For the use only of a Registered Medical Practitioner or a Hospital or a Laboratory

Rosuvastatin Tablets IP

Crestor® film coated tablets 5mg, 10mg, 20mg and 40mg

Abbreviated Prescribing Information

INDICATIONS AND USAGE

Hyperlipidemia and Mixed Dyslipidemia: CRESTOR is indicated as adjunctive therapy to diet to reduce elevated Total-C, LDL-C, ApoB, nonHDL-C, and triglycerides and to increase HDL-C in adult patients with primary hyperlipidemia or mixed dyslipidemia. Lipid-altering agents should be used in addition to a diet restricted in saturated fat and cholesterol when response to diet and nonpharmacological interventions alone has been inadequate.

Children and adolescents 10 to 17 years of age: Adjunct to diet to reduce Total-C, LDL-C and ApoB levels in adolescent boys and girls, who are at least one year post-menarche, 10-17 years of age with heterozygous familial hypercholesterolemia if after an adequate trial of diet therapy the following findings are present: LDL-C > 190 mg/dL or > 160 mg/dL and there is a positive family history of premature cardiovascular disease (CVD) or two or more other CVD risk factors.

Hypertriglyceridemia: CRESTOR is indicated as adjunctive therapy to diet for the treatment of adult patients with hypertriglyceridemia.

Primary Dysbetalipoproteinemia (Type III Hyperlipoproteinemia): CRESTOR is indicated as an adjunct to diet for the treatment of patients with primary dysbetalipoproteinemia (Type III Hyperlipoproteinemia).

Homozygous Familial Hypercholesterolemia: CRESTOR is indicated as adjunctive therapy to other lipid-lowering treatments (e.g., LDL apheresis) or alone if such treatments are unavailable to reduce LDL-C, Total-C, and ApoB in adult patients with homozygous familial hypercholesterolemia.

Slowing of the Progression of Atherosclerosis: CRESTOR is indicated as adjunctive therapy to diet to slow the progression of atherosclerosis in adult patients as part of a treatment strategy to lower Total-C and LDL-C to target levels.

Primary Prevention of Cardiovascular Disease: In individuals without clinically evident coronary heart disease but with an increased risk of cardiovascular disease based on age ≥ 50 years old in men and ≥ 60 years old in women, hsCRP ≥ 2 mg/L, and the presence of at least one additional cardiovascular disease risk factor such as hypertension, low HDL-C, smoking, or a family history of premature coronary heart disease, CRESTOR is indicated to:

- reduce the risk of stroke
- reduce the risk of myocardial infarction
- reduce the risk of arterial revascularization procedures

General Dosing Information: The dose range for CRESTOR is 5 to 40 mg orally once daily. The usual starting dose is 10-20 mg. CRESTOR can be administered as a single dose at

any time of day, with or without food. When initiating CRESTOR therapy or switching from another HMG-CoA reductase inhibitor therapy, the appropriate CRESTOR starting dose should first be utilized, and only then titrated according to the patient's response and individualized goal of therapy. After initiation or upon titration of CRESTOR, lipid levels should be analyzed within 2 to 4 weeks and the dosage adjusted accordingly. The 40 mg dose of CRESTOR should be used only for those patients who have not achieved their LDL-C goal utilizing the 20 mg dose.

Dosaging in Asian Patients: In Asian patients, consider initiation of CRESTOR therapy with 5 mg once daily due to increased Rosuvastatin plasma concentrations. The increased systemic exposure should be taken into consideration when treating Asian patients not adequately controlled at doses up to 20mg/day.

Dosing in Patients with Severe Renal Impairment: For patients with severe renal impairment (CLcr <30 mL/min/1.73 m2) not on hemodialysis, dosing of CRESTOR should be started at 5 mg once daily and not exceed 10 mg once daily.

CONTRAINDICATIONS:

Hypersensitivity.

Active Liver disease and unexplained persistent elevation of Liver enzymes.

Women who are pregnant or may become pregnant.

Nursing mother.

WARNINGS AND PRECAUTIONS:

CRESTOR should be prescribed with caution in patients with predisposing factors for myopathy (e.g., age ≥ 65 years, inadequately treated hypothyroidism, renal impairment). The risk of myopathy during treatment with CRESTOR may be increased with concurrent administration of some other lipid-lowering therapies (fibrates or niacin), gemfibrozil, cyclosporine, lopinavir/ritonavir, or atazanavir/ritonavir.

It is recommended that liver enzyme tests be performed before the initiation of CRESTOR, and if signs or symptoms of liver injury occur. Caution should be exercised when anticoagulants are given in conjunction with CRESTOR because of its potentiation of the effect of coumarin-type anticoagulants in prolonging the prothrombin time/INR.

