

Summary of product characteristics for pharmaceutical products

1. Name of the medicinal product

DIAX-TS 2.5 (Dutasteride 0.5 mg, Tadalafil 2.5 mg and Solifenacin Succinate 2.5 mg Tablets)

DIAX-TS 5 mg (Dutasteride 0.5 mg, Tadalafil 5 mg and Solifenacin Succinate 5 mg Tablets)

DIAX-TS 10 mg (Dutasteride 0.5 mg, Tadalafil 10 mg and Solifenacin Succinate 10 mg Tablets)

2. Qualitative and quantitative composition

DIAX-TS 2.5 (Dutasteride 0.5 mg, Tadalafil 2.5 mg and Solifenacin Succinate 2.5 mg Tablets)

Each film coated tablet contains:

Dutasteride BP 0.5 mg

Tadalafil BP 2.5 mg

Solifenacin Succinate BP.....2.5 mg

DIAX-TS 5 mg (Dutasteride 0.5 mg, Tadalafil 5 mg and Solifenacin Succinate 5 mg Tablets)

Each film coated tablet contains:

Dutasteride BP 0.5 mg

Tadalafil BP 5.0 mg

Solifenacin Succinate BP.....5.0 mg

DIAX-TS 10 mg (Dutasteride 0.5 mg, Tadalafil 10 mg and Solifenacin Succinate 10 mg Tablets)

Each film coated tablet contains:

Dutasteride BP 0.5 mg

Tadalafil BP 10 mg
Solifenacin Succinate BP..... 10 mg
Colors Ferric Oxide Red USP NF,
Ferric Oxide Yellow USP-NF, Titanium Dioxide USP.

For a full list of excipients, see section 6.1.

3. Pharmaceutical form

DIAX-TS 2.5 (Dutasteride 0.5 mg, Tadalafil 2.5 mg and Solifenacin Succinate 2.5 mg Tablets)

A brown colored, round shaped, biconvex, film coated tablet, breakline on one side and plain on other side.

DIAX-TS 5 mg (Dutasteride 0.5 mg, Tadalafil 5 mg and Solifenacin Succinate 5 mg Tablets)

A Yellow colored, round shaped, biconvex, film coated tablet, breakline on one side and plain on other side.

DIAX-TS 10 mg (Dutasteride 0.5 mg, Tadalafil 10 mg and Solifenacin Succinate 10 mg Tablets)

A Yellow colored, round shaped, biconvex, film coated tablet, breakline on one side and plain on other side.

4. Clinical particulars

4.1 Therapeutic indications

Dutasteride

Treatment of benign prostatic hyperplasia (BPH) and related erectile dysfunction, urinary incontinence and urgency.

4.2 Posology and method of administration

As directed by the physician.

Adults (including elderly):

The recommended dose of Dutasteride is 0.5 mg taken orally once a day. Although an improvement may be observed at an early stage, it can take up to 6 months before a response to the treatment can be achieved. No dose adjustment is necessary in the elderly.

The recommended dose of Tadalafil is 5 mg, taken at approximately the same time every day with or without food. For adult men being treated for both benign prostatic hyperplasia and erectile dysfunction the recommended dose is also 5 mg taken at approximately the same time every day. Patients who are unable to tolerate tadalafil 5 mg for the treatment of benign prostatic hyperplasia should consider an alternative therapy as the efficacy of tadalafil 2.5 mg for the treatment of benign prostatic hyperplasia has not been demonstrated. Dose adjustments are not required in elderly patients.

The recommended dose is 5 mg solifenacin succinate once daily. If needed, the dose may be increased to 10 mg solifenacin succinate once daily.

Renal impairment

The effect of renal impairment on dutasteride pharmacokinetics has not been studied. No adjustment in dosage is anticipated for patients with renal impairment (see section 5.2).

Dose adjustments of Tadalafil are not required in patients with mild to moderate renal impairment. For patients with severe renal impairment, 10 mg is the maximum recommended dose.

Once-a-day dosing of 2.5 or 5 mg tadalafil both for the treatment of erectile dysfunction or benign prostatic hyperplasia is not recommended in patients with severe renal impairment (see sections 4.4 and 5.2).

No dose adjustment of Solifenacin is necessary for patients with mild to moderate renal impairment (creatinine clearance > 30 ml/min). Patients with severe renal impairment (creatinine clearance ≤ 30 ml/min) should be treated with caution and receive no more than 5 mg once daily (see Section 5.2).

Hepatic impairment

The effect of hepatic impairment on dutasteride pharmacokinetics has not been studied so caution should be used in patients with mild to moderate

hepatic impairment (see section 4.4 and section 5.2). In patients with severe hepatic impairment, the use of dutasteride is contraindicated (see section 4.3).

There is limited clinical data on the safety of TADALAFIL in patients with severe hepatic impairment (Child-Pugh class C); if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. There are no available data about the administration of doses higher than 10mg of tadalafil to patients with hepatic impairment.

Once-a-day dosing both for the treatment of erectile dysfunction and benign prostatic hyperplasia has not been evaluated in patients with hepatic impairment; therefore, if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician (see sections 4.4 and 5.2).

No dose adjustment of Solifenacin is necessary for patients with mild hepatic impairment. Patients with moderate hepatic impairment (Child-Pugh score of 7 to 9) should be treated with caution and receive no more than 5 mg once daily (see Section 5.2).

Method of administration Oral use

4.3 Contradictions

Dutasteride

- hypersensitivity to the active substance or other 5-alpha reductase inhibitors or to any of the excipients listed in section 6.1.
- women and children and adolescents (see section 4.6).
- patients with severe hepatic impairment.

Tadalafil

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

In clinical studies, tadalafil was shown to augment the hypotensive effects of nitrates. This is thought to result from the combined effects of nitrates and tadalafil on the nitric oxide/cGMP pathway. Therefore, administration of tadalafil to patients who are using any form of organic nitrate is contraindicated (see section 4.5).

Tadalafil must not be used in men with cardiac disease for whom sexual activity is inadvisable. Physicians should consider the potential cardiac risk

of sexual activity in patients with pre- existing cardiovascular disease.

The following groups of patients with cardiovascular disease were not included in clinical trials and the use of tadalafil is therefore contraindicated:

- patients with myocardial infarction within the last 90 days,
- patients with unstable angina or angina occurring during sexual intercourse,
- patients with New York Heart Association Class 2 or greater heart failure in the last 6 months,
- patients with uncontrolled arrhythmias, hypotension (<90/50 mm Hg), or uncontrolled hypertension,
- patients with a stroke within the last 6 months

Tadalafil is contraindicated in patients who have loss of vision in one eye because of non- arteritic anterior ischaemic optic neuropathy (NAION), regardless of whether this episode was in connection or not with previous PDE5 inhibitor exposure (see section 4.4).

The co-administration of PDE5 inhibitors, including tadalafil, with guanylate cyclase stimulators, such as riociguat, is contraindicated as it may potentially lead to symptomatic hypotension (see section 4.5).

Solifenacin Succinate

Solifenacin is contraindicated in patients with urinary retention, severe gastro-intestinal condition (including toxic megacolon), myasthenia gravis or narrow-angle glaucoma and in patients at risk for these conditions.

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Patients undergoing haemodialysis (see section 5.2).
- Patients with severe hepatic impairment (see section 5.2).
- Patients with severe renal impairment or moderate hepatic impairment and who are on treatment with a potent CYP3A4 inhibitor, e.g. ketoconazole (see section 4.5).

4.4 Special warnings and precautions for use

Dutasteride

Combination therapy should be prescribed after careful benefit risk assessment due to the potential increased risk of adverse events (including

cardiac failure) and after consideration of alternative treatment options including monotherapies (see section 4.2).

Cardiovascular adverse events

In two 4-year clinical studies, the incidence of cardiac failure (a composite term of reported events, primarily cardiac failure and congestive cardiac failure) was higher among subjects taking the combination of dutasteride and an alpha blocker, primarily tamsulosin, than it was among subjects not taking the combination. In these two trials, the incidence of cardiac failure was low ($\leq 1\%$) and variable between the studies (see section 5.1).

Effects on prostate specific antigen (PSA) and prostate cancer detection

Digital rectal examination, as well as other evaluations for prostate cancer, must be performed on patients prior to initiating therapy with dutasteride and periodically thereafter.

Serum prostate-specific antigen (PSA) concentration is an important component in the detection of prostate cancer. Dutasteride causes a decrease in mean serum PSA levels by approximately 50%, after 6 months of treatment.

Patients receiving dutasteride should have a new PSA baseline established after 6 months of treatment. It is recommended to monitor PSA values regularly thereafter. Any confirmed increase from lowest PSA level while on dutasteride may signal the presence of prostate cancer (particularly high grade cancer) or noncompliance to therapy with dutasteride and should be carefully evaluated, even if those values are still within the normal range for men not taking a 5 α -reductase inhibitor (see section 5.1). In the interpretation of a PSA value for a patient taking dutasteride, previous PSA values should be sought for comparison.

Treatment with dutasteride does not interfere with the use of PSA as a tool to assist in the diagnosis of prostate cancer after a new baseline has been established (see section 5.1).

Total serum PSA levels return to baseline within 6 months of discontinuing treatment. The ratio of free to total PSA remains constant even under the influence of dutasteride. If clinicians elect to use percent free PSA as an aid in the detection of prostate cancer in men undergoing dutasteride therapy, no adjustment to its value appears necessary.

Prostate cancer and high-grade tumours

Results of one clinical study (the REDUCE study) in men at increased risk of prostate cancer revealed a higher incidence of Gleason 8-10 prostate cancers in dutasteride treated men compared to placebo. The relationship between dutasteride and high grade prostate cancer is not clear. Men taking dutasteride should be regularly evaluated for prostate cancer risk including PSA testing (see section 5.1).

Hepatic impairment

Dutasteride was not studied in patients with liver disease. Caution should be used in the administration of dutasteride to patients with mild to moderate hepatic impairment (see section 4.2, section 4.3 and section 5.2).

Breast neoplasia

Breast cancer has been reported in men taking dutasteride in clinical trials (see section 5.1) and during the post-marketing period. Physicians should instruct their patients to promptly report any changes in their breast tissue such as lumps or nipple discharge. Currently it is not clear if there is a causal relationship between the occurrence of male breast cancer and long term use of dutasteride.

