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SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Crestor 5 mg, 10 mg, 20 mg, or 40 mg film-coated tablets ▼

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 5 mg, 10 mg, 20 mg or 40 mg rosuvastatin (as rosuvastatin calcium)

Each 5 mg tablet contains 94.88 mg lactose monohydrate.

Each 10 mg tablet contains 91.3 mg lactose monohydrate.

Each 20 mg tablet contains 182.6 mg lactose monohydrate.

Each 40 mg tablet contains 168.32 mg lactose monohydrate.

For excipients see 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.

Crestor 5 mg

Round, yellow coloured, intagliated with 'ZD4522' and '5' on one side and plain on the reverse.

Crestor 10 mg Tablet

Round, pink coloured, intagliated with 'ZD4522' and '10' on one side and plain on the reverse.

Crestor 20 mg Tablet

Round, pink coloured, intagliated with 'ZD4522' and '20' on one side and plain on the reverse.

Crestor 40 mg Tablet

Oval, pink coloured, intagliated with 'ZD4522' on one side and '40' on the reverse.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Primary hypercholesterolaemia (type IIa including heterozygous familial hypercholesterolaemia) or mixed dyslipidaemia (type IIb) as an adjunct to diet when response to diet and other non-pharmacological treatments (e.g. exercise, weight reduction) is inadequate.

Homozygous familial hypercholesterolaemia as an adjunct to diet and other lipid lowering treatments (e.g. LDL apheresis) or if such treatments are not appropriate.

4.2 Posology and method of administration

Before treatment initiation the patient should be placed on a standard cholesterol-lowering diet that should continue during treatment. The dose should be individualised according to the goal of therapy and patient response, using current consensus guidelines.

The recommended start dose is 5 mg or 10 mg orally once daily in both statin naïve or patients switched from another HMG CoA reductase inhibitor. The choice of start dose should take into account the individual patient's cholesterol level and future cardiovascular risk as well as the potential risk for adverse

reactions (see below). A dose adjustment to the next dose level can be made after 4 weeks, if necessary (see Section 5.1 Pharmacodynamic properties). In light of the increased reporting rate of adverse reactions with the 40 mg dose compared to lower doses (see Section 4.8 Undesirable effects), a final titration to the maximum dose of 40 mg should only be considered in patients with severe hypercholesterolaemia at high cardiovascular risk (in particular those with familial hypercholesterolaemia), who do not achieve their treatment goal on 20 mg, and in whom routine follow-up will be performed (see Section 4.4 Special warnings and precautions). Specialist supervision is recommended when the 40 mg dose is initiated.

Crestor may be given at any time of day, with or without food.

Paediatric use

Safety and efficacy have not been established in children. Paediatric experience is limited to a small number of children (aged 8 years or above) with homozygous familial hypercholesterolaemia. Therefore, Crestor is not recommended for paediatric use at this time.

Use in the elderly

A start dose of 5 mg is recommended in patients >70 years (see section 4.4 Special warnings and precautions for use). No other dose adjustment is necessary in relation to age.

Dosage in patients with renal insufficiency

No dose adjustment is necessary in patients with mild to moderate renal impairment. The recommended start dose is 5 mg in patients with moderate renal impairment (creatinine clearance of <60 ml/min). The 40 mg dose is contraindicated in patients with moderate renal impairment. The use of Crestor in patients with severe renal impairment is contraindicated for all doses. (see Section 4.3 Contraindications and Section 5.2 Pharmacokinetic properties).

Dosage in patients with hepatic impairment

There was no increase in systemic exposure to rosuvastatin in subjects with Child-Pugh scores of 7 or below. However, increased systemic exposure has been observed in subjects with Child-Pugh scores of 8 and 9 (see Section 5.2 Pharmacokinetic properties). In these patients an assessment of renal function should be considered (see Section 4.4 Special warnings and special precautions for use). There is no experience in subjects with Child-Pugh scores above 9.

Crestor is contraindicated in patients with active liver disease (see Section 4.3 Contraindications).

Race

Increased systemic exposure has been seen in Asian subjects (see section 4.4 Special warnings and special precautions for use and section 5.2 Pharmacokinetic properties). The recommended start dose is 5 mg for patients of Asian ancestry. The 40 mg dose is contraindicated in these patients.

Genetic polymorphisms

Specific types of genetic polymorphisms are known that can lead to increased rosuvastatin exposure (see Section 5.2). For patients who are known to have such specific types of polymorphisms, a lower daily dose of Crestor is recommended.

Dosage in patients with pre-disposing factors to myopathy

The recommended start dose is 5 mg in patients with predisposing factors to myopathy (see Section 4.4 Special warnings and special precautions for use).

The 40 mg dose is contraindicated in some of these patients (see Section 4.3 Contraindications).

