-linearity

Dose proportionality in exposure was established for azilsartan in the azilsartan medoxomil dose range of 20 mg to 320 mg after single or multiple dosing.

Characteristics in specific groups of patients

Paediatric population

The pharmacokinetics of azilsartan have not been studied in children under 18 years of age.

Older people

Pharmacokinetics of azilsartan do not differ significantly between young (age range 18-45 years) and elderly (age range 65-85 years) patients.

Renal impairment

In patients with mild, moderate, and severe renal impairment azilsartan total exposure (AUC) was +30%, +25% and +95% increased. No increase (+5%) was observed in end-stage renal disease patients who were dialysed. However, there is no clinical experience in patients with severe renal impairment or end stage renal disease (see section 4.2). Hemodialysis does not remove azilsartan from the systemic circulation.

Hepatic impairment

Administration of Ipreziv for up to 5 days in subjects with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment resulted in slight increase in azilsartan exposure (AUC increased by 1.3 to 1.6 fold, see section 4.2). Ipreziv has not been studied in patients with severe hepatic impairment.

Gender

Pharmacokinetics of azilsartan do not differ significantly between males and females. No dose adjustment is necessary based on gender.

Race

Pharmacokinetics of azilsartan do not differ significantly between black and white populations. No dose adjustment is necessary based on race.

5.3 Preclinical safety data

In preclinical safety studies, azilsartan medoxomil and M-II, the major human metabolite, were examined for repeated-dose toxicity, reproduction toxicity, mutagenicity and carcinogenicity.

In the repeated-dose toxicity studies, doses producing exposure comparable to that in the clinical therapeutic range caused reduced red cell parameters, changes in the kidney and renal haemodynamics, as well as increased serum potassium in normotensive animals. These effects, which

were prevented by oral saline supplementation, do not have clinical significance in treatment of hypertension.

In rats and dogs, increased plasma renin activity and hypertrophy/hyperplasia of the renal juxtaglomerular cells were observed. These changes, also a class effect of angiotensin converting enzyme inhibitors and other angiotensin II receptor antagonists, do not appear to have clinical significance.

Azilsartan and M-II crossed the placenta and were found in the fetuses of pregnant rats and were excreted into the milk of lactating rats. In the reproduction toxicity studies, there were no effects on male or female fertility. There is no evidence of a teratogenic effect, but animal studies indicated some hazardous potential to the postnatal development of the offspring such as lower body weight, a slight delay in physical development (delayed incisor eruption, pinna detachment, eye opening), and higher mortality.

Azilsartan and M-II showed no evidence of mutagenicity and relevant clastogenic activity in *in vitro* studies and no evidence of carcinogenicity in rats and mice.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Mannitol (E 421)
Fumaric acid (E 297)
Sodium hydroxide
Hydroxypropylcellulose (E 463)
Croscarmellose sodium
Cellulose, microcrystalline (E 460)
Magnesium stearate (E 572)

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 light and moisture.
This medicinal product does not require any special temperature storage conditions.

6.5 Nature and contents of container

Cartons containing aluminum blisters packs integrated with desiccant.

Pack sizes:

One blister pack contains either 14 tablets or 15 tablets.

14, 28, 30, 56, 90 or 98 tablets.

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

Takeda Pharma A/S
Dybendal Alle 10
2630 Taastrup
Denmark

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/11/735/005 14 tablets
EU/1/11/735/006 28 tablets
EU/1/11/735/014 30 tablets
EU/1/11/735/007 56 tablets
EU/1/11/735/015 90 tablets
EU/1/11/735/008 98 tablets

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

7 December 2011

10. DATE OF REVISION OF THE TEXT

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

Medicinal product no longer authorised

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 for how to report adverse reactions.

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 80 mg tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 80 mg of azilsartan medoxomil (as potassium).

For a full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Tablet.

White to nearly white round tablets, 9.6 mm in diameter, debossed "ASL" on one side and "80" on the other.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Ipreziv is indicated for the treatment of essential hypertension in adults.

4.2 Posology and method of administration

Posology

The recommended starting dose is 40 mg once daily. The dose may be increased to a maximum of 80 mg once daily for patients whose blood pressure is not adequately controlled at the lower dose.

Near-maximal antihypertensive effect is evident at 2 weeks, with maximal effects attained by 4 weeks.

If blood pressure is not adequately controlled with Ipreziv alone, additional blood pressure reduction can be achieved when Ipreziv is coadministered with other antihypertensive medicinal products, including diuretics (such as chlortalidone and hydrochlorothiazide) and calcium channel blockers (see sections 4.3, 4.4, 4.5 and 5.1).

Special populations

Older people (65 years and over)

No initial dose adjustment with Ipreziv is necessary in elderly patients (see section 5.2), although consideration can be given to 20 mg as a starting dose in the very elderly (≥ 75 years), who may be at risk of hypotension.

Renal impairment

Caution should be exercised in hypertensive patients with severe renal impairment and end stage renal disease as there is no experience of use of Ipreziv in these patients (see sections 4.4 and 5.2).

Hemodialysis does not remove azilsartan from the systemic circulation.

No dose adjustment is required in patients with mild or moderate renal impairment.

Hepatic impairment

Ipreziv has not been studied in patients with severe hepatic impairment and therefore its use is not recommended in this patient group (see sections 4.4 and 5.2).

As there is limited experience of use of Ipreziv in patients with mild to moderate hepatic impairment close monitoring is recommended and consideration should be given to 20 mg as a starting dose (see section 5.2).