Tadalafil

Before treatment with tadalafil tablets

A medical history and physical examination should be undertaken to diagnose erectile dysfunction or benign prostatic hyperplasia and determine potential underlying causes, before pharmacological treatment is considered.

Prior to initiating any treatment for erectile dysfunction, physicians should consider the cardiovascular status of their patients, since there is a degree of cardiac risk associated with sexual activity. Tadalafil has vasodilator properties, resulting in mild and transient decreases in blood pressure (see section 5.1) and as such potentiates the hypotensive effect of nitrates (see section 4.3).

The evaluation of erectile dysfunction should include a determination of potential underlying causes and the identification of appropriate treatment following an appropriate medical assessment. It is not known if tadalafil is effective in patients who have undergone pelvic surgery or radical non-nerve-sparing prostatectomy.

Tadalafil 5 mg - Prior to initiating treatment with tadalafil for benign prostatic hyperplasia patients should be examined to rule out the presence of carcinoma of the prostate and carefully assessed for cardiovascular conditions (see section 4.3).

Cardiovascular

Serious cardiovascular events, including myocardial infarction, sudden cardiac death, unstable angina pectoris, ventricular arrhythmia, stroke, transient ischaemic attacks, chest pain, palpitations and tachycardia, have been reported either post marketing and/or in clinical trials. Most of the patients in whom these events have been reported had pre-existing

cardiovascular risk factors. However, it is not possible to definitively determine whether these events are related directly to these risk factors, to tadalafil, to sexual activity, or to a combination of these or other factors.

In patients receiving concomitant antihypertensive medicinal products, tadalafil may induce a blood pressure decrease. When initiating daily treatment with tadalafil, appropriate clinical considerations should be given to a possible dose adjustment of the antihypertensive therapy.

In patients who are taking α_1 blockers, concomitant administration of tadalafil may lead to symptomatic hypotension in some patients (see section 4.5). The combination of tadalafil and doxazosin is not recommended.

Vision

Visual defects and cases of NAION have been reported in connection with the intake of tadalafil and other PDE5 inhibitors. Analyses of observational data suggest an increased risk of acute NAION in men with erectile dysfunction following exposure to tadalafil or other PDE5 inhibitors. As this may be relevant for all patients exposed to tadalafil, the patient should be advised that in case of sudden visual defect, he should stop taking tadalafil and consult a physician immediately (see section 4.3).

Decreased or sudden hearing loss

Cases of sudden hearing loss have been reported after the use of tadalafil. Although other risk factors were present in some cases (such as age, diabetes, hypertension and previous hearing loss history) patients should be advised to stop taking tadalafil and seek prompt medical attention in the event of sudden decrease or loss of hearing.

Renal and hepatic impairment

Due to increased tadalafil exposure (AUC), limited clinical experience and the lack of ability to influence clearance by dialysis, once-a-day dosing of tadalafil is not recommended in patients with severe renal impairment.

There is limited clinical data on the safety of single-dose administration of tadalafil in patients with severe hepatic insufficiency (Child-Pugh Class C). Once-a-day administration has not been evaluated in patients with hepatic insufficiency. If tadalafil is prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician.

Priapism and anatomical deformation of the penis

Patients who experience erections lasting 4 hours or more should be instructed to seek immediate medical assistance. If priapism is not treated immediately, penile tissue damage and permanent loss of potency may result.

Tadalafil, should be used with caution in patients with anatomical deformation of the penis (such as angulation, cavernosal fibrosis, or Peyronie's disease) or in patients who have conditions which may predispose them to priapism (such as sickle cell anaemia, multiple myeloma or leukaemia).

Use with CYP3A4 inhibitors

Caution should be exercised when prescribing tadalafil to patients using potent CYP3A4 inhibitors (ritonavir, saquinavir, ketoconazole, itraconazole, and erythromycin), as increased tadalafil exposure (AUC) has been observed if the medicinal products are combined (see section 4.5).

Tadalafil tablets and other treatments for erectile dysfunction

The safety and efficacy of combinations of tadalafil and other PDE5 inhibitors or other treatments for erectile dysfunction have not been studied. The patients should be informed not to take tadalafil in such combinations.

Lactose

Tadalafil 2.5 mg film-coated tablet contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

Sodium

This medicine contains sodium

Solifenacin Succinate

Other causes of frequent urination (heart failure or renal disease) should be assessed before treatment with solifenacin. If urinary tract infection is present, an appropriate antibacterial therapy should be started.

Solifenacin should be used with caution in patients with:

- clinically significant bladder outflow obstruction at risk of urinary retention.
- gastrointestinal obstructive disorders.
- risk of decreased gastrointestinal motility.
- severe renal impairment (creatinine clearance \leq 30 ml/min; see sections 4.2 and 5.2), and doses should not exceed 5 mg for these patients.
- moderate hepatic impairment (Child-Pugh score of 7 to 9; see sections 4.2 and 5.2), and doses should not exceed 5 mg for these patients.
- concomitant use of a potent CYP3A4 inhibitor, e.g. ketoconazole (see sections 4.2 and 4.5).
- hiatus hernia/gastro-oesophageal reflux and/or who are concurrently taking

medicinal products (such as bisphosphonates) that can cause or exacerbate oesophagitis.

- autonomic neuropathy.

QT prolongation and Torsade de Pointes have been observed in patients with risk factors, such as pre-existing long QT syndrome and hypokalaemia.

Safety and efficacy have not yet been established in patients with a neurogenic cause for detrusor overactivity.

Angioedema with airway obstruction has been reported in some patients on solifenacin. If angioedema occurs, solifenacin should be discontinued and appropriate therapy and/or measures should be taken.

Anaphylactic reaction has been reported in some patients treated with solifenacin. In patients who develop anaphylactic reactions, solifenacin should be discontinued and appropriate therapy and/or measures should be taken.

The maximum effect of solifenacin can be determined after 4 weeks at the earliest.

Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

This medicine contains sodium

4.5 Interaction with other medicinal products and other forms of interaction

Dutasteride

For information on the decrease of serum PSA levels during treatment with dutasteride and guidance concerning prostate cancer detection, please see section 4.4.

Effects of other drugs on the pharmacokinetics of dutasteride

Use together with CYP3A4 and/or P-glycoprotein-inhibitors

Dutasteride is mainly eliminated via metabolism. In vitro studies indicate that this metabolism is catalysed by CYP3A4 and CYP3A5. No formal interaction studies have been performed with potent CYP3A4 inhibitors. However, in a population pharmacokinetic study, dutasteride serum concentrations were on average 1.6 to 1.8 times greater, respectively, in a small number of patients treated concurrently with verapamil or diltiazem (moderate inhibitors of CYP3A4 and inhibitors of P-glycoprotein) than in other patients.

Long-term combination of dutasteride with drugs that are potent inhibitors of

the enzyme CYP3A4 (e.g. ritonavir, indinavir, nefazodone, itraconazole, ketoconazole administered orally) may increase serum concentrations of dutasteride. Further inhibition of 5-alpha reductase at increased dutasteride exposure, is not likely. However, a reduction of the dutasteride dosing frequency can be considered if side effects are noted. It should be noted that in the case of enzyme inhibition, the long half-life may be further prolonged and it can take more than 6 months of concurrent therapy before a new steady state is reached.

Administration of 12g colestyramine one hour after a 5mg single dose of dutasteride did not affect the pharmacokinetics of dutasteride.

Effects of dutasteride on the pharmacokinetics of other drugs

Dutasteride has no effect on the pharmacokinetics of warfarin or digoxin. This indicates that dutasteride does not inhibit/induce CYP2C9 or the transporter P-glycoprotein. *In vitro* interaction studies indicate that dutasteride does not inhibit the enzymes CYP1A2, CYP2D6, CYP2C9, CYP2C19 or CYP3A4.

In a small study (N=24) of two weeks duration in healthy men, dutasteride (0.5 mg daily) had no effect on the pharmacokinetics of tamsulosin or terazosin. There was also no indication of a pharmacodynamic interaction in this study.

Tadalafil

Interaction studies were conducted with 10 mg and/or 20 mg tadalafil, as indicated below. With regard to those interaction studies where only the 10 mg tadalafil dose was used, clinically relevant interactions at higher doses cannot be completely ruled out.

Effects of other substances on tadalafil

Cytochrome P450 inhibitors

Tadalafil is principally metabolised by CYP3A4. A selective inhibitor of CYP3A4, ketoconazole (200 mg daily), increased tadalafil (10 mg) exposure (AUC) 2-fold and C_{max} by 15%, relative to the AUC and C_{max} values for tadalafil alone. Ketoconazole (400 mg daily) increased tadalafil (20mg) exposure (AUC) 4-fold and C_{max} by 22%. Ritonavir, a protease inhibitor (200 mg twice daily), which is an inhibitor of CYP3A4, CYP2C9, CYP2C19, and CYP2D6, increased tadalafil (20 mg) exposure (AUC) 2-fold with no change in C_{max} . Although specific interactions have not been studied, other protease inhibitors, such as saquinavir, and other CYP3A4 inhibitors, such as erythromycin, clarithromycin, itraconazole, and grapefruit juice, should be co-administered with caution, as they would be expected to increase plasma concentrations of tadalafil (see section 4.4). Consequently, the incidence of the adverse reactions

listed in section 4.8 might be increased.

Transporters

The role of transporters (for example, p-glycoprotein) in the disposition of tadalafil is not known. Therefore, there is the potential of drug interactions mediated by inhibition of transporters.

Cytochrome P450 inducers

A CYP3A4 inducer, rifampicin, reduced tadalafil AUC by 88%, relative to the AUC values for tadalafil alone (10 mg). This reduced exposure can be anticipated to decrease the efficacy of tadalafil; the magnitude of decreased efficacy is unknown. Other inducers of CYP3A4, such as phenobarbital, phenytoin, and carbamazepine, may also decrease plasma concentrations of tadalafil.