Interactions requiring dose adjustments

Ciclosporin: Increased systemic exposure to rosuvastatin has been observed in patients taking concomitant CRESTOR and Ciclosporin. For the CRESTOR dose range (10 – 40 mg) this combination is not recommended.

Gemfibrozil: Increased systemic exposure to rosuvastatin has been observed in subjects taking concomitant CRESTOR and gemfibrozil. Therefore, combination therapy with CRESTOR and gemfibrozil should be avoided. If used, do not exceed CRESTOR 10 mg once daily. (See Section 4.4 Special warnings and special precautions for use, Section 4.5 Interactions with other medicaments and other forms of interaction.)

Concomitant therapy

Rosuvastatin is a substrate of various transporter proteins (e.g. OATP1B1 and BCRP). The risk of myopathy (including rhabdomyolysis) is increased when Crestor is administered concomitantly with certain medicinal products that may increase the plasma concentration of rosuvastatin due to interactions with these transporter proteins (e.g. ciclosporin and certain protease inhibitors including combinations of ritonavir with atazanavir, lopinavir, and/or tipranavir; see Sections 4.4 and 4.5). It is recommended that prescribers consult the relevant product information when considering administration of such products together with CRESTOR.³ Whenever possible, alternative medications should be considered, and, if necessary, consider temporarily discontinuing Crestor therapy. In situations where co-administration of these medicinal products with Crestor is unavoidable, the benefit and the risk of concurrent treatment and Crestor dosing adjustments should be carefully considered (see Section 4.5).

4.3 Contraindications

Crestor is contraindicated:

- in patients with hypersensitivity to rosuvastatin or to any of the excipients.
- in patients with active liver disease including unexplained, persistent elevations of serum transaminases and any serum transaminase elevation exceeding 3 x the upper limit of normal (ULN).
- in patients with severe renal impairment (creatinine clearance <30 ml/min).
- in patients with myopathy.
- in patients receiving concomitant ciclosporin.
- during pregnancy and lactation and in women of childbearing potential not using appropriate contraceptive measures.

The 40 mg dose is contraindicated in patients with pre-disposing factors for myopathy/rhabdomyolysis. Such factors include:

- moderate renal impairment (creatinine clearance < 60 ml/min)
- hypothyroidism
- personal or family history of hereditary muscular disorders
- previous history of muscular toxicity with another HMG-CoA reductase inhibitor or fibrate
- alcohol abuse
- situations where an increase in plasma levels may occur
- Asian patients
- concomitant use of fibrates.

(See sections 4.4 Special warnings and special precautions for use, 4.5 Interaction with other medicinal products and other forms of interaction and 5.2 Pharmacokinetic properties).

4.4 Special warnings and special precautions for use

Renal Effects

Proteinuria, detected by dipstick testing and mostly tubular in origin, has been observed in patients treated with higher doses of Crestor, in particular 40 mg, where it was transient or intermittent in most cases. Proteinuria has not been shown to be predictive of acute or progressive renal disease (see Section 4.8 Undesirable effects). The reporting rate for serious renal events in post-marketing use is higher at the 40mg dose. An assessment of renal function should be considered during routine follow-up of patients treated with a dose of 40 mg.

Skeletal Muscle Effects

Effects on skeletal muscle e.g. myalgia, myopathy, and rarely, rhabdomyolysis, have been reported in Crestor-treated patients with all doses and in particular with doses > 20mg. Very rare cases of rhabdomyolysis have been reported with the use of ezetimibe in combination with HMG-CoA reductase inhibitors. A pharmacodynamic interaction cannot be excluded (see Section 4.5 Interactions with other medicinal products and other forms of interactions) and caution should be exercised with their combined use.

As with other HMG-CoA reductase inhibitors, the reporting rate for rhabdomyolysis associated with Crestor in post-marketing use is higher at the 40 mg dose.

There have been very rare reports of an immune-mediated necrotizing myopathy clinically characterized by persistent proximal muscle weakness and elevated serum creatine kinase during treatment or following discontinuation of statins, including rosuvastatin. Additional neuromuscular and serologic testing may be necessary. Treatment with immunosuppressive agents may be required.

Creatine Kinase Measurement

Creatine Kinase (CK) should not be measured following strenuous exercise or in the presence of a plausible alternative cause of CK increase which may confound interpretation of the result. If CK levels are significantly elevated at baseline (>5xULN) a confirmatory test should be carried out within 5 – 7 days. If the repeat test confirms a baseline CK >5xULN, treatment should not be started.

Before Treatment

Crestor, as with other HMG-CoA reductase inhibitors, should be prescribed with caution in patients with pre-disposing factors for myopathy/rhabdomyolysis, such factors include:

- renal impairment
- hypothyroidism
- personal or family history of hereditary muscular disorders
- previous history of muscular toxicity with another HMG-CoA reductase inhibitor or fibrate
- alcohol abuse
- age >70 years
- situations where an increase in plasma levels may occur (see section 5.2 Pharmacokinetic properties).
- concomitant use of fibrates.