Intravascular volume depletion

For patients with possible depletion of intravascular volume or salt depletion (e.g. patients with vomiting, diarrhoea or taking high doses of diuretics), Ipreziv should be initiated under close medical supervision and consideration can be given to 20 mg as a starting dose (see section 4.4).

Heart failure

Caution should be exercised in hypertensive patients with congestive heart failure as there is no experience of use of Ipreziv in these patients (see section 4.4).

Black population

No dose adjustment is required in the black population, although smaller reductions in blood pressure are observed compared with a non-black population (see section 5.1). This generally has been true for other angiotensin II receptor (AT₁) antagonists and angiotensin-converting enzyme inhibitors.

Consequently, up-titration of Ipreziv and concomitant therapy may be needed more frequently for blood pressure control in black patients.

Paediatric population

The safety and efficacy of Ipreziv in children and adolescents 0 to < 18 years have not yet been established.

No data are available.

Method of administration

Ipreziv is for oral use and may be taken with or without food (see section 5.2).

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients.
- Second and third trimester of pregnancy (see sections 4.4 and 4.6).
- The concomitant use of Ipreziv with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60 mL/min/1.73m²) (see sections 4.5 and 5.1).

4.4 Special warnings and precautions for use

Activated 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 congestive heart failure, severe renal impairment or renal artery stenosis), treatment with medicinal products that affect this system, such as angiotensin-converting enzyme inhibitors and angiotensin II receptor antagonists, has been associated with acute hypotension, azotaemia, oliguria or, rarely, acute renal failure. The possibility of similar effects cannot be excluded with Ipreziv.

Caution should be exercised in hypertensive patients with severe renal impairment, congestive heart failure or renal artery stenosis, as there is no experience of use of Ipreziv in these patients (see sections 4.2 and 5.2).

Excessive blood pressure decreases in patients with ischaemic cardiomyopathy or ischaemic cerebrovascular disease could result in a myocardial infarction or stroke.

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.

Kidney transplantation

There is currently no experience on the use of Ipreziv in patients who have recently undergone kidney transplantation.

Hepatic impairment

Ipreziv has not been studied in patients with severe hepatic impairment and therefore its use is not recommended in this patient group (see sections 4.2 and 5.2).

Hypotension in volume- and/or salt-depleted patients

In patients with marked volume- and/or salt-depletion (e.g. patients with vomiting, diarrhoea or taking high doses of diuretics) symptomatic hypotension could occur after initiation of treatment with Ipreziv. Hypovolemia should be corrected prior to administration of Ipreziv, or the treatment should start under close medical supervision, and consideration can be given to a starting dose of 20 mg.

Primary hyperaldosteronism

Patients with primary hyperaldosteronism generally will not respond to antihypertensive medicinal products acting through inhibition of the renin-angiotensin system. Therefore, the use of Ipreziv is not recommended in these patients.

Hyperkalaemia

Based on experience with the use of other medicinal products that affect the renin-angiotensin-aldosterone system, concomitant use of Ipreziv with potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium, or other medicinal products that may increase potassium levels (e.g. heparin) may lead to increases in serum potassium in hypertensive patients (see section 4.5). In the elderly, in patients with renal insufficiency, in diabetic patients and/or in patients with other co-morbidities, the risk of hyperkalaemia, which may be fatal, is increased. Monitoring of potassium should be undertaken as appropriate.

Aortic and mitral valve stenosis, obstructive hypertrophic cardiomyopathy

Special caution is indicated in patients suffering from aortic or mitral valve stenosis, or hypertrophic obstructive cardiomyopathy (HOCM).

Pregnancy

Angiotensin II receptor antagonists should not be initiated during pregnancy. Unless continued angiotensin II receptor antagonist 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 angiotensin II receptor antagonists should

be stopped immediately, and, if appropriate, alternative therapy should be started (see sections 4.3 and 4.6).

Lithium

As with other angiotensin II receptor antagonists the combination of lithium and Ipreziv is not recommended (see section 4.5).

4.5 Interaction with other medicinal products and other forms of interaction

Concomitant use not recommended

Lithium

Reversible increases in serum lithium concentrations and toxicity have been reported during concurrent use of lithium and angiotensin-converting enzyme inhibitors. A similar effect may occur with angiotensin II receptor antagonists. Due to the lack of experience with concomitant use of azilsartan medoxomil and lithium, this combination is not recommended. If the combination proves necessary, careful monitoring of serum lithium levels is recommended.

Caution required with concomitant use

Non-steroidal anti-inflammatory drugs (NSAIDs), including selective COX-2 inhibitors, acetylsalicylic acid > 3 g/day, and non-selective NSAIDs

When angiotensin II receptor antagonists are administered simultaneously with NSAIDs (i.e. selective COX-2 inhibitors, acetylsalicylic acid (> 3 g/day) and non-selective NSAIDs), attenuation of the antihypertensive effect may occur. Furthermore, concomitant use of angiotensin II receptor antagonists and NSAIDs may lead to an increased risk of worsening of renal function and an increase in serum potassium. Therefore, adequate hydration and monitoring of renal function at the beginning of the treatment are recommended.

Potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium and other substances that may increase potassium levels

Concomitant use of potassium-sparing diuretics, potassium supplements, salt substitutes containing potassium, or other medicinal products (e.g. heparin) may increase potassium levels. Monitoring of serum potassium should be undertaken as appropriate (see section 4.4).

Additional information

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).

No clinically significant interactions have been reported in studies of azilsartan medoxomil or azilsartan given with amlodipine, antacids, chlortalidone, digoxin, fluconazole, glyburide, ketoconazole, metformin, and warfarin.