Effects of tadalafil on other medicinal products

Nitrates

In clinical studies, tadalafil (5, 10 and 20 mg) was shown to augment the hypotensive effects of nitrates. Therefore, administration of tadalafil to patients who are using any form of organic nitrate is contraindicated (see section 4.3). Based on the results of a clinical study in which 150 subjects receiving daily doses of tadalafil 20 mg for 7 days and 0.4 mg sublingual nitroglycerin at various times, this interaction lasted for more than 24 hours and was no longer detectable when 48 hours had elapsed after the last tadalafil dose. Thus, in a patient prescribed any dose of tadalafil (2.5 mg- 20 mg), where nitrate administration is deemed medically necessary in a life-threatening situation, at least 48 hours should have elapsed after the last dose of tadalafil before nitrate administration is considered. In such circumstances, nitrates should only be administered under close medical supervision with appropriate haemodynamic monitoring.

Anti-hypertensives (including calcium channel blockers)

The co-administration of doxazosin (4 and 8 mg daily) and tadalafil (5 mg daily dose and 20 mg as a single dose) increases the blood pressure-lowering effect of this alpha-blocker in a significant manner. This effect lasts at least twelve hours and may be symptomatic, including syncope. Therefore, this combination is not recommended (see section 4.4).

In interaction studies performed in a limited number of healthy volunteers, these effects were not reported with alfuzosin or tamsulosin. However, caution should be exercised when using tadalafil in patients treated with any alpha-blockers, and notably in the elderly. Treatments should be initiated at minimal dosage and progressively adjusted.

In clinical pharmacology studies, the potential for tadalafil to augment the

hypotensive effects of antihypertensive medicinal products was examined. Major classes of antihypertensive medicinal products were studied, including calcium-channel blockers (amlodipine), angiotensin converting enzyme (ACE) inhibitors (enalapril), beta-adrenergic receptor blockers (metoprolol), thiazide diuretics (bendrofluazide), and angiotensin II receptor blockers (various types and doses, alone or in combination with thiazides, calcium-channel blockers, beta-blockers, and/or alpha-blockers). Tadalafil (10 mg, except for studies with angiotensin II receptor blockers and amlodipine in which a 20 mg dose was applied) had no clinically significant interaction with any of these classes. In another clinical pharmacology study, tadalafil (20 mg) was studied in combination with up to 4 classes of antihypertensives. In subjects taking multiple antihypertensives, the ambulatory-blood-pressure changes appeared to relate to the degree of blood pressure control. In this regard, study subjects whose blood pressure was well controlled, the reduction was minimal and similar to that seen in healthy subjects. In study subjects whose blood pressure was not controlled, the reduction was greater, although this reduction was not associated with hypotensive symptoms in the majority of subjects. In patients receiving concomitant antihypertensive medicinal products, tadalafil 20 mg may induce a blood pressure decrease, which (with the exception of alpha-blockers - see above) is, in general, minor and not likely to be clinically relevant. Analysis of Phase 3 clinical trial data showed no difference in adverse events in patients taking tadalafil with or without antihypertensive medicinal products. However, appropriate clinical advice should be given to patients regarding a possible decrease in blood pressure when they are treated with antihypertensive medicinal products.

Riociguat

Preclinical studies showed an additive systemic blood pressure lowering effect when PDE5 inhibitors were combined with riociguat. In clinical studies, riociguat has been shown to augment the hypotensive effects of PDE5 inhibitors. There was no evidence of favourable clinical effect of the combination in the population studied. Concomitant use of riociguat with PDE5 inhibitors, including tadalafil, is contraindicated (see section 4.3).

5- alpha reductase inhibitors

In a clinical trial that compared tadalafil 5 mg coadministered with finasteride 5 mg to placebo plus finasteride 5 mg in the relief of BPH symptoms, no new adverse reactions were identified. However, as a formal drug-drug interaction study evaluating the effects of tadalafil and 5-alpha reductase inhibitors (5-ARIs) has not been performed, caution should be exercised when tadalafil is co-administered with 5-ARIs.

CYP1A2 substrates (e.g. theophylline)

When tadalafil 10 mg was administered with theophylline (a non-selective phosphodiesterase inhibitor) in a clinical pharmacology study, there was no

pharmacokinetic interaction. The only pharmacodynamic effect was a small (3.5 bpm) increase in heart rate. Although this effect is minor and was of no clinical significance in this study, it should be considered when co-administering these medicinal products.

Ethinylestradiol and terbutaline

Tadalafil has been demonstrated to produce an increase in the oral bioavailability of ethinylestradiol; a similar increase may be expected with oral administration of terbutaline, although the clinical consequence of this is uncertain.

Alcohol

Alcohol concentrations (mean maximum blood concentration 0.08%) were not affected by co-administration with tadalafil (10 mg or 20 mg). In addition, no changes in tadalafil concentrations were seen 3 hours after co-administration with alcohol. Alcohol was administered in a manner to maximise the rate of alcohol absorption (overnight fast with no food until 2 hours after alcohol). Tadalafil (20 mg) did not augment the mean blood pressure decrease produced by alcohol (0.7 g/kg or approximately 180 ml of 40% alcohol [vodka] in an 80 kg male) but, in some subjects, postural dizziness and orthostatic hypotension were observed. When tadalafil was administered with lower doses of alcohol (0.6 g/kg), hypotension was not observed and dizziness occurred with similar frequency to alcohol alone. The effect of alcohol on cognitive function was not augmented by tadalafil (10 mg).

Cytochrome P450 metabolised medicinal products

Tadalafil is not expected to cause clinically significant inhibition or induction of the clearance of medicinal products metabolised by CYP450 isoforms. Studies have confirmed that tadalafil does not inhibit or induce CYP450 isoforms, including CYP3A4, CYP1A2, CYP2D6, CYP2E1, CYP2C9 and CYP2C19.

CYP2C9 substrates (e.g. R-warfarin)

Tadalafil (10 mg and 20 mg) had no clinically significant effect on exposure (AUC) to S-warfarin or R-warfarin (CYP2C9 substrate), nor did tadalafil affect changes in prothrombin time induced by warfarin.

Aspirin

Tadalafil (10 mg and 20 mg) did not potentiate the increase in bleeding time caused by acetylsalicylic acid.

Antidiabetic medicinal products

Specific interaction studies with antidiabetic medicinal products were not conducted.

Solifenacin Succinate

Pharmacological interactions

Concomitant medication with other medicinal products with anticholinergic properties may result in more pronounced therapeutic effects and undesirable effects. An interval of approximately one week should be allowed after stopping treatment with solifenacin, before commencing other anticholinergic therapy. The therapeutic effect of solifenacin may be reduced by concomitant administration of cholinergic receptor agonists.

Solifenacin can reduce the effect of medicinal products that stimulate the motility of the gastro-intestinal tract, such as metoclopramide and cisapride.

Pharmacokinetic interactions

In vitro studies have demonstrated that at therapeutic concentrations, solifenacin does not inhibit CYP1A1/2, 2C9, 2C19, 2D6, or 3A4 derived from human liver microsomes. Therefore, solifenacin is unlikely to alter the clearance of drugs metabolised by these CYP enzymes.

Effect of other medicinal products on the pharmacokinetics of solifenacin

Solifenacin is metabolised by CYP3A4. Simultaneous administration of ketoconazole (200 mg/day), a potent CYP3A4 inhibitor, resulted in a two-fold increase of the AUC of solifenacin, while ketoconazole at a dose of 400 mg/day resulted in a three-fold increase of the AUC of solifenacin. Therefore, the maximum dose of solifenacin succinate should be restricted to 5 mg, when used simultaneously with ketoconazole or therapeutic doses of other potent CYP3A4 inhibitors (e.g. ritonavir, nelfinavir, itraconazole) (see section 4.2).

Simultaneous treatment of solifenacin and a potent CYP3A4 inhibitor is contraindicated in patients with severe renal impairment or moderate hepatic impairment.

The effects of enzyme induction on the pharmacokinetics of solifenacin and its metabolites have not been studied as well as the effect of higher affinity CYP3A4 substrates on solifenacin exposure. Since solifenacin is metabolised by CYP3A4, pharmacokinetic interactions are possible with other CYP3A4 substrates with higher affinity (e.g. verapamil, diltiazem) and CYP3A4 inducers (e.g. rifampicin, phenytoin, carbamazepine).

Effect of solifenacin on the pharmacokinetics of other medicinal products

Oral Contraceptives

Intake of solifenacin showed no pharmacokinetic interaction of solifenacin on combined oral contraceptives (ethinylestradiol/levonorgestrel).

Warfarin

Intake of solifenacin did not alter the pharmacokinetics of R-warfarin or S-warfarin or their effect on prothrombin time.

Digoxin

Intake of solifenacin showed no effect on the pharmacokinetics of digoxin.

4.6 Fertility, pregnancy and lactation

Dutasteride is contraindicated for use by women.

Tadalafil is not indicated for use by women.

Pregnancy

As with other 5 alpha reductase inhibitors, dutasteride inhibits the conversion of testosterone to dihydrotestosterone and may, if administered to a woman carrying a male foetus, inhibit the development of the external genitalia of the foetus (see section 4.4). Small amounts of dutasteride have been recovered from the semen in subjects receiving Dutasteride 0.5 mg day. It is not known whether a male foetus may be adversely affected if his mother is exposed to the semen of a patient being treated with dutasteride (the risk of which is greatest during the first 16 weeks of pregnancy).

As with all 5 alpha reductase inhibitors, when the patient's partner is or may potentially be pregnant it is recommended that the patient avoids exposure of his partner to semen by use of a condom.

There are limited data from the use of tadalafil in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/foetal development, parturition or postnatal development (see section 5.3). As a precautionary measure, it is preferable to avoid the use of tadalafil during pregnancy.

For information on preclinical data, see section 5.3.

Breast-feeding

It is not known whether dutasteride is excreted in human milk.

Available pharmacodynamic/toxicological data in animals have shown excretion of tadalafil in milk. A risk to the suckling child cannot be excluded. tadalafil should not be used during breast feeding.

No data on the excretion of solifenacin in human milk are available. In mice, solifenacin and/or its metabolites was excreted in milk, and caused a dose dependent failure to thrive in neonatal mice (see Section 5.3). The use of solifenacin should therefore be avoided during breast-feeding.