In such patients the risk of treatment should be considered in relation to possible benefit and clinical monitoring is recommended. If CK levels are significantly elevated at baseline (>5xULN) treatment should not be started.

Whilst on Treatment

Patients should be asked to report inexplicable muscle pain, weakness or cramps immediately, particularly if associated with malaise or fever. CK levels should be measured in these patients. Therapy should be discontinued if CK levels are markedly elevated (>5xULN) or if muscular symptoms are severe and cause daily discomfort (even if CK levels are \leq 5x ULN). If symptoms resolve and CK levels return to

normal, then consideration should be given to re-introducing Crestor or an alternative HMG-CoA reductase inhibitor at the lowest dose with close monitoring.

Routine monitoring of CK levels in asymptomatic patients is not warranted. There have been very rare reports of an immune-mediated necrotising myopathy (IMNM) during or after treatment with statins, including rosuvastatin. IMNM is clinically characterised by proximal muscle weakness and elevated serum creatine kinase, which persist despite discontinuation of statin treatment.

In clinical trials there was no evidence of increased skeletal muscle effects in the small number of patients dosed with Crestor and concomitant therapy. However, an increase in the incidence of myositis and myopathy has been seen in patients receiving other HMG-CoA reductase inhibitors together with fibric acid derivatives including gemfibrozil, ciclosporin, nicotinic acid, azole antifungals, protease inhibitors and macrolide antibiotics. Gemfibrozil increases the risk of myopathy when given concomitantly with some HMG-CoA reductase inhibitors. Therefore, the combination of Crestor and gemfibrozil is not recommended. If used, do not exceed CRESTOR 10 mg once daily. The benefit of further alterations in lipid levels by the combined use of Crestor with fibrates or niacin should be carefully weighed against the potential risks of such combinations. The 40 mg dose is contraindicated with concomitant use of a fibrate. (See Section 4.5 Interaction with other medicinal products and other forms of interaction and Section 4.8 Undesirable effects.)

Combination with rosuvastatin and fusidic acid is not recommended. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving this combination (see Section 4.5).

Cases of myopathy and rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with HMG-CoA reductase inhibitors, including CRESTOR. These risks can occur at any dose level, but are increased at the highest dose (40 mg).

Crestor should not be used in any patient with an acute, serious condition suggestive of myopathy or predisposing to the development of renal failure secondary to rhabdomyolysis (e.g. sepsis, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders; or uncontrolled seizures).

Liver Effects

As with other HMG-CoA reductase inhibitors, Crestor should be used with caution in patients who consume excessive quantities of alcohol and/or have a history of liver disease.

It is recommended that liver function tests be carried out prior to, and 3 months following, the initiation of treatment. Crestor should be discontinued or the dose reduced if the level of serum transaminases is greater than 3 times the upper limit of normal. The reporting rate for serious hepatic events (consisting mainly of increased hepatic transaminases) in post-marketing use is higher at the 40 mg dose.

In patients with secondary hypercholesterolaemia caused by hypothyroidism or nephrotic syndrome, the underlying disease should be treated prior to initiating therapy with Crestor.

Race

Pharmacokinetic studies show an increase in exposure in Asian subjects compared with Caucasians (see section 4.2 Posology and Method of administration and section 5.2 Pharmacokinetic properties).

Protease inhibitors

Increased systemic exposure to rosuvastatin has been observed in subjects receiving rosuvastatin concomitantly with various protease inhibitors in combination with ritonavir. Consideration should be given both to the benefit of lipid lowering by use of Crestor in HIV patients receiving protease inhibitors and the potential for increased rosuvastatin plasma concentrations when initiating and up titrating Crestor doses in patients treated with protease inhibitors. The concomitant use with certain protease inhibitors is not recommended unless the dose of Crestor is adjusted. (see Sections 4.2 and 4.5).

Lactose intolerance

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

Interstitial lung disease

Exceptional cases of interstitial lung disease have been reported with some statins, especially with long term therapy (see Section 4.8). Presenting features can include dyspnoea, non-productive cough and deterioration in general health (fatigue, weight loss and fever). If it is suspected a patient has developed interstitial lung disease, statin therapy should be discontinued.

Diabetes Mellitus

As with other HMG-CoA reductase inhibitors, increases in HbA1c and serum glucose levels have been observed in patients treated with rosuvastatin, and in some instances these increases may exceed the threshold for the diagnosis of diabetes mellitus, primarily in patients already at high risk for developing diabetes (see Sections 4.8 and 5.1). Patients at risk (i.e. those with fasting glucose 5.6 - 6.9 mmol/L, body mass index > 30kg/m², raised triglycerides or hypertension) should be monitored both clinically and biochemically.

In the JUPITER study, the reported overall frequency of diabetes mellitus was 2.8% in rosuvastatin and 2.3% in placebo, mostly in patient with fasting glucose 5.6 to 6.9 mmol/l.