Azilsartan medoxomil is rapidly hydrolysed to the active moiety azilsartan by esterases in the gastrointestinal tract and/or during drug absorption (see section 5.2). *In vitro* studies indicated that interactions based on esterase inhibition are unlikely.

4.6 Fertility, pregnancy and lactation

Pregnancy

The use of angiotensin II receptor antagonists is not recommended during the first trimester of pregnancy (see section 4.4).

The use of angiotensin II receptor antagonists is contraindicated during the second and third trimester of pregnancy (see sections 4.3 and 4.4).

There are no data from the use of Ipreziv in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3).

Epidemiological evidence regarding the risk of teratogenicity following exposure to angiotensin converting enzyme inhibitors during the first trimester of pregnancy has not been conclusive; however, a small increase in risk cannot be excluded. Whilst there are no controlled epidemiological data on the risk with angiotensin II receptor antagonists, similar risks may exist for this class of medicinal products. Unless continued angiotensin II receptor antagonist 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 angiotensin II receptor antagonists should be stopped immediately and, if appropriate, alternative therapy should be started.

Exposure to angiotensin II receptor antagonist 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 angiotensin II receptor antagonists have occurred from the second trimester of pregnancy, ultrasound check of renal function and skull is recommended.

Infants whose mothers have taken Angiotensin II receptor antagonists should be closely observed for hypotension (see sections 4.3 and 4.4).

Breastfeeding

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

Fertility

No data are available on the effect of Ipreziv on human fertility. Nonclinical studies demonstrated that azilsartan did not appear to affect male or female fertility in the rat (see section 5.3).

4.7 Effects on ability to drive and use machines

Based on its pharmacodynamic properties it is expected that azilsartan medoxomil would have negligible influence on the ability to drive and use machines. However, when taking any antihypertensive it should be taken into account that occasionally dizziness or tiredness may occur.

4.8 Undesirable effects

Summary of the safety profile

Ipreziv at doses of 20, 40 or 80 mg has been evaluated for safety in clinical studies in patients treated for up to 56 weeks. In these clinical studies, adverse reactions associated with treatment with Ipreziv were mostly mild or moderate, with an overall incidence similar to placebo. The most common adverse reaction was dizziness. The incidence of adverse reactions with Ipreziv was not affected by gender, age, or race.

Tabulated list of adverse reactions

Adverse reactions based on pooled data (40 and 80 mg doses) are listed below according to system organ class and preferred terms. These are ranked by frequency, using the following convention: very common ($\geq 1/10$); common ($\geq 1/100$, $< 1/10$); uncommon ($\geq 1/1,000$, $< 1/100$); rare ($\geq 1/10,000$, $< 1/1,000$); very rare ($< 1/10,000$), including isolated reports. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Adverse reactions were reported at a similar frequency for the Ipreziv 20 mg dose as with the 40 and 80 mg doses in one placebo controlled study.

System organ class	Frequency	Adverse reaction
Nervous system disorders	Common	Dizziness
Vascular disorders	Uncommon	Hypotension
Gastrointestinal disorders	Common Uncommon	Diarrhoea Nausea
Skin and subcutaneous tissue disorders	Uncommon Rare	Rash, pruritus Angioedema
Musculoskeletal and connective tissue disorders	Uncommon	Muscle spasms
General disorders and administration site conditions	Uncommon	Fatigue Peripheral oedema
Investigations	Common Uncommon	Blood creatine phosphokinase increased Blood creatinine increased Blood uric acid increased / Hyperuricemia

Description of selected adverse reactions

When Ipreziv was coadministered with chlortalidone, the frequencies of blood creatinine increased and hypotension were increased from uncommon to common.

When Ipreziv was coadministered with amlodipine, the frequency of peripheral oedema was increased from uncommon to common, but was lower than amlodipine alone.

Investigations

Serum creatinine

The incidence of elevations in serum creatinine following treatment with Ipreziv was similar to placebo in the randomised placebo-controlled monotherapy studies. Coadministration of Ipreziv with diuretics, such as chlortalidone, resulted in a greater incidence of creatinine elevations, an observation consistent with that of other angiotensin II receptor antagonists and angiotensin converting enzyme inhibitors. The elevations in serum creatinine during coadministration of Ipreziv with diuretics were associated with larger blood pressure reductions compared with a single medicinal product. Many of these elevations were transient or nonprogressive while subjects continued to receive treatment. Following discontinuation of treatment, the majority of the elevations that had not resolved during treatment were reversible, with the creatinine levels of most subjects returning to Baseline or near-Baseline values.

Uric acid

Small mean increases of serum uric acid were observed with Ipreziv (10.8 $\mu\text{mol/l}$) compared with placebo (4.3 $\mu\text{mol/l}$).

Hemoglobin and hematocrit

Small decreases in hemoglobin and hematocrit (mean decreases of approximately 3 g/l and 1 volume percent, respectively) were observed in placebo-controlled monotherapy studies. This effect is also seen with other inhibitors of the renin-angiotensin-aldosterone system.

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

Symptoms

Based on pharmacological considerations, the main manifestation of an overdose is likely to be symptomatic hypotension and dizziness. During controlled clinical studies in healthy subjects, once daily doses up to 320 mg of Ipreziv were administered for 7 days and were well tolerated.

Management

If symptomatic hypotension should occur, supportive treatment should be instituted and vital signs monitored.