Fertility

Dutasteride has been reported to affect semen characteristics (reduction in sperm count, semen volume, and sperm motility) in healthy men (see section 5.1). The possibility of reduced male fertility cannot be excluded.

Effects were seen in dogs that might indicate impairment of fertility. Two subsequent clinical studies suggest that this effect is unlikely in humans, although a decrease in sperm concentration was seen in some men (see sections 5.1 and 5.3).

4.7 Effects on ability to drive and use machines

Based on the pharmacodynamic properties of dutasteride, treatment with dutasteride would not be expected to interfere with the ability to drive or operate machinery.

tadalafil has negligible influence on the ability to drive or use machines. Although the frequency of reports of dizziness in placebo and tadalafil arms in clinical trials was similar, patients should be aware of how they react to tadalafil before driving or using machines.

Since solifenacin, like other anticholinergics may cause blurred vision, and, uncommonly, somnolence and fatigue (see section 4.8. undesirable effects), the ability to drive and use machines may be negatively affected.

4.8 Undesirable effects

Dutasteride

The adverse reactions frequency is defined using the following conventions: very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$), not known (cannot be estimated from the available data).

Monotherapy

Approximately 19% of the 2167 patients who received dutasteride in the 2 year Phase III placebo-controlled trials developed adverse reactions during the first year of treatment. The majority of events were mild to moderate and occurred in the reproductive system. No change to the adverse event profile was apparent over a further 2 years in open-label extension studies.

The following table shows adverse reactions from controlled clinical trials and

post-marketing experience. The listed adverse events from clinical trials are investigator-judged drug-related events (with incidence more than or equal to 1%) reported with a higher incidence in patients treated with dutasteride compared with placebo during the first year of treatment. Adverse events from post-marketing experience were identified from spontaneous post-marketing reports; therefore the true incidence is not known:

Organ system	Adverse reaction	Incidence from clinical trial data	
		Incidence during year 1 of treatment (n=2167)	Incidence during year 2 of treatment (n=1744)
Reproductive system and breast disorders	Impotence*	6.0%	1.7%
	Altered (decreased) libido*	3.7%	0.6%
	Ejaculation disorders ^	1.8%	0.5%
	Breast disorders ⁺	1.3%	1.3%
		Incidence estimated from post-marketing data	
Immune system disorders	Allergic reactions including rash, pruritus, urticaria, localised oedema, and angioedema	Not known	
Psychiatric disorders	Depressed mood	Not known	
Skin and subcutaneous tissue disorders	Alopecia (primarily body hair loss), hypertrichosis	Uncommon	
Reproductive system and breast disorders	Testicular pain and swelling	Not known	

* These sexual adverse events are associated with dutasteride treatment (including monotherapy and combination with tamsulosin). These adverse events may persist after treatment discontinuation. The role of dutasteride in this persistence is unknown.

⁺ includes breast tenderness and breast enlargement

^ includes semen volume decreased

Dutasteride in combination with the alpha-blocker tamsulosin

Data from the 4 year CombAT Study, comparing dutasteride 0.5mg (n=1623) and tamsulosin 0.4mg (n=1611) once daily alone and in combination (n=1610) have shown that the incidence of any investigator-judged drug-related adverse event during the first, second, third and fourth years of treatment respectively was 22%, 6%, 4% and 2% for dutasteride/tamsulosin combination therapy, 15%, 6%, 3% and 2% for dutasteride monotherapy and 13%, 5%, 2% and 2% for tamsulosin monotherapy. The higher incidence of adverse events in the combination therapy group in the first year of treatment was due to a higher incidence of reproductive disorders, specifically ejaculation disorders, observed in this group.

The following investigator-judged drug-related adverse events have been reported with an incidence of greater than or equal to 1% during the first year of treatment in the CombAT Study; the incidence of these events during the four years of treatment is shown in the table below:

System Class	Organ	Adverse Reaction	Incidence during treatment period			
			Year 1	Year 2	Year 3	Year 4
		Combination ^a (n)	(n=1610)	(n=1428)	(n=1283)	(n=1200)
		Dutasteride	(n=1623)	(n=1464)	(n=1325)	(n=1200)
		Tamsulosin	(n=1611)	(n=1468)	(n=1281)	(n=1112)
Nervous system disorders		Dizziness				
		Combination ^a	1.4%	0.1%	<0.1%	0.2%
		Dutasteride	0.7%	0.1%	<0.1%	<0.1%
		Tamsulosin	1.3%	0.4%	<0.1%	0%
Cardiac disorders		Cardiac failure (composite term ^b)				
		Combination ^a	0.2%	0.4%	0.2%	0.2%
		Dutasteride	<0.1%	0.1%	<0.1%	0%
		Tamsulosin	0.1%	<0.1%	0.4%	0.2%
Reproductive system and breast disorders, Psychiatric disorders, Investigations		Impotence ^c				
		Combination ^a	6.3%	1.8%	0.9%	0.4%

Dutasteride	5.1%	1.6%	0.6%	0.3%
Tamsulosin	3.3%	1.0%	0.6%	1.1%
Altered (decreased) libido ^c				
Combination ^a	5.3%	0.8%	0.2%	0%
Dutasteride	3.8%	1.0%	0.2%	0%
Tamsulosin	2.5%	0.7%	0.2%	<0.1%
Ejaculation disorders ^c				
Combination ^a	9.0%	1.0%	0.5%	<0.1%
Dutasteride	1.5%	0.5%	0.2%	0.3%
Tamsulosin	2.7%	0.5%	0.2%	0.3%
Breast disorders ^d				
Combination ^a	2.1%	0.8%	0.9%	0.6%
Dutasteride	1.7%	1.2%	0.5%	0.7%
Tamsulosin	0.8%	0.4%	0.2%	0%

- a. Combination = dutasteride 0.5 mg once daily plus tamsulosin 0.4 mg once daily.
- b. Cardiac failure composite term comprised of Cardiac failure congestive, cardiac failure, left ventricular failure, cardiac failure acute, cardiogenic shock, left ventricular failure acute, right ventricular failure, right ventricular failure acute, ventricular failure, cardiopulmonary failure, congestive cardiomyopathy.
- c. These sexual adverse events are associated with dutasteride treatment (including monotherapy and combination with tamsulosin). These adverse events may persist after treatment discontinuation. The role of dutasteride in this persistence is unknown.
- d. Includes breast tenderness and breast enlargement.

Other data

The REDUCE study revealed a higher incidence of Gleason 8-10 prostate cancers in dutasteride treated men compared to placebo (see section 4.4 and 5.1). Whether the effect of dutasteride to reduce prostate volume, or study related factors, impacted the results of this study has not been established.

The following has been reported in clinical trials and post-marketing use: male breast cancer (see section 4.4).

Tadalafil

The most commonly reported adverse reactions in patients taking tadalafil for the treatment of erectile dysfunction or benign prostatic hyperplasia were headache, dyspepsia, back pain and myalgia, in which the incidences increase with increasing dose of tadalafil. The adverse reactions reported were transient, and generally mild or moderate. The majority of headaches reported with tadalafil once-a-day dosing are experienced within the first 10 to 30 days of starting treatment.

Reporting of suspected adverse reactions

Healthcare professionals are asked to report any suspected adverse reactions via pharmacy and poisons board, Pharmacovigilance Electronic Reporting System (PvERS) <https://pv.pharmacyboardkenya.org>

4.9 Overdose

Dutasteride

In volunteer studies, single daily doses of dutasteride up to 40 mg/day (80 times the therapeutic dose) have been administered for 7 days without significant safety concerns. In clinical studies, doses of 5mg daily have been administered to subjects for 6 months with no additional adverse effects to those seen at therapeutic doses of 0.5 mg. There is no specific antidote for dutasteride, therefore, in suspected overdosage symptomatic and supportive treatment should be given as appropriate.

Tadalafil

Single doses of up to 500 mg have been given to healthy subjects, and multiple daily doses up to 100 mg have been given to patients. Adverse events were similar to those seen at lower doses.

In cases of overdose, standard supportive measures should be adopted, as required. Haemodialysis contributes negligibly to tadalafil elimination.

Solifenacin Succinate

Symptoms

Overdosage with solifenacin succinate can potentially result in severe anticholinergic effects. The highest dose of solifenacin succinate accidentally given to a single patient was 280 mg in a 5 hour period, resulting in mental status changes not requiring hospitalisation.

Treatment

In the event of overdose with solifenacin succinate the patient should be treated with activated charcoal. Gastric lavage is useful if performed within 1 hour, but vomiting should not be induced.

As for other anticholinergics, symptoms can be treated as follows:

- Severe central anticholinergic effects such as hallucinations or pronounced excitation: treat with physostigmine or carbachol.
- Convulsions or pronounced excitation: treat with benzodiazepines.
- Respiratory insufficiency: treat with artificial respiration.
- Tachycardia: treat with beta-blockers.
- Urinary retention: treat with catheterisation.
- Mydriasis: treat with pilocarpine eye drops and/or place patient in dark room.

As with other antimuscarinics, in case of overdosing, specific attention should be paid to patients with known risk for QT-prolongation (i.e. hypokalaemia, bradycardia and concurrent administration of medicinal products known to prolong QT-interval) and relevant pre-existing cardiac diseases (i.e. myocardial ischaemia, arrhythmia, congestive heart failure).

5. Pharmacological properties

5.1 Pharmacodynamic properties of Dutasteride

Pharmacotherapeutic group: testosterone-5-alpha reductase inhibitors.

In treatment of benign prostatic hyperplasia

ATC code: G04C B02.

Dutasteride reduces circulating levels of dihydrotestosterone (DHT) by inhibiting both type 1 and type 2, 5 α -reductase isoenzymes which are responsible for the conversion of testosterone to DHT.

Monotherapy

Effects on DHT/Testosterone

Effect of daily doses of dutasteride on the reduction on DHT is dose

dependent and is observed within 1-2 weeks (85% and 90% reduction, respectively).

In patients with BPH treated with dutasteride 0.5 mg/day, the median decrease in serum DHT was 94% at 1 year and 93% at 2 years and the median increase in serum testosterone was 19% at both 1 and 2 years.