Endocrine Effects

Although clinical studies have shown that CRESTOR alone does not reduce basal plasma cortisol concentration or impair adrenal reserve, caution should be exercised if CRESTOR is administered concomitantly with drugs that may decrease the levels or activity of endogenous steroid hormones such as ketoconazole, spironolactone, and cimetidine.

Paediatric population

The evaluation of linear growth (height), weight, BMI (body mass index), and secondary characteristics of sexual maturation by Tanner staging in paediatric patients 10 to 17 years of age taking rosuvastatin is limited to a one-year period. After 52 weeks of study treatment, no effect on growth, weight, BMI or sexual maturation was detected (see Section 5.1). The clinical trial experience in children and adolescent patients is limited and the long-term effects of rosuvastatin (>1 year) on puberty are unknown.

In a clinical trial of children and adolescents receiving rosuvastatin for 52 weeks, CK elevations >10xULN and muscle symptoms following exercise or increased physical activity were observed more frequently compared to observations in clinical trials in adults (see Section 4.8).

4.5 Interaction with other medicinal products and other forms of interaction

Transporter protein inhibitors: Rosuvastatin is a substrate for certain transporter proteins including the hepatic uptake transporter OATP1B1 and efflux transporter BCRP. Concomitant administration of Crestor with medicinal products that are inhibitors of these transporter proteins may result in increased rosuvastatin plasma concentrations and an increased risk of myopathy (see Sections 4.2, 4.4 and 4.5 Table 1).

Ciclosporin: During concomitant treatment with Crestor and ciclosporin, rosuvastatin AUC values were on average 7 times higher than those observed in healthy volunteers (see Section 4.3 Contraindications). Crestor is contraindicated in patients receiving concomitant ciclosporin (see Section 4.3).

Concomitant administration did not affect plasma concentrations of ciclosporin.

Vitamin K antagonists: As with other HMG-CoA reductase inhibitors, the initiation of treatment or dosage up-titration of Crestor in patients treated concomitantly with vitamin K antagonists (e.g. warfarin or another coumarin anticoagulant) may result in an increase in International Normalised Ratio (INR). Discontinuation or down-titration of Crestor may result in a decrease in INR. In such situations, appropriate monitoring of INR is desirable.

Ezetimibe: Concomitant use of 10 mg Crestor and 10 mg ezetimibe resulted in a 1.2 fold increase in AUC of rosuvastatin in hypercholesterolaemic subjects (Table 1). A pharmacodynamic interaction, in terms of adverse effects, between Crestor and ezetimibe cannot be ruled out (see Section 4.4).

Gemfibrozil and other lipid-lowering products: Concomitant use of Crestor and gemfibrozil resulted in a 2-fold increase in rosuvastatin C_{max} and AUC (see Section 4.4 Special warnings and special precautions for use).

Based on data from specific interaction studies, no pharmacokinetic relevant interaction with fenofibrate is expected, however a pharmacodynamic interaction may occur.

Gemfibrozil, fenofibrate, other fibrates and lipid lowering doses (> or equal to 1g/day) of niacin (nicotinic acid) increase the risk of myopathy when given concomitantly with HMG-CoA reductase inhibitors, probably because they can produce myopathy when given alone. The 40 mg dose is contraindicated with concomitant use of a fibrate (see Section 4.3 Contraindications and Section 4.4 Special warnings and special precautions for use). These patients should also start with the 5 mg dose.

Protease inhibitors: Although the exact mechanism of interaction is unknown, concomitant protease inhibitor use may strongly increase rosuvastatin exposure (see Table 1). In a pharmacokinetic study, co-administration of 20 mg rosuvastatin and a combination product of two protease inhibitors (400 mg lopinavir / 100 mg ritonavir) in healthy volunteers was associated with an approximately two-fold and five-fold increase in rosuvastatin steady-state AUC₍₀₋₂₄₎ and C_{max} respectively. Therefore, concomitant use of rosuvastatin in HIV patients receiving protease inhibitors is not recommended (see also Section 4.4).

Antacid: The simultaneous dosing of Crestor with an antacid suspension containing aluminium and magnesium hydroxide resulted in a decrease in rosuvastatin plasma concentration of approximately 50%. This effect was mitigated when the antacid was dosed 2 hours after Crestor. The clinical relevance of this interaction has not been studied.

Erythromycin: Concomitant use of Crestor and erythromycin resulted in a 20% decrease in AUC (0-t) and a 30% decrease in C_{max} of rosuvastatin. This interaction may be caused by the increase in gut motility caused by erythromycin.