Azilsartan is not removed by dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Angiotensin II antagonists, plain
ATC Code: C09CA09

Mechanism of action and pharmacodynamic effect

Azilsartan medoxomil is an orally active prodrug that is rapidly converted to the active moiety, azilsartan, which selectively antagonises the effects of angiotensin II by blocking its binding to the AT₁ receptor in multiple tissues (see section 5.2). Angiotensin II is the principal pressor agent of the renin-angiotensin system, with effects that include vasoconstriction, stimulation of synthesis and release of aldosterone, cardiac stimulation, and renal reabsorption of sodium.

Blockade of the AT₁ receptor inhibits the negative regulatory feedback of angiotensin II on renin secretion, but the resulting increases in plasma renin activity and angiotensin II circulating levels do not overcome the antihypertensive effect of azilsartan.

Essential hypertension

In seven double blind controlled studies, a total of 5941 patients (3672 given Ipreziv, 801 given placebo, and 1468 given active comparator) were evaluated. Overall, 51% of patients were male and 26% were 65 years or older (5% ≥ 75 years); 67% were white and 19% were black.

Ipreziv was compared with placebo and active comparators in two 6-week randomized, double blind studies. Blood pressure reductions compared with placebo based on 24 hour mean blood pressure by ambulatory blood pressure monitoring (ABPM) and clinic blood pressure measurements at trough are shown in the table below for both studies. Additionally, Ipreziv 80 mg resulted in significantly greater reductions in SBP than the highest approved doses of olmesartan medoxomil and valsartan.

	Placebo	Ipreziv 20 mg	Ipreziv 40 mg#	Ipreziv 80 mg#	OLM-M 40 mg#	Valsartan 320 mg#
Primary End point:						
24-Hour Mean SBP: LS Mean Change from Baseline (BL) to Week 6 (mm Hg)						
Study 1						
Change from BL	-1.4	-12.2 *	-13.5 *	-14.6 *†	-12.6	-
Study 2						
Change from BL	-0.3	-	-13.4 *	-14.5 *†	-12.0	-10.2
Key Secondary End Point:						
Clinic SBP: LS Mean Change from Baseline (BL) to Week 6 (mm Hg) (LOCF)						
Study 1						
Change from BL	-2.1	-14.3 *	-14.5 *	-17.6 *	-14.9	-
Study 2						
Change from BL	-1.8	-	-16.4 *†	-16.7 *†	-13.2	-11.3

OLM-M = olmesartan medoxomil, LS = least squares, LOCF = last observation carried forward

* Significant difference vs. Placebo at 0.05 level within the framework of the step-wise analysis

† Significant difference vs. Comparator(s) at 0.05 level within the framework of the step-wise analysis

Maximum dose achieved in study 2. Doses were force-titrated at Week 2 from 20 to 40 mg and 40 to 80 mg for Ipreziv, and 20 to 40 mg and 160 to 320 mg, respectively, for olmesartan medoxomil and valsartan

In these two studies, clinically important and most common adverse events included dizziness, headache and dyslipidemia. For Ipreziv, olmesartan medoxomil and valsartan, respectively dizziness was observed at an incidence of 3.0%, 3.3% and 1.8%; headache at 4.8%, 5.5% and 7.6% and dyslipidemia at 3.5%, 2.4% and 1.1%.

In active-comparator studies with either valsartan or ramipril, the blood-pressure-lowering effect with Ipreziv was sustained during long-term treatment. Ipreziv had a lower incidence of cough (1.2%) compared with ramipril (8.2%).

The antihypertensive effect of Ipreziv occurred within the first 2 weeks of dosing with the full effect achieved by 4 weeks. The blood pressure lowering effect of Ipreziv was also maintained throughout the 24-hour dosing interval. The placebo-corrected trough-to-peak ratios for SBP and DBP were approximately 80% or higher.

Rebound hypertension was not observed following abrupt cessation of Ipreziv therapy after 6 months of treatment.

No overall differences in safety and effectiveness were observed between elderly patients and younger patients, but greater sensitivity to blood pressure lowering effects in some elderly individuals cannot be ruled out (see section 4.2). As with other angiotensin II receptor antagonists and angiotensin converting enzyme inhibitors the antihypertensive effect was lower in black patients (usually a low-renin population).

Coadministration of Ipreziv 40 and 80 mg with a calcium channel blocker (amlodipine) or a thiazide-type diuretic (chlortalidone) resulted in additional blood pressure reductions compared with the other antihypertensive alone. Dose dependent adverse events including dizziness, hypotension and serum creatinine elevations were more frequent with diuretic coadministration compared with Ipreziv alone, while hypokalemia was less frequent compared with diuretic alone.

Beneficial effects of Ipreziv on mortality and cardiovascular morbidity and target organ damage are currently unknown.

Effect on cardiac repolarisation

A thorough QT/QTc study was conducted to assess the potential of Ipreziv to prolong the QT/QTc interval in healthy subjects. There was no evidence of QT/QTc prolongation at a dose of 320 mg of Ipreziv.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with Ipreziv in one or more subsets of the paediatric population in hypertension (see section 4.2 for information on paediatric use).

Additional information

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.

5.2 Pharmacokinetic properties

Following oral administration, azilsartan medoxomil is rapidly hydrolyzed to the active moiety azilsartan in the gastrointestinal tract and/or during absorption. Based on *in vitro* studies, carboxymethylenbutenolidase is involved in the hydrolysis in the intestine and liver. In addition, plasma esterases are involved in the hydrolysis of azilsartan medoxomil to azilsartan.