Effect on prostate volume

Significant reductions in prostate volume have been detected as early as one month after initiation of treatment and reductions continued through Month 24 ($p < 0.001$). Dutasteride led to a mean reduction of total prostate volume of 23.6% (from 54.9 ml at baseline to 42.1 ml) at Month 12 compared with a mean reduction of 0.5% (from 54.0 ml to 53.7 ml) in the placebo group.

Significant ($p < 0.001$) reductions also occurred in prostate transitional zone volume as early as one month continuing through Month 24, with a mean reduction in prostate transitional zone volume of 17.8% (from 26.8 ml at baseline to 21.4 ml) in the dutasteride group compared to a mean increase of 7.9% (from 26.8 ml to 27.5 ml) in the placebo group at Month 12. The reduction of the prostate volume seen during the first 2 years of double-blind treatment was maintained during an additional 2 years of open-label extension studies. Reduction of the size of the prostate leads to improvement of symptoms and a decreased risk for AUR and BPH-related surgery.

Clinical studies

Dutasteride 0.5 mg/day or placebo was evaluated in 4325 male subjects with moderate to severe symptoms of BPH who had prostates ≥ 30 ml and a PSA value within the range 1.5 - 10 ng/mL in three primary efficacy 2-year multicenter, multinational, placebo-controlled, double-blind studies. The studies then continued with an open-label extension to 4 years with all patients remaining in the study receiving dutasteride at the same 0.5mg dose. 37% of initially placebo- randomized patients and 40% of dutasteride-randomized patients remained in the study at 4 years. The majority (71%) of the 2,340 subjects in the open-label extensions completed the 2 additional years of open-label treatment.

The most important clinical efficacy parameters were American Urological Association Symptom Index (AUA-SI), maximum urinary flow (Q_{max}) and the incidence of acute urinary retention and BPH-related surgery.

AUA-SI is a seven-item questionnaire about BPH-related symptoms with a maximum score of 35. At baseline the average score was approx. 17. After six months, one and two years treatment the placebo group had an average improvement of 2.5, 2.5 and 2.3 points respectively while the dutasteride group improved 3.2, 3.8 and 4.5 points respectively. The differences between the groups were statistically significant. The improvement in AUA-SI seen during the first 2 years of double-blind treatment was maintained during an additional 2 years of open-label extension studies.

Qmax (maximum urine flow)

Mean baseline Qmax for the studies was approx 10 ml/sec (normal Qmax \geq 15 ml/sec). After one and two years treatment the flow in the placebo group had improved by 0.8 and 0.9 ml/sec respectively and 1.7 and 2.0 ml/sec respectively in the dutasteride group. The difference between the groups was statistically significant from Month 1 to Month 24. The increase in maximum urinary flow rate seen during the first 2 years of double blind treatment maintained during an additional 2 years of open-label extension studies.

Acute urinary retention and surgical intervention

After two years of treatment, the incidence of AUR was 4.2% in the placebo group against 1.8% in the dutasteride group (57% risk reduction). This difference is statistically significant and means that 42 patients (95% CI 30-73) need to be treated for two years to avoid one case of AUR.

The incidence of BPH-related surgery after two years was 4.1% in the placebo group and 2.2% in the dutasteride group (48% risk reduction). This difference is statistically significant and means that 51 patients (95% CI 33-109) need to be treated for two years to avoid one surgical intervention.

Hair distribution

The effect of dutasteride on hair distribution was not formally studied during the phase III programme, however, 5 α -reductase inhibitors could reduce hair loss and may induce hair growth in subjects with male pattern hair loss (male androgenetic alopecia).

Thyroid function

Thyroid function was evaluated in a one year study in healthy men. Free thyroxine levels were stable on dutasteride treatment but TSH levels were mildly increased (by 0.4 MCIU/mL) compared to placebo at the end of one year's treatment. However, as TSH levels were variable, median TSH ranges (1.4 - 1.9 MCIU/mL) remained within normal limits (0.5 - 5/6 MCIU/mL), free thyroxine levels were stable within the normal range and similar for both placebo and dutasteride treatment, the changes in TSH were not considered clinically significant. In all the clinical studies, there has been no evidence that dutasteride adversely affects thyroid function.

Breast neoplasia

In the 2 year clinical trials, providing 3374 patient years of exposure to dutasteride, and at the time of registration in the 2 year open label extension, there were 2 cases of breast cancer reported in dutasteride-treated patients and 1 case in a patient who received placebo. In the 4 year CombAT and REDUCE clinical trials providing 17489 patient years exposure to dutasteride and 5027 patient years exposure to dutasteride and tamsulosin combination there were no additional cases in any of the treatment groups.

Two case control, epidemiological studies, one conducted in a US (n=339 breast cancer cases and n=6,780 controls) and the other in a UK (n=398 breast cancer cases and n=3,930 controls) healthcare database, showed no increase in the risk of developing male breast cancer with the use of 5-alpha reductase inhibitors (see section 4.4). Results from the first study did not identify a positive association for male breast cancer (relative risk for ≥ 1 -year of use before breast cancer diagnosis compared with < 1 -year of use: 0.70: 95% CI 0.34, 1.45). In the second study, the estimated odds ratio for breast cancer associated with the use of 5-alpha reductase inhibitors compared with non-use was 1.08: 95% CI 0.62, 1.87).

Currently it is not clear if there is a causal relationship between the occurrence of male breast cancer and long term use of dutasteride.

Effects on male fertility

The effects of dutasteride 0.5mg/day on semen characteristics were evaluated in healthy volunteers aged 18 to 52 (n=27 dutasteride, n=23 placebo) throughout 52 weeks of treatment and 24 weeks of post-treatment follow-up. At 52 weeks, the mean percent reduction from baseline in total sperm count, semen volume and sperm motility were 23%, 26% and 18%, respectively, in the dutasteride group when adjusted for changes from baseline in the placebo group. Sperm concentration and sperm morphology were unaffected. After 24 weeks of follow-up, the mean percent change in total sperm count in the dutasteride group remained 23% lower than baseline. While mean values for all parameters at all time points remained within the normal ranges and did not meet the predefined criteria for a clinically significant change (30%), two subjects in the dutasteride group had decreases in sperm count of greater than 90% from baseline at 52 weeks, with partial recovery at the 24 week follow-up. The possibility of reduced male fertility cannot be excluded.

Dutasteride in combination with the alpha-blocker tamsulosin

Dutasteride 0.5 mg/day (n = 1,623), tamsulosin 0.4 mg/day (n = 1,611) or the combination of dutasteride 0.5 mg plus tamsulosin 0.4 mg (n = 1,610) were evaluated in male subjects with moderate to severe symptoms of BPH who had prostates ≥ 30 ml and a PSA value within the range 1.5 - 10 ng/mL in a multicentre, multinational, randomized double-blind, parallel group study (the CombAT study). Approximately 53% of subjects had previous exposure to 5-alpha reductase inhibitor or alpha-blocker treatment. The primary efficacy endpoint during the first 2 years of treatment was change in International Prostate Symptom Score (IPSS), an 8-item instrument based on AUA-SI with an additional question on quality of life. Secondary efficacy endpoints at 2 years included maximum urine flow rate (Qmax) and prostate volume.

The combination achieved significance for IPSS from Month 3 compared to dutasteride and from Month 9 compared to tamsulosin.

For Qmax combination achieved significance from Month 6 compared to both dutasteride and tamsulosin.

The primary efficacy endpoint at 4 years of treatment was time to first event of AUR or BPH- related surgery. After 4 years of treatment, combination therapy statistically significantly reduced the risk of AUR or BPH-related surgery (65.8% reduction in risk $p<0.001$ [95% CI 54.7% to 74.1%]) compared to tamsulosin monotherapy. The incidence of AUR or BPH-related surgery by Year 4 was 4.2% for combination therapy and 11.9% for tamsulosin ($p<0.001$). Compared to dutasteride monotherapy, combination therapy reduced the risk of AUR or BPH-related surgery by 19.6% ($p=0.18$ [95% CI -10.9% to 41.7%]). The incidence of AUR or BPH- related surgery by Year 4 was 4.2% for combination therapy and 5.2% for dutasteride.

Secondary efficacy endpoints after 4 years of treatment included time to clinical progression (defined as a composite of: IPSS deterioration by ≥ 4 points, BPH-related events of AUR, incontinence, urinary tract infection (UTI), and renal insufficiency) change in International Prostate Symptom Score (IPSS), maximum urine flow rate (Qmax) and prostate volume. Results following 4 years of treatment are presented below:

Parameter	Time-point	Combination	Dutasteride	Tamsulosin
AUR or BPH related surgery(%)	Incidence at Month 48	4.2	5.2	11.9 ^a
Clinical progression* (%)	Month 48	12.6	17.8 ^b	21.5 ^a
IPSS (units)	[Baseline] Month 48 (Change from Baseline)	[16.6] -6.3	[16.4] -5.3 ^b	[16.4] -3.8 ^a
Qmax (mL/sec)	[Baseline] Month 48 (Change from Baseline)	[10.9] 2.4	[10.6] 2.0	[10.7] 0.7 ^a
Prostate Volume (ml)	[Baseline] Month 48 (% Change from Baseline)	[54.7] -27.3	[54.6] -28.0	[55.8] +4.6 ^a
Prostate Transition Zone Volume (ml)#	[Baseline] Month 48 (% Change from Baseline)	[27.7] -17.9	[30.3] -26.5	[30.5] 18.2 ^a
BPH Impact Index (BII)(units)	[Baseline] Month 48 (Change from Baseline)	[5.3] -2.2	[5.3] -1.8 ^b	[5.3] -1.2 ^a

IPSS Question 8 (BPH related Health Status) (units)	[Baseline] Month 48 (Change from Baseline)	[3.6] -1.5	[3.6] -1.3 ^b	[3.6] -1.1 ^a
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Baseline values are mean values and changes from baseline are adjusted mean changes.

* Clinical progression was defined as a composite of: IPSS deterioration by ≥ 4 points, BPH-related events of AUR, incontinence, UTI, and renal insufficiency.