Oral contraceptive/hormone replacement therapy (HRT): Concomitant use of Crestor and an oral contraceptive resulted in an increase in ethinyl estradiol and norgestrel AUC of 26% and 34%, respectively. These increased plasma levels should be considered when selecting oral contraceptive doses. There are no pharmacokinetic data available in subjects taking concomitant Crestor and HRT and therefore a similar effect cannot be excluded. However, the combination has been extensively used in women in clinical trials and was well tolerated.

Other medicinal products: Based on data from specific interaction studies no clinically relevant interactions with digoxin is expected.

Cytochrome P450 enzymes: Results from *in vitro* and *in vivo* studies show that rosuvastatin is neither an inhibitor nor an inducer of cytochrome P450 isoenzymes. In addition, rosuvastatin is a poor substrate for these isoenzymes. No clinically relevant interactions have been observed between rosuvastatin and either fluconazole (an inhibitor of CYP2C9 and CYP3A4) or ketoconazole (an inhibitor of CYP2A6 and CYP3A4). Concomitant administration of itraconazole (an inhibitor of CYP3A4) and rosuvastatin resulted in a 28% increase in AUC of rosuvastatin. This small increase is not considered clinically significant. Therefore, drug interactions resulting from cytochrome P450-mediated metabolism are not expected.

Fusidic Acid: Interaction studies with rosuvastatin and fusidic acid have not been conducted. As with other statins, muscle related events, including rhabdomyolysis, have been reported in post-marketing experience with rosuvastatin and fusidic acid given concurrently. Therefore, the combination rosuvastatin and fusidic acid is not recommended. If possible, temporary suspension of rosuvastatin treatment is recommended. If unavoidable, patients should be closely monitored.

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.

Interactions requiring rosuvastatin dose adjustments (see also Table 1): When it is necessary to co-administer Crestor with other medicinal products known to increase exposure to rosuvastatin, doses of Crestor should be adjusted. It is recommended that prescribers consult the relevant product information when considering administration of such products together with Crestor*. Start with a 5 mg once daily dose of Crestor if the expected increase in exposure (AUC) is approximately 2-fold or higher. The maximum daily dose of Crestor should be adjusted so that the expected rosuvastatin exposure would not

likely exceed that of a 40 mg daily dose of Crestor taken without interacting medicinal products, for example a 20 mg dose of Crestor with gemfibrozil (1.9-fold increase), and a 10 mg dose of Crestor with combination ritonavir/atazanavir (3.1-fold increase).

Table 1 Effect of co-administered medicinal products on rosuvastatin exposure (AUC; in order of decreasing magnitude) from published clinical trials

Interacting drug dose regimen	Rosuvastatin dose regimen	Change in rosuvastatin AUC*
Ciclosporin 75 mg BID to 200 mg BID, 6 months	10 mg OD, 10 days	7.1-fold ↑
Atazanavir 300 mg/ritonavir 100 mg OD, 8 days	10 mg, single dose	3.1-fold ↑
Simeprevir 150 mg OD, 7 days*	10 mg, single dose	2.8-fold ↑
Lopinavir 400 mg/ritonavir 100 mg BID, 17 days	20 mg OD, 7 days	2.1-fold ↑
Clopidogrel 300 mg loading, followed by 75 mg at 24 hours	20 mg, single dose	2-fold ↑
Gemfibrozil 600 mg BID, 7 days	80 mg, single dose	1.9-fold ↑
Eltrombopag 75 mg OD, 5** days	10 mg, single dose	1.6-fold ↑
Darunavir 600 mg/ritonavir 100 mg BID, 7 days	10 mg OD, 7 days	1.5-fold ↑
Tipranavir 500 mg/ritonavir 200 mg BID, 11 days	10 mg, single dose	1.4-fold ↑
Dronedaron 400 mg BID	Not available	1.4-fold ↑
Itraconazole 200 mg OD, 5 days	10 mg or 80 mg, single dose	**1.4-fold ↑
Ezetimibe 10 mg OD, 14 days	10 mg, OD, 14 days	**1.2-fold ↑
Fosamprenavir 700 mg/ritonavir 100 mg BID, 8 days	10 mg, single dose	↔
Aleglitazar 0.3 mg, 7 days	40 mg, 7 days	↔
Silymarin 140 mg TID, 5 days	10 mg, single dose	↔
Fenofibrate 67 mg TID, 7 days	10 mg, 7 days	↔
Rifampin 450 mg OD, 7 days	20 mg, single dose	↔
Ketoconazole 200 mg BID, 7 days	80 mg, single dose	↔
Fluconazole 200 mg OD, 11 days	80 mg, single dose	↔
Erythromycin 500 mg QID, 7 days	80 mg, single dose	20***% ↓
Baicalin 50 mg TID, 14 days	20 mg, single dose	47% ↓

*Data given as x-fold change represent a simple ratio between co-administration and rosuvastatin alone. Data given as % change represent % difference relative to rosuvastatin alone.

Increase is indicated as “↑”, no change as “↔”, decrease as “↓”.