Absorption

The estimated absolute oral bioavailability of azilsartan medoxomil based on plasma levels of azilsartan is approximately 60%. After oral administration of azilsartan medoxomil, peak plasma concentrations (C_{max}) of azilsartan are reached within 1.5 to 3 hours. Food does not affect the bioavailability of azilsartan (see section 4.2).

Distribution

The volume of distribution of azilsartan is approximately 16 litres. Azilsartan is highly bound to plasma proteins (> 99%), mainly serum albumin. Protein binding is constant at azilsartan plasma concentrations well above the range achieved with recommended doses.

Biotransformation

Azilsartan is metabolised to two primary metabolites. The major metabolite in plasma is formed by *O*-dealkylation, referred to as metabolite M-II, and the minor metabolite is formed by decarboxylation, referred to as metabolite M-I. Systemic exposures to the major and minor metabolites in humans were approximately 50% and less than 1% that of azilsartan, respectively. M-I and M-II do not contribute to the pharmacologic activity of Ipreziv. The major enzyme responsible for azilsartan metabolism is CYP2C9.

Elimination

Following an oral dose of ¹⁴C-labelled azilsartan medoxomil, approximately 55% of radioactivity was recovered in feces and approximately 42% in urine, with 15% of the dose excreted in urine as azilsartan. The elimination half-life of azilsartan is approximately 11 hours and renal clearance is approximately 2.3 ml/min. Steady-state levels of azilsartan are achieved within 5 days and no accumulation in plasma occurs with repeated once-daily dosing.

Linearity/non-linearity

Dose proportionality in exposure was established for azilsartan in the azilsartan medoxomil dose range of 20 mg to 320 mg after single or multiple dosing.

Characteristics in specific groups of patients

Paediatric population

The pharmacokinetics of azilsartan have not been studied in children under 18 years of age.

Older people

Pharmacokinetics of azilsartan do not differ significantly between young (age range 18-45 years) and elderly (age range 65-85 years) patients.

Renal impairment

In patients with mild, moderate, and severe renal impairment azilsartan total exposure (AUC) was +30%, +25% and +95% increased. No increase (+5%) was observed in end-stage renal disease patients who were dialysed. However, there is no clinical experience in patients with severe renal impairment or end stage renal disease (see section 4.2). Hemodialysis does not remove azilsartan from the systemic circulation.

Hepatic impairment

Administration of Ipreziv for up to 5 days in subjects with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment resulted in slight increase in azilsartan exposure (AUC increased by 1.3 to 1.6 fold, see section 4.2). Ipreziv has not been studied in patients with severe hepatic impairment.

Gender

Pharmacokinetics of azilsartan do not differ significantly between males and females. No dose adjustment is necessary based on gender.

Race

Pharmacokinetics of azilsartan do not differ significantly between black and white populations. No dose adjustment is necessary based on race.

5.3 Preclinical safety data

In preclinical safety studies, azilsartan medoxomil and M-II, the major human metabolite, were examined for repeated-dose toxicity, reproduction toxicity, mutagenicity and carcinogenicity.

In the repeated-dose toxicity studies, doses producing exposure comparable to that in the clinical therapeutic range caused reduced red cell parameters, changes in the kidney and renal haemodynamics, as well as increased serum potassium in normotensive animals. These effects, which

were prevented by oral saline supplementation, do not have clinical significance in treatment of hypertension.

In rats and dogs, increased plasma renin activity and hypertrophy/hyperplasia of the renal juxtaglomerular cells were observed. These changes, also a class effect of angiotensin converting enzyme inhibitors and other angiotensin II receptor antagonists, do not appear to have clinical significance.

Azilsartan and M-II crossed the placenta and were found in the fetuses of pregnant rats and were excreted into the milk of lactating rats. In the reproduction toxicity studies, there were no effects on male or female fertility. There is no evidence of a teratogenic effect, but animal studies indicated some hazardous potential to the postnatal development of the offspring such as lower body weight, a slight delay in physical development (delayed incisor eruption, pinna detachment, eye opening), and higher mortality.

Azilsartan and M-II showed no evidence of mutagenicity and relevant clastogenic activity in *in vitro* studies and no evidence of carcinogenicity in rats and mice.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Mannitol (E 421)
Fumaric acid (E 297)
Sodium hydroxide
Hydroxypropylcellulose (E 463)
Croscarmellose sodium
Cellulose, microcrystalline (E 460)
Magnesium stearate (E 572)

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 light and moisture.
This medicinal product does not require any special temperature storage conditions.

6.5 Nature and contents of container

Cartons containing aluminum blisters packs integrated with desiccant.

Pack sizes:

One blister pack contains either 14 tablets or 15 tablets.

14, 28, 30, 56, 90 or 98 tablets.

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

Takeda Pharma A/S
Dybendal Alle 10
2630 Taastrup
Denmark

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/11/735/016 14 tablets
EU/1/11/735/009 28 tablets
EU/1/11/735/017 30 tablets
EU/1/11/735/010 56 tablets
EU/1/11/735/018 90 tablets
EU/1/11/735/011 98 tablets

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

7 December 2011

10. DATE OF REVISION OF THE TEXT

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

Medicinal product no longer authorised

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

Takeda Ireland Ltd.
Bray Business Park
Kilruddery
Co Wicklow
Ireland

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

Medicinal product subject to medical prescription

C. OTHER CONDITIONS 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)

The MAH shall perform the pharmacovigilance activities and interventions detailed in the agreed RMP presented in Module 1.8.2. of the Marketing Authorisation and any agreed subsequent updates of the RMP.