Proteinuria and Haematuria

Increases in HbA1c and fasting serum glucose levels have been reported with HMG-CoA reductase inhibitors, including CRESTOR

ADVERSE REACTIONS: Rhabdomyolysis**,** Liver enzyme abnormalities**,** Myalgia**,** Abdominal pain**,** Nausea**,** Headache, asthenia.

USE IN SPECIFIC POPULATIONS

Teratogenic effects: Pregnancy Category X.

Nursing Mothers: It is not known whether rosuvastatin is excreted in human milk, but a small amount of another drug in this class does pass into breast milk. HMG-CoA reductase inhibitors have a potential to cause serious adverse reactions in nursing infants, women who require CRESTOR treatment should be advised not to nurse their infants.

Paediatric Use: The same warnings and precautions for adults should be considered for children and adolescents. There was no detectable effect of CRESTOR on growth, weight, BMI (body mass index), or sexual maturation [see Clinical Studies (14.5)] in pediatric patients (10 to 17 years of age). Adolescent females should be counseled on appropriate contraceptive methods while on CRESTOR therapy. CRESTOR has not been studied in controlled clinical trials involving prepubertal patients or patients younger than 10 years of age. Doses of CRESTOR greater than 20 mg have not been studied in the pediatric population.

Geriatric Use: No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Renal Impairment: Rosuvastatin exposure is not influenced by mild to moderate renal impairment (CLcr ≥ 30mL/min/1.73 m2). CRESTOR dosing should be adjusted in patients with severe renal impairment (CLcr <30 mL/min/1.73 m2) not requiring hemodialysis.

Hepatic Impairment: CRESTOR is contraindicated in patients with active liver disease, which may include unexplained persistent elevations of hepatic transaminase levels. Chronic alcohol liver disease is known to increase rosuvastatin exposure.

Asian Patients: Pharmacokinetic studies have demonstrated an approximate 2-fold increase in median exposure to rosuvastatin in Asian subjects when compared with Caucasian controls. CRESTOR dosage should be adjusted in Asian patients.

OVERDOSAGE:

There is no specific treatment in the event of overdose. In the event of overdose, the patient should be treated symptomatically and supportive measures instituted as required. Hemodialysis does not significantly enhance clearance of rosuvastatin.

DRUG INTERACTIONS

Cyclosporine: Cyclosporine increased rosuvastatin exposure (AUC) 7-fold.

Gemfibrozil: Gemfibrozil significantly increased rosuvastatin exposure. Due to an observed increased risk of myopathy/rhabdomyolysis, combination therapy with CRESTOR and gemfibrozil should be avoided.

Protease Inhibitors: Coadministration of rosuvastatin with certain protease inhibitors given in combination with ritonavir has differing effects on rosuvastatin exposure. The protease inhibitor combinations lopinavir/ritonavir and atazanavir/ritonavir increase rosuvastatin exposure (AUC) up to threefold.

Coumarin Anticoagulants: CRESTOR significantly increased INR in patients receiving coumarin anticoagulants.

Niacin: The risk of skeletal muscle effects may be enhanced when CRESTOR is used in combination with lipid- modifying doses (≥1 g/day) of niacin.

Fenofibrate: When CRESTOR was coadministered with fenofibrate, no clinically significant increase in the AUC of rosuvastatin or fenofibrate was observed. Because it is known that the risk of myopathy during treatment with HMG-COA reductase inhibitors is increased with concomitant use of fenofibrates.

Colchicine: Cases of myopathy, including rhabdomyolysis, have been reported with HMG-CoA reductase inhibitors, including rosuvastatin, coadministered with colchicine, and caution should be exercised when prescribing CRESTOR with colchicine [see Warnings and Precautions.

PATIENT COUNSELING INFORMATION

Skeletal Muscle Effects: Patients should be advised to report promptly unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever or if these muscle signs or symptoms persist after discontinuing CRESTOR.

Concomitant Use of Antacids: When taking CRESTOR with an aluminum and magnesium hydroxide combination antacid, the antacid should be taken at least 2 hours after CRESTOR administration.

Pregnancy: If the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the foetus and the lack of known clinical benefit with continued use during pregnancy.

Liver Enzymes: It is recommended that liver enzyme tests be performed before the initiation of CRESTOR and if signs or symptoms of liver injury occur. All patients treated with CRESTOR should be advised to promptly report any symptoms that may indicate liver injury, including fatigue, anorexia, right upper abdominal discomfort, dark urine or jaundice.

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For more information, refer full prescribing information version 4 dated 18 September 2013.