Measured at selected sites (13% of randomized patients)

- a. Combination achieved significance ($p < 0.001$) vs. tamsulosin at Month 48
- b. Combination achieved significance ($p < 0.001$) vs. dutasteride at Month 48

Cardiac failure

In a 4 year BPH study of dutasteride in combination with tamsulosin in 4844 men (the CombAT study) the incidence of the composite term cardiac failure in the combination group (14/1610, 0.9%) was higher than in either monotherapy group: dutasteride, (4/1623, 0.2%) and tamsulosin, (10/1611, 0.6%).

In a separate 4-year study in 8231 men aged 50 to 75, with a prior negative biopsy for prostate cancer and baseline PSA between 2.5 ng/mL and 10.0 ng/mL in the case of men 50 to 60 years of age, or 3 ng/mL and 10.0 ng/mL in the case of men older than 60 years of age) (the REDUCE study), there was a higher incidence of the composite term cardiac failure in subjects taking dutasteride 0.5 mg once daily (30/4105, 0.7%) compared to subjects taking placebo (16/4126, 0.4%). A post-hoc analysis of this study showed a higher incidence of the composite term cardiac failure in subjects taking dutasteride and an alpha blocker concomitantly (12/1152, 1.0%), compared to subjects taking dutasteride and no alpha blocker (18/2953, 0.6%), placebo and an alpha blocker (1/1399, $< 0.1\%$), or placebo and no alpha blocker (15/2727, 0.6%) (see section 4.4).

In a meta-analysis of 12-randomised, placebo- or comparator-controlled clinical studies (n=18,802) that evaluated the risks of developing cardiovascular adverse events from the use of Dutasteride (by comparison with controls), no consistent statistically significant increase in the risk of heart failure (RR 1.05; 95% CI 0.71, 1.57), acute myocardial infarction (RR 1.00; 95% CI 0.77, 1.30) or stroke (RR 1.20; 95% CI 0.88, 1.64) were found.

Prostate cancer and high grade tumours

In a 4-year comparison of placebo and dutasteride in 8231 men aged 50 to 75, with a prior negative biopsy for prostate cancer and baseline PSA between

2.5 ng/mL and 10.0 ng/mL in the case of men 50 to 60 years of age, or 3 ng/mL and 10.0 ng/mL in the case of men older than 60 years of age) (the REDUCE study) 6,706 subjects had prostate needle biopsy (primarily protocol mandated) data available for analysis to determine Gleason Scores. There were 1517 subjects diagnosed with prostate cancer in the study. The majority of biopsy-detectable prostate cancers in both treatment groups were diagnosed as low grade (Gleason 5-6, 70%).

There was a higher incidence of Gleason 8-10 prostate cancers in the dutasteride group (n=29, 0.9%) compared to the placebo group (n=19, 0.6%) (p=0.15). In Years 1-2, the number of subjects with Gleason 8-10 cancers was similar in the dutasteride group (n=17, 0.5%) and the placebo group (n=18, 0.5%). In Years 3-4, more Gleason 8-10 cancers were diagnosed in the dutasteride group (n=12, 0.5%) compared with the placebo group (n=1, <0.1%) (p=0.0035). There are no data available on the effect of dutasteride beyond 4 years in men at risk of prostate cancer. The percentage of subjects diagnosed with Gleason 8-10 cancers was consistent across study time periods (Years 1-2 and Years 3-4) in the dutasteride group (0.5% in each time period), while in the placebo group, the percentage of subjects diagnosed with Gleason 8-10 cancers was lower during Years 3-4 than in Years 1-2 (<0.1% versus 0.5%, respectively) (see section 4.4). There was no difference in the incidence of Gleason 7-10 cancers (p=0.81).

The additional 2-year follow-up study of the REDUCE trial did not identify any new cases of Gleason 8-10 prostate cancers.

In a 4 year BPH study (CombAT) where there were no protocol-mandated biopsies and all diagnoses of prostate cancer were based on for-cause biopsies, the rates of Gleason 8-10 cancer were (n=8, 0.5%) for dutasteride, (n=11, 0.7%) for tamsulosin and (n=5, 0.3%) for combination therapy.

Four different epidemiological, population-based studies (two of which were based on a total population of 174,895, one on a population of 13,892, and one on a population of 38,058) showed that the use of 5-alpha reductase inhibitors is not associated with the occurrence of high grade prostate cancer, nor with prostate cancer, or overall mortality.

The relationship between dutasteride and high grade prostate cancer is not clear.

Effects on sexual function:

The effects of dutasteride-tamsulosin fixed dose combination on sexual function were assessed in a double-blind, placebo-controlled study in sexually

active men with BPH (n=243 dutasteride-tamsulosin combination, n=246 placebo). A statistically significant ($p<0.001$) greater reduction (worsening) in the Men's Sexual Health Questionnaire (MSHQ) score was observed at 12 months in the combination group. The reduction was mainly related to a worsening of the ejaculation and overall satisfaction domains rather than the erection domains. These effects did not affect study participants' perception of the combination, which was rated with a statistically significant greater satisfaction throughout the duration of the study compared with placebo ($p<0.05$). In this study the sexual adverse events occurred during the 12 months of treatment and approximately half of these resolved within 6 months post-treatment.

Dutasteride-tamsulosin combination and dutasteride monotherapy are known to cause sexual function adverse effects (see section 4.8).

As observed in other clinical studies, including CombAT and REDUCE, the incidence of adverse events related to sexual function decreases over time with continued therapy.

Pharmacodynamic properties of Tadalafil

Pharmacotherapeutic group: Urologicals, Drugs used in erectile dysfunction

ATC code: G04BE08.

Mechanism of action

Tadalafil is a selective, reversible inhibitor of cyclic guanosine monophosphate (cGMP)-specific phosphodiesterase type 5 (PDE5). When sexual stimulation causes the local release of nitric oxide, inhibition of PDE5 by tadalafil produces increased levels of cGMP in the corpus cavernosum. This results in smooth muscle relaxation and inflow of blood into the penile tissues, thereby producing an erection. Tadalafil has no effect in the treatment of erectile dysfunction in the absence of sexual stimulation.

Tadalafil 5 mg - The effect of PDE5 inhibition on cGMP concentration in the corpus cavernosum is also observed in the smooth muscle of the prostate, the bladder and their vascular supply. The resulting vascular relaxation increases blood perfusion which may be the mechanism by which symptoms of benign prostatic hyperplasia are reduced. These vascular effects may be complemented by inhibition of bladder afferent nerve activity and smooth muscle relaxation of the prostate and bladder.

Pharmacodynamic effects

Studies *in vitro* have shown that tadalafil is a selective inhibitor of PDE5. PDE5

is an enzyme found in corpus cavernosum smooth muscle, vascular and visceral smooth muscle, skeletal muscle, platelets, kidney, lung, and cerebellum. The effect of tadalafil is more potent on PDE5 than on other phosphodiesterases. Tadalafil is >10,000-fold more potent for PDE5 than for PDE1, PDE2, and PDE4 enzymes which are found in the heart, brain, blood vessels, liver, and other organs. Tadalafil is >10,000-fold more potent for PDE5 than for PDE3, an enzyme found in the heart and blood vessels. This selectivity for PDE5 over PDE3 is important because PDE3 is an enzyme involved in cardiac contractility. Additionally, tadalafil is approximately 700-fold more potent for PDE5 than for PDE6, an enzyme which is found in the retina and is responsible for phototransduction. Tadalafil is also >10,000-fold more potent for PDE5 than for PDE7 through PDE10.

Clinical efficacy and safety

Tadalafil administered to healthy subjects produced no significant difference compared to placebo in supine systolic and diastolic blood pressure (mean maximal decrease of 1.6/0.8 mmHg, respectively), in standing systolic and diastolic blood pressure (mean maximal decrease of 0.2/4.6 mmHg, respectively), and no significant change in heart rate.

In a study to assess the effects of tadalafil on vision, no impairment of colour discrimination (blue/green) was detected using the Farnsworth-Munsell 100-hue test. This finding is consistent with the low affinity of tadalafil for PDE6 compared to PDE5. Across all clinical studies, reports of changes in colour vision were rare (<0.1%).

Three studies were conducted in men to assess the potential effect on spermatogenesis of tadalafil 10 mg (one 6-month study) and 20 mg (one 6-month and one 9-month study) administered daily. In two of these studies decreases were observed in sperm count and concentration related to tadalafil treatment of unlikely clinical relevance. These effects were not associated with changes in other parameters, such as motility, morphology, and FSH.

Erectile dysfunction

Three clinical studies were conducted in 1054 patients in an at-home setting to define the period of responsiveness to tadalafil on demand. Tadalafil demonstrated statistically significant improvement in erectile function and the ability to have successful sexual intercourse up to 36 hours following dosing, as well as patients' ability to attain and maintain erections for successful intercourse compared to placebo as early as 16 minutes following dosing.

In a 12-week study performed in 186 patients (142 tadalafil, 44 placebo) with erectile dysfunction secondary to spinal cord injury, tadalafil significantly improved the erectile function leading to a mean per-subject proportion of successful attempts in patients treated with tadalafil 10 or 20 mg (flexible-dose, on demand) of 48% as compared to 17% with placebo.

Tadalafil at doses of 2 to 100mg has been evaluated in 16 clinical studies involving 3250 patients, including patients with erectile dysfunction of various severities (mild, moderate, severe), etiologies, ages (range 21-86 years), and ethnicities. Most patients reported erectile dysfunction of at least 1 year in duration. In the primary efficacy studies of general populations, 81% of patients reported that TADALAFIL improved their erections as compared to 35% with placebo. Also, patients with erectile dysfunction in all severity categories reported improved erections whilst taking TADALAFIL (86%, 83%, and 72% for mild, moderate, and severe, respectively, as compared to 45%, 42%, and 19% with placebo). In the primary efficacy studies, 75% of intercourse attempts were successful in TADALAFIL-treated patients as compared to 32% with placebo.