An updated RMP should be submitted:

- At the request of the European Medicines Agency;
- Whenever the risk management system is modified, especially as the result of new information being received that may lead to a significant change to the benefit/risk profile or as the result of an important (pharmacovigilance or risk minimisation) milestone being reached.

If the dates for submission of a PSUR and the update of a RMP coincide, they can be submitted at the same time.

Medicinal product no longer authorised

ANNEX III
LABELLING AND PACKAGE LEAFLET

Medicinal product no longer authorised

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

Carton

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 20 mg tablets
azilsartan medoxomil

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each tablet contains 20 mg azilsartan medoxomil (as potassium)

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

14 tablets
28 tablets
30 tablets
56 tablets
90 tablets
98 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 REACH AND SIGHT OF CHILDREN

Keep out of the reach and sight 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 light and moisture.

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

Takeda Pharma A/S
Dybendal Alle 10
2630 Taastrup
Denmark

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/11/735/001 14 tablets
EU/1/11/735/002 28 tablets
EU/1/11/735/012 30 tablets
EU/1/11/735/003 56 tablets
EU/1/11/735/013 90 tablets
EU/1/11/735/004 98 tablets

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

Medicinal product subject to medical prescription.

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Ipreziv 20 mg

MINIMUM PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING

Blister pack

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 20 mg tablets
azilsartan medoxomil

2. NAME OF THE MARKETING AUTHORISATION HOLDER

Takeda Logo

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. OTHER

Medicinal product no longer authorised

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

Carton

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 40 mg tablets
azilsartan medoxomil

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each tablet contains 40 mg azilsartan medoxomil (as potassium)

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

14 tablets
28 tablets
30 tablets
56 tablets
90 tablets
98 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 REACH AND SIGHT OF CHILDREN

Keep out of the reach and sight 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 light and moisture.

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

Takeda Pharma A/S
Dybendal Alle 10
2630 Taastrup
Denmark

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/11/735/005 14 tablets
EU/1/11/735/006 28 tablets
EU/1/11/735/014 30 tablets
EU/1/11/735/007 56 tablets
EU/1/11/735/015 90 tablets
EU/1/11/735/008 98 tablets

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

Medicinal product subject to medical prescription.

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Ipreziv 40 mg

MINIMUM PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING

Blister pack

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 40 mg tablets
azilsartan medoxomil

2. NAME OF THE MARKETING AUTHORISATION HOLDER

Takeda Logo

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. OTHER

Medicinal product no longer authorised

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

Carton

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 80 mg tablets
azilsartan medoxomil

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each tablet contains 80 mg azilsartan medoxomil (as potassium)

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

14 tablets
28 tablets
30 tablets
56 tablets
90 tablets
98 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 REACH AND SIGHT OF CHILDREN

Keep out of the reach and sight 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 light and moisture.

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

Takeda Pharma A/S
Dybendal Alle 10
2630 Taastrup
Denmark

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/11/735/016 14 tablets
EU/1/11/735/009 28 tablets
EU/1/11/735/017 30 tablets
EU/1/11/735/010 56 tablets
EU/1/11/735/018 90 tablets
EU/1/11/735/011 98 tablets

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

Medicinal product subject to medical prescription.

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Ipreziv 80 mg

MINIMUM PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING

Blister pack

1. NAME OF THE MEDICINAL PRODUCT

Ipreziv 80 mg tablets
azilsartan medoxomil

2. NAME OF THE MARKETING AUTHORISATION HOLDER

Takeda Logo

3. EXPIRY DATE

EXP

4. BATCH NUMBER

Lot

5. OTHER

Medicinal product no longer authorised

Medicinal product no longer authorised

B. PACKAGE LEAFLET

PACKAGE LEAFLET: INFORMATION FOR THE USER

IPREZIV 20 MG TABLETS IPREZIV 40 MG TABLETS IPREZIV 80 MG TABLETS azilsartan medoxomil

▼ This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get. See the end of section 4 for how to report side effects.

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 get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet:

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

1. WHAT IPREZIV IS AND WHAT IT IS USED FOR

Ipreziv contains an active substance called azilsartan medoxomil and belongs to a class of medicines called angiotensin II receptor antagonists (AIIRAs). Angiotensin II is a substance which occurs naturally in the body and which causes the blood vessels to tighten, therefore increasing your blood pressure. Ipreziv blocks this effect so that the blood vessels relax, which helps lower your blood pressure.

This medicine is used for treating high blood pressure (essential hypertension) in adult patients (over 18 years of age).

2. WHAT YOU NEED TO KNOW BEFORE YOU TAKE IPREZIV

Do NOT take Ipreziv if you

- are **allergic** (hypersensitive) to azilsartan medoxomil or any of the other ingredients of Ipreziv (see section 6).
- are **more than 3 months pregnant**. (It is also better to avoid Ipreziv in early pregnancy - see pregnancy section).
- have diabetes mellitus or impaired kidney function and you are treated with a blood pressure lowering medicine containing **aliskiren**.

Warnings and precautions

Before you take, or whilst you are taking Ipreziv, tell your doctor if you:

- have kidney problems
- are on dialysis or had a recent kidney transplant

- have severe liver disease
- have heart problems (including heart failure, recent heart attack)
- have ever had a stroke
- have low blood pressure or feel dizzy or lightheaded
- are vomiting, have recently had severe vomiting, or have diarrhoea
- have elevated levels of potassium in your blood
- have a disease of the adrenal gland called primary hyperaldosteronism
- have been told that you have a narrowing of the valves in your heart (called “aortic or mitral valve stenosis”) or that the thickness of your heart muscle is abnormally increased (called “obstructive hypertrophic cardiomyopathy”).
- are taking any of the following medicines used to treat high blood pressure:
 - o an ACE-inhibitor (for example enalapril, lisinopril, ramipril), in particular if you have diabetes-related kidney problems.
 - o aliskiren

Your doctor may check your kidney function, blood pressure, and the amount of electrolytes (e.g. potassium) in your blood at regular intervals.