**Several interaction studies have been performed at different Crestor dosages, the table shows the most significant ratio

OD = once daily; BID = twice daily; TID = three times daily; QID = four times daily

4.6 Pregnancy and lactation

Crestor is contraindicated in pregnancy and lactation.

Women of child bearing potential should use appropriate contraceptive measures.

Since cholesterol and other products of cholesterol biosynthesis are essential for the development of the foetus, the potential risk from inhibition of HMG-CoA reductase outweighs the advantage of treatment during pregnancy. Animal studies provide limited evidence of reproductive toxicity (see Section 5.3 Preclinical safety data). If a patient becomes pregnant during use of this product, treatment should be discontinued immediately.

Rosuvastatin is excreted in the milk of rats. There are no data with respect to excretion in milk in humans. (see Section 4.3 Contraindications).

4.7 Effects on ability to drive and use machines

Studies to determine the effect of Crestor on the ability to drive and use machines have not been conducted. However, based on its pharmacodynamic properties, Crestor is unlikely to affect this ability. When driving vehicles or operating machines, it should be taken into account that dizziness may occur during treatment.

4.8 Undesirable effects

The adverse events seen with Crestor are generally mild and transient. In controlled clinical trials, less than 4% of Crestor-treated patients were withdrawn due to adverse events.

Tabulated list of adverse reactions

Based on data from clinical studies and extensive post-marketing experience, the following table presents the adverse reaction profile for rosuvastatin. Adverse reactions listed below are classified according to frequency and system organ class (SOC).

The frequencies of adverse events are ranked according to the following: Common ($\geq 1/100$ to $< 1/10$); Uncommon ($\geq 1/1000$ to $< 1/100$); Rare ($\geq 1/10,000$, $< 1/1000$); Very rare ($< 1/10,000$); Not known (cannot be estimated from the available data)

Table 2. Adverse reactions based on data from clinical studies and post-marketing experience

System organ class	Common	Uncommon	Rare	Very rare	Not known
<i>Blood and lymphatic system disorders</i>			Thrombocytopenia		
<i>Immune system disorders</i>			Hypersensitivity reactions including angioedema		
<i>Endocrine disorders</i>	Diabetes mellitus ¹				
<i>Psychiatric disorders</i>					Depression

<i>Nervous system disorders</i>	Headache Dizziness		Cognitive impairment: Confusion Memory loss Forgetfulness Amnesia Memory impairment	Polyneuropathy	Sleep disturbances (including insomnia and nightmares) Peripheral neuropathy
<i>Respiratory, thoracic and mediastinal disorders</i>					Cough Dyspnoea
<i>Gastrointestinal disorders</i>	Constipation Nausea Abdominal pain		Pancreatitis		Diarrhoea
<i>Hepatobiliary disorders</i>			Increased hepatic transaminases	Jaundice Hepatitis	
<i>Skin and subcutaneous tissue disorders</i>		Pruritis Rash Urticaria			Stevens-Johnson syndrome
<i>Musculoskeletal and connective tissue disorders</i>	Myalgia		Myopathy (including myositis) Rhabdomyolysis	Arthralgia	Tendon disorders, sometimes complicated by rupture Immune-mediated necrotising myopathy
<i>Renal and urinary disorders</i>				Haematuria	
<i>Reproductive system and breast disorders</i>				Gynaecomastia	
<i>General disorders and administration site conditions</i>	Asthenia				Oedema

¹ Frequency will depend on the presence or absence of risk factors (fasting blood glucose ≥ 5.6 mmol/L, BMI >30 kg/m², raised triglycerides, history of hypertension). Observed in the JUPITER study (reported overall frequency 2.8% in rosuvastatin and 2.3% in placebo). Primarily in patients already at high risk for developing diabetes (See Sections 4.4 and 5.1).

As with other HMG-CoA reductase inhibitors, the incidence of adverse drug reactions tends to be dose dependent.

Renal Effects: Proteinuria, detected by dipstick testing and mostly tubular in origin, has been observed in patients treated with Crestor. Shifts in urine protein from none or trace to ++ or more were seen in <1% of patients at some time during treatment with 10 and 20 mg, and in approximately 3% of patients treated with 40 mg. A minor increase in shift from none or trace to + was observed with the 20 mg dose. In most cases, proteinuria decreases or disappears spontaneously on continued therapy. Review of data from clinical trials and post-marketing experience to date has not identified a causal association between proteinuria and acute or progressive renal disease.

Haematuria has been observed in patients treated with Crestor and clinical trial data show that the occurrence is low.

Skeletal muscle effects: Effects on skeletal muscle e.g. myalgia, myopathy (including myositis), and rarely rhabdomyolysis, with and without acute renal failure have been reported in Crestor-treated patients with all doses and in particular with doses > 20 mg.

A dose-related increase in CK levels has been observed in patients taking rosuvastatin; the majority of cases were mild, asymptomatic and transient. If CK levels are elevated (>5xULN), treatment should be discontinued (see Section 4.4 Special warnings and special precautions for use).