For once-a-day evaluation of tadalafil at doses of 2.5, 5, and 10 mg 3 clinical studies were initially conducted involving 853 patients of various ages (range 21-82 years) and ethnicities, with erectile dysfunction of various severities (mild, moderate, severe) and etiologies. In the two primary efficacy studies of general populations, the mean per-subject proportion of successful intercourse attempts were 57 and 67% on tadalafil 5mg, 50% on tadalafil 2.5mg as compared to 31 and 37% with placebo. In the study in patients with erectile dysfunction secondary to diabetes, the mean per-subject proportion of successful attempts were 41 and 46% on tadalafil 5mg and 2.5mg, respectively, as compared to 28% with placebo. Most patients in these three studies were responders to previous on-demand treatment with PDE5 inhibitors. In a subsequent study, 217 patients who were treatment-naïve to PDE5 inhibitors were randomised to tadalafil 5mg once a day vs. placebo. The mean per-subject proportion of successful sexual intercourse attempts was 68% for tadalafil patients compared to 52% for patients on placebo.

Benign prostatic hyperplasia

TADALAFIL was studied in 4 clinical studies of 12 weeks duration enrolling over 1500 patients with signs and symptoms of benign prostatic hyperplasia. The improvement in the total international prostate symptom score with TADALAFIL 5mg in the four studies were -4.8, -5.6, -6.1 and -6.3 compared to -2.2, -3.6, -3.8 and -4.2 with placebo. The improvements in total international prostate symptom score occurred as early as 1 week. In one of the studies, which also included tamsulosin 0.4 mg as an active comparator, the improvement in total international prostate symptom score with TADALAFIL 5mg, tamsulosin and placebo were -6.3, -5.7 and -4.2 respectively.

One of these studies assessed improvements in erectile dysfunction and signs and symptoms of benign prostatic hyperplasia in patients with both conditions. The improvements in the erectile function domain of the international index of erectile function and the total international prostate

symptom score in this study were 6.5 and -6.1 with TADALAFIL 5 mg compared to 1.8 and -3.8 with placebo, respectively. The mean per-subject proportion of successful sexual intercourse attempts was 71.9% with TADALAFIL 5 mg compared to 48.3% with placebo.

The maintenance of the effect was evaluated in an open-label extension to one of the studies, which showed that the improvement in total international prostate symptom score seen at 12 weeks was maintained for up to 1 additional year of treatment with TADALAFIL 5mg.

Paediatric population

A single study has been performed in paediatric patients with Duchenne Muscular Dystrophy (DMD) in which no evidence of efficacy was seen. The randomised, double blind, placebo controlled, parallel, 3 arm study of tadalafil was conducted in 331 boys aged 7-14 years with DMD receiving concurrent corticosteroid therapy. The study included a 48 week double-blind period where patients were randomised to tadalafil 0.3 mg/kg, tadalafil 0.6 mg/kg, or placebo daily. Tadalafil did not show efficacy in slowing the decline in ambulation as measured by the primary 6 minute walk distance (6MWD) endpoint: least squares (LS) mean change in 6MWD at 48 weeks was 51.0 meters (m) in the placebo group, compared with 64.7 m in the tadalafil 0.3 mg/kg group ($p = 0.307$) and 59.1 m in the tadalafil 0.6 mg/kg group ($p = 0.538$). In addition, there was no evidence of efficacy from any of the secondary analyses performed in this study. The overall safety results from this study were generally consistent with the known safety profile of tadalafil and with adverse events (AEs) expected in a paediatric DMD population receiving corticosteroids.

The European Medicines Agency has waived the obligation to submit the results of studies in all subsets of the paediatric population in the treatment of the erectile dysfunction. See section 4.2 for information on paediatric use.

Pharmacodynamic properties of Solifenacin Succinate

Pharmacotherapeutic group: Urinary antispasmodics; Drugs for urinary frequency and incontinence ATC code: G04B D08.

Mechanism of action

Solifenacin is a competitive, specific cholinergic-receptor antagonist.

The urinary bladder is innervated by parasympathetic cholinergic nerves. Acetylcholine contracts the detrusor smooth muscle through muscarinic receptors of which the M_3 subtype is predominantly involved. In vitro and in vivo pharmacological studies indicate that solifenacin is a competitive

inhibitor of the muscarinic M₃ subtype receptor. In addition, solifenacin showed to be a specific antagonist for muscarinic receptors by displaying low or no affinity for various other receptors and ion channels tested.

Pharmacodynamic effects

Treatment with solifenacin succinate in doses of 5 mg and 10 mg daily was studied in several double blind, randomised, controlled clinical trials in men and women with overactive bladder.

As shown in the table below, both the 5 mg and 10 mg doses of solifenacin succinate produced statistically significant improvements in the primary and secondary endpoints compared with placebo. Efficacy was observed within one week of starting treatment and stabilises over a period of 12 weeks. A long-term open label study demonstrated that efficacy was maintained for at least 12 months. After 12 weeks of treatment approximately 50% of patients suffering from incontinence before treatment were free of incontinence episodes, and in addition 35% of patients achieved a micturition frequency of less than 8 micturitions per day.

Treatment of the symptoms of overactive bladder also results in a benefit on a number of Quality of Life measures, such as general health perception, incontinence impact, role limitations, physical limitations, social limitations, emotions, symptom severity, severity measures and sleep/energy.

Results (pooled data) of four controlled Phase 3 studies with a treatment duration of 12 weeks

	Placebo	Solifenacin succinate 5 mg o.d.	Solifenacin succinate 10 mg o.d.	Tolterodine 2 mg b.i.d.
No. of micturitions/24 h				
Mean baseline	11.9	12.1	11.9	12.1
Mean reduction from baseline	1.4	2.3	2.7	1.9
% change from baseline	(12%)	(19%)	(23%)	(16%)

n	1138	552	1158	250
p-value*		<0.001	<0.001	0.004
No. of urgency episodes/24 h				
Mean baseline	6.3	5.9	6.2	5.4
Mean reducti onfrom baseline	2.0	2.9	3.4	2.1
% change from baseline	(32%)	(49%)	(55%)	(39%)
n	1124	548	1151	250
p-value*		<0.001	<0.001	0.031
No. of incontinence episodes/24 h				
Mean baseline	2.9	2.6	2.9	2.3
Mean reducti onfrom baseline	1.1	1.5	1.8	1.1
% change from baseline	(38%)	(58%)	(62%)	(48%)
n	781	314	778	157
p-value*		<0.001	<0.001	0.009
No. of nocturia episodes/24 h				
Mean baseline	1.8	2.0	1.8	1.9
Mean reducti onfrom baseline	0.4	0.6	0.6	0.5
% change from baseline	(22%)	(30%)	(33%)	(26%)
n	1005	494	1035	232
p-value*		0.025	<0.001	0.199
Volume voided/micturition				
Mean baseline	166 ml	146 ml	163 ml	147 ml
Mean increa sefrom baseline	9 ml	32 ml	43 ml	24 ml

% change from baseline	(5%)	(21%)	(26%)	(16%)
n	1135	552	1156	250
p-value*		<0.001	<0.001	<0.001
No. of pads/24 h				
Mean baseline	3.0	2.8	2.7	2.7
Mean reduction from baseline	0.8	1.3	1.3	1.0
% change from baseline	(27%)	(46%)	(48%)	(37%)
n	238	236	242	250
p-value*		<0.001	<0.001	0.010

Note: In 4 of the pivotal studies, solifenacin succinate 10 mg and placebo were used. In 2 out of the 4 studies also solifenacin succinate 5 mg was used and one of the studies included tolterodine 2 mg bid.

Not all parameters and treatment groups were evaluated in each individual study. Therefore, the numbers of patients listed may deviate per parameter and treatment group.

* P-value for the pair wise comparison to placebo

5.2 Pharmacokinetic properties

Dutasteride

Absorption

Following oral administration of a single 0.5 mg dutasteride dose, the time to peak serum concentrations of dutasteride is 1 to 3 hours. The absolute bioavailability is approximately 60%. The bioavailability of dutasteride is not affected by food.

Distribution

Dutasteride has a large volume of distribution (300 to 500 L) and is highly bound to plasma proteins (>99.5%). Following daily dosing, dutasteride serum concentrations achieve 65% of steady state concentration after 1 month and approximately 90% after 3 months.

Steady state serum concentrations (C_{ss}) of approximately 40 ng/mL are achieved after 6 months of dosing 0.5mg once a day.

Dutasteride partitioning from serum into semen averaged 11.5%.

Dutasteride is extensively metabolised in vivo. In vitro, dutasteride is metabolised by the cytochrome P450 3A4 and 3A5 to three monohydroxylated metabolites and one dihydroxylated metabolite.

Biotransformation

Following oral dosing of dutasteride 0.5 mg/day to steady state, 1.0% to 15.4% (mean of 5.4%) of the administered dose is excreted as unchanged dutasteride in the faeces. The remainder is excreted in the faeces as 4 major metabolites comprising 39%, 21%, 7%, and 7% each of drug-related material and 6 minor metabolites (less than 5% each). Only trace amounts of unchanged dutasteride (less than 0.1% of the dose) are detected in human urine.

Elimination

The elimination of dutasteride is dose dependent and the process appears to be described by two elimination pathways in parallel, one that is saturable at clinically relevant concentrations and one that is non saturable.

At low serum concentrations (less than 3ng/mL), dutasteride is cleared rapidly by both the concentration dependent and concentration independent elimination pathways. Single doses of 5 mg or less showed evidence of rapid clearance and a short half-life of 3 to 9 days.

At therapeutic concentrations, following repeat dosing of 0.5 mg/day, the slower, linear elimination pathway is dominating and the half-life is approx. 3-5 weeks.

Elderly

Dutasteride pharmacokinetics were evaluated in 36 healthy male subjects between the ages of 24 and 87 years following administration of a single 5mg dose of dutasteride. No significant influence of age was seen on the exposure of dutasteride but the half-life was shorter in men under 50 years of age. Half-life was not statistically different when comparing the 50-69 year old group to the greater than 70 years old.

Renal impairment

The effect of renal impairment on dutasteride pharmacokinetics has not been studied. However, less than 0.1% of a steady-state 0.5 mg dose of dutasteride is recovered in human urine, so no clinically significant increase of the dutasteride plasma concentrations is anticipated for patients with renal impairment (see section 4.2).

Hepatic impairment

The effect on the pharmacokinetics of dutasteride in hepatic impairment has not been studied (see section 4.3). Because dutasteride is eliminated mainly through metabolism the plasma levels of dutasteride are expected to

be elevated in these patients and the half-life of dutasteride be prolonged (see section 4.2 and section 4.4).