See also information under the heading “Do not take Ipreziv”.

You must tell your doctor if you think you are (or might become) pregnant. Ipreziv is not recommended in early pregnancy, and must NOT be taken if you are more than 3 months pregnant, as it may cause serious harm to your baby if used at that stage (see pregnancy section).

As with all other angiotensin II receptor antagonist medicines, azilsartan medoxomil may be less effective in lowering the blood pressure in black patients.

Children and adolescents

There is no experience with the use of Ipreziv in children or adolescents under 18 years of age. Therefore, Ipreziv should not be given to children or adolescents.

Other medicines and Ipreziv

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

Ipreziv can affect the way some other medicines work and some medicines can have an effect on Ipreziv.

In particular, tell your doctor if you are taking any of the following medicines:

- Lithium (a medicine for mental health problems)
- Non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, diclofenac or celecoxib (medicines to relieve pain and inflammation)
- Aspirin (acetylsalicylic acid) if taking more than 3 g per day (medicine to relieve pain and inflammation)
- Medicines that increase the amount of potassium in your blood; these include potassium supplements, potassium-sparing medicines (certain ‘water tablets’) or salt substitutes containing potassium
- Heparin (a medicine for thinning the blood)
- Diuretics (water tablets)
- Aliskiren or other medicines to lower your blood pressure (angiotensin converting enzyme inhibitor or angiotensin II receptor blocker, such as enalapril, lisinopril, ramipril or valsartan, telmisartan, irbesartan).

Your doctor may need to change your dose and/or to take other precautions if you are taking an ACE-inhibitor or aliskiren (see also information under the headings “Do not take Ipreziv” and “Warnings and precautions”).

Pregnancy and breast-feeding

Pregnancy

You must tell your doctor if you think you are (or might become) pregnant. Your doctor will normally advise you to stop taking Ipreziv before you become pregnant or as soon as you know you are pregnant and will advise you to take another medicine instead of Ipreziv.

Ipreziv is not recommended in early pregnancy, and must NOT be taken when more than 3 months pregnant, as it may cause serious harm to your baby if used after the third month of pregnancy.

Breast-feeding

Tell your doctor if you are breast-feeding or about to start breast-feeding. Ipreziv is not recommended for mothers who are breast-feeding, and your doctor may choose another treatment for you if you wish to breast-feed, especially if your baby is newborn, or was born prematurely.

Driving and using machines

Ipreziv is unlikely to have an effect on driving or using machines. However some people may feel tired or dizzy when taking Ipreziv and if this happens to you, do not drive or use any tools or machines.

3. HOW TO TAKE IPREZIV

Always take Ipreziv exactly as your doctor has told you. You should check with your doctor or pharmacist if you are not sure. It is important to keep taking Ipreziv every day.

Ipreziv is for oral use. Take the tablet with plenty of water.

You can take Ipreziv with or without food.

- The usual starting dose is 40 mg once a day. Your doctor may increase this dose to a maximum of 80 mg once a day depending on blood pressure response.
- For patients such as the very elderly (75 years and above) your doctor may recommend a lower starting dose of 20 mg once a day.
- If you suffer from mild or moderate liver disease your doctor may recommend a lower starting dose of 20 mg once a day.
- For patients who recently have lost body fluids e.g. through vomiting or diarrhoea, or by taking water tablets, your doctor may recommend a lower starting dose of 20 mg once a day.
- If you suffer from other coexisting illnesses such as severe kidney disease or heart failure your doctor will decide on the most appropriate starting dose.

A reduction in your blood pressure will be measurable within 2 weeks of initiation of treatment and the full effect of your dose will be observed by 4 weeks.

If you take more Ipreziv than you should

If you take too many tablets, or if someone else takes your medicine, contact your doctor immediately. You may feel faint or dizzy if you have taken more than you should.

If you forget to take Ipreziv

Do not take a double dose to make up for a forgotten dose. Just take the next dose at the usual time.

If you stop taking Ipreziv

If you stop taking Ipreziv, your blood pressure may increase again. Therefore do not stop taking Ipreziv without first talking to your doctor about alternative treatment options.

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

4. POSSIBLE SIDE EFFECTS

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

STOP taking Ipreziv and seek medical help immediately if you have any of the following allergic reactions, which occur rarely (less than 1 in 1000 people):

- Difficulties in breathing, or swallowing, or swelling of the face, lips, tongue and/or throat (angioedema)
- Itching of the skin with raised lumps.

Other possible side effects include:

Common side effects affecting less than 1 in 10 people:

- Dizziness
- Diarrhoea
- Increased blood creatine phosphokinase (an indicator of muscle damage).

Uncommon side effects affecting less than 1 in 100 people:

- Low blood pressure, which may make you feel faint or dizzy
- Feeling tired
- Swelling of the hands, ankles or feet (peripheral oedema)
- Skin rash and itching
- Nausea
- Muscle spasms
- Increased serum creatinine in the blood (an indicator of kidney function)
- Increased uric acid in the blood (an indicator of kidney function).