Liver Effects: As with other HMG-CoA reductase inhibitors, a dose-related increase in transaminases has been observed in a small number of patients taking rosuvastatin; the majority of cases were mild, asymptomatic and transient.

Laboratory Effects: As with other HMG-CoA reductase inhibitors, a dose-related increase in liver transaminases and CK has been observed in a small number of patients taking rosuvastatin. Increases in HbA1c have also been observed in patients treated with rosuvastatin (See Section 5.1). Abnormal urinalysis testing (dipstick-positive proteinuria) has been seen in a small number of patients taking CRESTOR and other HMG-CoA reductase inhibitors. The protein detected was mostly tubular in origin. In most cases, proteinuria decreases or disappears spontaneously on continued therapy, and is not predictive of acute or progressive renal disease.

Other effects:

In a long-term controlled clinical trial CRESTOR was shown to have no harmful effects on the ocular lens. In CRESTOR treated patients, there was no impairment of adrenocortical function.

The following adverse events have been reported with some statins:

Sexual dysfunction.

Exceptional cases of interstitial lung disease, especially with long term therapy (see Section 4.4).

Tendon disorders, sometimes complicated by rupture.

The reporting rates for rhabdomyolysis, serious renal events and serious hepatic events (consisting mainly of increased hepatic transaminases) is higher at the 40 mg dose.

Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form

(<http://forms.gov.il/globaldata/getsequence/getsequence.aspx?formType=AdversEffectMedic@moh.health.gov.il>) or by email (adr@MOH.HEALTH.GOV.IL).

4.9 Overdose

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. Liver function and CK levels should be monitored. Haemodialysis is unlikely to be of benefit.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: HMG-CoA reductase inhibitors

ATC code: C10A A07

Mechanism of action

Rosuvastatin is a selective and competitive inhibitor of HMG-CoA reductase, the rate-limiting enzyme that converts 3-hydroxy-3-methylglutaryl coenzyme A to mevalonate, a precursor for cholesterol. The primary site of action of rosuvastatin is the liver, the target organ for cholesterol lowering.

Rosuvastatin increases the number of hepatic LDL receptors on the cell-surface, enhancing uptake and catabolism of LDL and it inhibits the hepatic synthesis of VLDL, thereby reducing the total number of VLDL and LDL particles.

Pharmacodynamic effects

Crestor reduces elevated LDL-cholesterol, total cholesterol and triglycerides and increases HDL-cholesterol. It also lowers ApoB, nonHDL-C, VLDL-C, VLDL-TG and increases ApoA-I (see Table 1). Crestor also lowers the LDL-C/HDL-C, total C/HDL-C and nonHDL-C/HDL-C and the ApoB/ApoA-I ratios.

Table 1 Dose response in patients with primary hypercholesterolaemia (type IIa and IIb) (adjusted mean percent change from baseline)

Dose	N	LDL-C	Total-C	HDL-C	TG	nonHDL-C	Apo B	ApoA-I
Placebo	13	-7	-5	3	-3	-7	-3	0
5	17	-45	-33	13	-35	-44	-38	4
10	17	-52	-36	14	-10	-48	-42	4
20	17	-55	-40	8	-23	-51	-46	5
40	18	-63	-46	10	-28	-60	-54	0

A therapeutic effect is obtained within 1 week following treatment initiation and 90% of maximum response is achieved in 2 weeks. The maximum response is usually achieved by 4 weeks and is maintained after that.

Clinical efficacy

Crestor is effective in adults with hypercholesterolaemia, with and without hypertriglyceridaemia, regardless of race, sex, or age and in special populations such as diabetics, or patients with familial hypercholesterolaemia.

From pooled phase III data, Crestor has been shown to be effective at treating the majority of patients with type IIa and IIb hypercholesterolaemia (mean baseline LDL-C about 4.8 mmol/l) to recognised European Atherosclerosis Society (EAS; 1998) guideline targets; about 80% of patients treated with 10 mg reached the EAS targets for LDL-C levels (<3 mmol/l).

In a large study, 435 patients with heterozygous familial hypercholesterolaemia were given Crestor from 20 mg to 80 mg in a force-titration design. All doses showed a beneficial effect on lipid parameters and treatment to target goals. Following titration to a daily dose of 40 mg (12 weeks of treatment), LDL-C was reduced by 53%. 33% of patients reached EAS guidelines for LDL-C levels (<3 mmol/l).

In a force-titration, open label trial, 42 patients with homozygous familial hypercholesterolaemia were evaluated for their response to Crestor 20 - 40 mg. In the overall population, the mean LDL-C reduction was 22%.

In clinical studies with a limited number of patients, Crestor has been shown to have additive efficacy in lowering triglycerides when used in combination with fenofibrate and in increasing HDL-C levels when used in combination with niacin (see Section 4.4 Special warnings and special precautions for use).