Tadalafil

Absorption

Tadalafil is readily absorbed after oral administration and the mean maximum observed plasma concentration (C_{\max}) is achieved at a median time of 2 hours after dosing. Absolute bioavailability of tadalafil following oral dosing has not been determined.

The rate and extent of absorption of tadalafil are not influenced by food, thus tadalafil may be taken with or without food. The time of dosing (morning versus evening) had no clinically relevant effects on the rate and extent of absorption.

Distribution

The mean volume of distribution is approximately 63 L, indicating that tadalafil is distributed into tissues. At therapeutic concentrations, 94% of tadalafil in plasma is bound to proteins. Protein binding is not affected by impaired renal function.

Less than 0.0005% of the administered dose appeared in the semen of healthy subjects.

Biotransformation

Tadalafil is predominantly metabolised by the cytochrome P450 (CYP) 3A4 isoform. The major circulating metabolite is the methylcatechol glucuronide. This metabolite is at least 13,000-fold less potent than tadalafil for PDE5. Consequently, it is not expected to be clinically active at observed metabolite concentrations.

Elimination

The mean oral clearance for tadalafil is 2.5 l/h and the mean half-life is 17.5 hours in healthy subjects.

Tadalafil is excreted predominantly as inactive metabolites, mainly in the faeces (approximately 61% of the dose) and to a lesser extent in the urine (approximately 36% of the dose).

Linearity/Non-Linearity

Tadalafil pharmacokinetics in healthy subjects are linear with respect to time and dose. Over a dose range of 2.5 to 20 mg, exposure (AUC) increases proportionally with dose. Steady-state plasma concentrations are attained within 5 days of once daily dosing.

Pharmacokinetics determined with a population approach in patients with erectile dysfunction are similar to pharmacokinetics in subjects without erectile dysfunction.

Special Populations

Elderly

Healthy elderly subjects (65 years or over) had a lower oral clearance of tadalafil, resulting in 25% higher exposure (AUC) relative to healthy subjects aged 19 to 45 years. This effect of age is not clinically significant and does not warrant a dose adjustment.

Renal impairment

In clinical pharmacology studies using single dose tadalafil (5 to 20mg), tadalafil exposure (AUC) approximately doubled in subjects with mild (creatinine clearance 51 to 80 ml/min) or moderate (creatinine clearance 31 to 50 ml/min) renal impairment and in subjects with end-stage renal disease on dialysis. In haemodialysis patients, C_{max} was 41% higher than that observed in healthy subjects. Haemodialysis contributes negligibly to tadalafil elimination.

Hepatic impairment

Tadalafil exposure (AUC) in subjects with mild and moderate hepatic impairment (Child-Pugh class A and B) is comparable to exposure in healthy subjects when a dose of 10 mg is administered. There is limited clinical data on the safety of tadalafil in patients with severe hepatic insufficiency (Child-Pugh class C). If tadalafil is prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. There are no available data about the administration of once-a-day dosing of tadalafil to patients with hepatic impairment. If tadalafil is prescribed once-a-day, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician.

Patients with diabetes

Tadalafil exposure (AUC) in patients with diabetes was approximately 19% lower than the AUC value for healthy subjects. This difference in exposure does not warrant a dose adjustment

Solifenacin Succinate

Absorption

After intake of solifenacin succinate tablets, maximum solifenacin plasma concentrations (C_{max}) are reached after 3 to 8 hours. The t_{max} is independent of the dose. The C_{max} and area under the curve (AUC) increase in proportion to the dose between 5 to 40 mg.

Absolute bioavailability is approximately 90%.

Food intake does not affect the C_{\max} and AUC of solifenacin.

Distribution

The apparent volume of distribution of solifenacin following intravenous administration is about 600 L. Solifenacin is to a great extent (approximately 98%) bound to plasma proteins, primarily α 1-acid glycoprotein.

Biotransformation

Solifenacin is extensively metabolised by the liver, primarily by cytochrome P450 3A4 (CYP3A4). However, alternative metabolic pathways exist, that can contribute to the metabolism of solifenacin. The systemic clearance of solifenacin is about 9.5 L/h and the terminal half-life of solifenacin is 45 - 68 hours. After oral dosing, one pharmacologically active (4R-hydroxysolifenacin) and three inactive metabolites (N-glucuronide, N-oxide and 4R-hydroxy-N-oxide of solifenacin) have been identified in plasma in addition to solifenacin.

Elimination

After a single administration of 10 mg [^{14}C -labelled]-solifenacin, about 70% of the radioactivity was detected in urine and 23% in faeces over 26 days. In urine, approximately 11% of the radioactivity is recovered as unchanged active substance; about 18% as the N-oxide metabolite, 9% as the 4R-hydroxy-N-oxide metabolite and 8% as the 4R-hydroxy metabolite (active metabolite).

Linearity/non-linearity

Pharmacokinetics are linear in the therapeutic dose range.

Other special populations

Elderly

No dosage adjustment based on patient age is required. Studies in elderly have shown that the exposure to solifenacin, expressed as the AUC, after administration of solifenacin succinate (5 mg and 10 mg once daily) was similar in healthy elderly subjects (aged 65 through 80 years) and healthy young subjects (aged less than 55 years). The mean rate of absorption expressed as t_{\max} was slightly slower in the elderly and the terminal half-life was approximately 20% longer in elderly subjects.

These modest differences were considered not clinically significant.

The pharmacokinetics of solifenacin have not been established in children and

adolescents.

Gender

The pharmacokinetics of solifenacin are not influenced by gender.

Race

The pharmacokinetics of solifenacin are not influenced by race.

Renal impairment

The AUC and C_{\max} of solifenacin in mild and moderate renally impaired patients, was not significantly different from that found in healthy volunteers. In patients with severe renal impairment (creatinine clearance ≤ 30 ml/min) exposure to solifenacin was significantly greater than in the controls with increases in C_{\max} of about 30%, AUC of more than 100% and $t_{1/2}$ of more than 60%.

A statistically significant relationship was observed between creatinine clearance and solifenacin clearance.

Pharmacokinetics in patients undergoing haemodialysis have not been studied.

Hepatic impairment

In patients with moderate hepatic impairment (Child-Pugh score of 7 to 9) the C_{\max} is not affected, AUC increased with 60% and $t_{1/2}$ doubled. Pharmacokinetics of solifenacin in patients with severe hepatic impairment have not been studied.

5.3 Preclinical safety data

Dutasteride

Current studies of general toxicity, genotoxicity and carcinogenicity did not show any particular risk to humans.

Reproduction toxicity studies in male rats have shown a decreased weight of the prostate and seminal vesicles, decreased secretion from accessory genital glands and a reduction in fertility indices (caused by the pharmacological effect of dutasteride). The clinical relevance of these findings is unknown.

As with other 5 alpha reductase inhibitors, feminisation of male foetuses in rats and rabbits has been noted when dutasteride was administered during gestation. Dutasteride has been found in blood from female rats after mating with dutasteride treated males. When dutasteride was administered during gestation to primates, no feminisation of male foetuses was seen at blood

exposures sufficiently in excess of those likely to occur via human semen. It is unlikely that a male foetus will be adversely affected following seminal transfer of dutasteride.

Tadalafil

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

There was no evidence of teratogenicity, embryotoxicity, or foetotoxicity in rats or mice that received up to 1000 mg/kg/day tadalafil. In a rat prenatal and postnatal development study, the no observed effect dose was 30 mg/kg/day. In the pregnant rat the AUC for calculated free drug at this dose was approximately 18-times the human AUC at a 20 mg dose.

There was no impairment of fertility in male and female rats. In dogs given tadalafil daily for 6 to 12 months at doses of 25 mg/kg/day (resulting in at least a 3-fold greater exposure [range 3.7-18.6] than seen in humans given a single 20 mg dose) and above, there was regression of the seminiferous tubular epithelium that resulted in a decrease in spermatogenesis in some dogs. See also section 5.1.

Solifenacin Succinate

Preclinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, fertility, embryofetal development, genotoxicity, and carcinogenic potential. In the pre- and postnatal development study in mice, solifenacin treatment of the mother during lactation caused dose-dependent lower postpartum survival rate, decreased pup weight and slower physical development at clinically relevant levels. Dose related increased mortality without preceding clinical signs occurred in juvenile mice treated from day 10 or 21 after birth with doses that achieved a pharmacological effect and both groups had higher mortality compared to adult mice. In juvenile mice treated from postnatal day 10, plasma exposure was higher than in adult mice; from postnatal day 21 onwards, the systemic exposure was comparable to adult mice. The clinical implications of the increased mortality in juvenile mice are not known.

6. Pharmaceutical particulars

6.1 List of Excipients

Betacyclodextrin

Purified Water

butylhydroxytoluene (E321)

Lactose Monohydrate

Maize Starch
Colloidal Silicon Dioxide
Povidone K-30
Isopropyl Alcohol
Croscarmellose Sodium
Crospovidone XL 10
Polyethylene Glycol (PEG 6000)
Microcrystalline Cellulose (PH 112)
Sodium lauryl sulphate
Magnesium Stearate

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

Do not store above 30°C.

Store in the original package, in order to protect from light.

6.5 Nature and contents of container

1 x10 Tablet Alu -Alu Blister packed. Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Not applicable

7. Marketing authorization holder and manufacturing site addresses

Market authorization holder:

Medfo Kenya Limited

P.O. Box 104425-00101,

Nairobi, Kenya.

Manufacturing site address:

4Care life Science (P) Limited

SurveyNo.23/3P&24,

Opp. Jeans Factory, Daduram Vistar, Village-Bagdol, Tal- Kathlal, Dist-
Kheda - 387630, Gujarat, India.

8. Marketing authorisation number(s)

DIAX-TS 2.5 mg-CTD9856

DIAX-TS 5 mg-CTD9854

DIAX-TS 10 mg-CTD9855

9. Date of first registration/renewal of the authorisation

DIAX-TS 2.5 mg- 20/06/2022

DIAX-TS 5 mg-21/06/22

DIAX-TS 10 mg- 23/06/22

10. Date of revision of the text

15/09/2023

11. Dosimetry:

Not applicable

12. Instructions for Preparation of Radiopharmaceuticals:

Not Applicable