Rare side effects affecting less than 1 in 1000 people:

- Changes in blood test results including decreased levels of a protein in the red blood cells (haemoglobin).

When Ipreziv is taken with chlortalidone (a water tablet), higher levels of certain chemicals in the blood (such as creatinine), which are indicators of kidney function, have been seen commonly (in less than 1 in 10 users), and low blood pressure is also common.

Swelling of the hands, ankles or feet is more common (in less than 1 in 10 users) when Ipreziv is taken with amlodipine (a calcium channel blocker for treating hypertension) than when Ipreziv is taken alone (less than 1 in 100 users). The frequency of this event is highest when amlodipine is taken alone.

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 IPREZIV

Keep out of the reach and sight of children.

Do not use Ipreziv after the expiry date which is stated on the carton after EXP. The expiry date refers to the last day of the month.

Store Ipreziv in the original package in order to protect it from light and moisture. This medicine does not require any special temperature storage conditions.

Medicines should not be disposed of via wastewater or household waste. Ask your pharmacist how to dispose of medicines no longer required. These measures will help to protect the environment.

6. CONTENTS OF THE PACK AND OTHER INFORMATION

What Ipreziv contains

- The **active substance** is azilsartan medoxomil (as potassium) either 20 mg, 40 mg or 80 mg
- The **other ingredients** are mannitol, fumaric acid, sodium hydroxide, hydroxypropylcellulose, croscarmellose sodium, microcrystalline cellulose, and magnesium stearate.

What Ipreziv looks like and contents of the pack

Ipreziv are white round tablets debossed “ASL” on one side and either “20”, “40” or “80” on the other.

Ipreziv is provided in blister packs with each blister pack having either 14 tablets or 15 tablets within cartons containing:

- 14, 28, 30, 56, 90 or 98 tablets for 20 mg tablets
- 14, 28, 30, 56, 90 or 98 tablets for 40 mg tablets
- 14, 28, 30, 56, 90 or 98 tablets for 80 mg tablets

Not all pack sizes may be marketed.

Marketing Authorisation Holder and Manufacturer

Marketing Authorisation Holder:

Takeda Pharma A/S, Dybendal Alle 10, 2630 Taastrup, Denmark

Manufacturer:

Takeda Ireland Limited, Bray Business Park, Kilruddery, Co. Wicklow, Ireland

For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

België/Belgique/Belgien

Takeda Belgium

Tél/Tel: +32 2 464 06 11

takeda-belgium@takeda.com

Lietuva

Takeda Global R & D Centre (Europe)

Tel: +44 (0) 203 116 8000

България

Takeda Global R & D Centre (Europe)

Tél/Tel: +44 (0) 203 116 8000

Luxembourg/Luxemburg

Takeda Belgium

Tél/Tel: +32 2 464 06 11

takeda-belgium@takeda.com

Česká republika

Takeda Global R & D Centre (Europe)

Tél/Tel: +44 (0) 203 116 8000

Magyarország

Takeda Global R & D Centre (Europe)

Tél/Tel: +44 (0) 203 116 8000

Danmark

Takeda Pharmaceuticals Nordics AB

Tlf: +46 (0) 8 5861 3380

Malta

Takeda Italia Farmaceutici SpA

Tel: +39 06 5026 01

Deutschland

Takeda GmbH

Tel: 0800 825 3325

Nederland

Takeda Nederland bv

Tel: +31 (0) 23 566 8777

Eesti

Takeda Global R & D Centre (Europe)
Tel: +44 0203 116 8000

Ελλάδα

Takeda Global R & D Centre (Europe)
Τηλ: +44 (0) 203 116 8000

España

Takeda Farmacéutica España
Tel: +34 93 184 5730

France

Laboratoires Takeda
Tél: +33 (0) 1 46 25 16 16

Hrvatska

Takeda Pharmaceuticals Croatia d.o.o.
Tel: +385 1 377 88 96

Ireland

Takeda UK Ltd
Tel: +44 (0) 1628 537 900

Ísland

Takeda Pharmaceuticals Nordics AB
Sími: +46 (0) 8 5052 1105

Italia

Takeda Italia Farmaceutici SpA
Tel: +39 06 5026 01

Κύπρος

Takeda Global R & D Centre (Europe)
Τηλ: +44 (0) 203 116 8000

Latvija

Takeda Global R & D Centre (Europe)
Tel: +44 (0) 203 116 8000

Norge

Takeda Pharmaceuticals Nordics AB
Tlf: + 46 (0) 8 5861 3380

Österreich

Takeda Pharma Ges m.b.H
Tel: +43 (1) 524 40 64

Polska

Takeda Global R & D Centre (Europe)
Tel: +44 (0) 203 116 8000

Portugal

Takeda - Farmacêuticos Portugal
Tel: +351 21 464 32 22

România

Takeda Global R & D Centre (Europe)
Tel: +44 (0) 203 116 8000

Slovenija

Takeda Global R & D Centre (Europe)
Tel: +44 (0) 203 116 8000

Slovenská republika

Takeda Global R & D Centre (Europe)
Tel: +44 (0) 203 116 8000

Suomi/Finland

Takeda Pharmaceuticals Nordics AB
Puh/Tel: +46 (0) 8 5052 1105

Sverige

Takeda Pharmaceuticals Nordics AB
Tel: + 46 (0) 8 5861 3380

United Kingdom

Takeda UK Ltd
Tel: +44 (0) 1628 537 900

This leaflet was last approved in {MM/YYYY}.

Detailed information on this medicine is available on the European Medicines Agency web site:

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