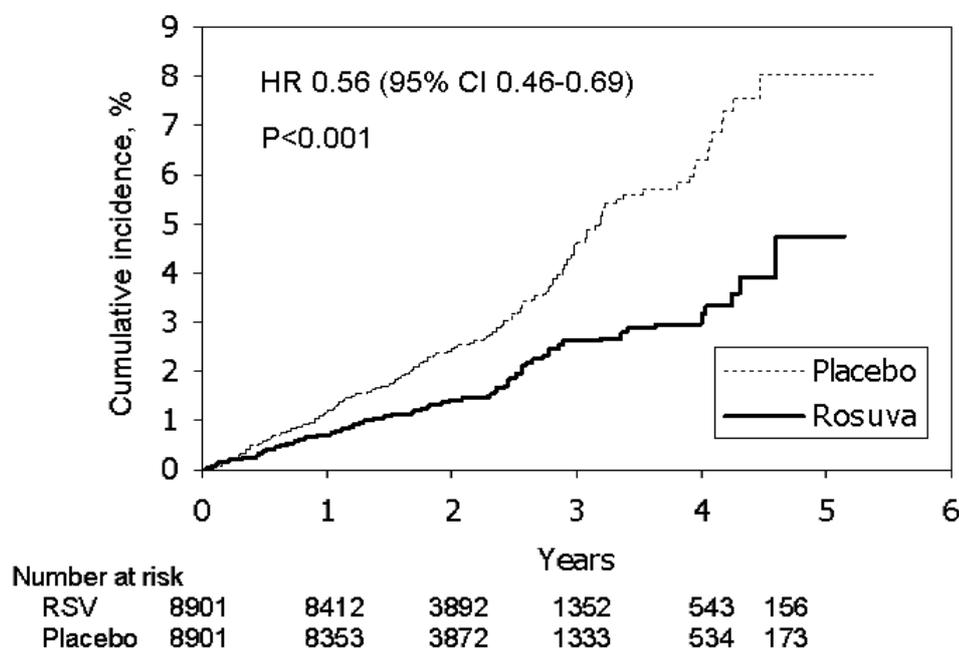
Rosuvastatin has not been proven to prevent the associated complications of lipid abnormalities, such as coronary heart disease as mortality and morbidity studies with Crestor have not yet been completed.

In a multi-centre, double-blind, placebo-controlled clinical study (METEOR), 984 patients between 45 and 70 years of age and at low risk for coronary heart disease (defined as Framingham risk <10% over 10 years), with a mean LDL-C of 4.0 mmol/l (154.5 mg/dL), but with subclinical atherosclerosis (detected by Carotid Intima Media Thickness) were randomised to 40 mg rosuvastatin once daily or placebo for 2 years. Rosuvastatin significantly slowed the rate of progression of the maximum CIMT for the 12 carotid artery sites compared to placebo by -0.0145 mm/year [95% confidence interval -0.0196, -0.0093; $p < 0.0001$]. The change from baseline was -0.0014 mm/year (-0.12%/year (non-significant)) for rosuvastatin compared to a progression of +0.0131 mm/year (1.12%/year ($p < 0.0001$)) for placebo. No direct correlation between CIMT decrease and reduction of the risk of cardiovascular events has yet been demonstrated. The population studied in METEOR is low risk for coronary heart disease and does not represent the target population of Crestor 40mg. The 40mg dose should only be prescribed in patients with severe hypercholesterolaemia at high cardiovascular risk (see Section 4.2).

In the **Justification for the Use of Statins in Primary Prevention: An Intervention Trial Evaluating Rosuvastatin (JUPITER)** study, the effect of CRESTOR (rosuvastatin calcium) on the occurrence of major atherosclerotic cardiovascular (CV) disease events was assessed in 17,802 men (≥ 50 years) and women (≥ 60 years) who had no established cardiovascular disease, LDL-C levels <130 mg/dL (3.3 mmol/l) and hs-CRP levels ≥ 2 mg/L. The study population had an estimated baseline coronary heart disease risk of 11.3% over 10 years based on the Framingham risk criteria and included a high percentage of patients with additional risk factors such as hypertension (58%), low HDL-C levels (23%), cigarette smoking (16%) or a family history of premature CHD (12%). Study participants were randomly assigned to placebo (n=8901) or rosuvastatin 20 mg once daily (n=8901) and were followed for a mean duration of 2 years. The JUPITER study was stopped early by the Data Safety Monitoring Board due to meeting predefined stopping rules for efficacy in rosuvastatin-treated subjects.

The primary end point was a composite end point consisting of the time-to-first occurrence of any of the following CV events: CV death, non-fatal myocardial infarction, non-fatal stroke, unstable angina or an arterial revascularization procedure.

Rosuvastatin significantly reduced the risk of CV events (252 events in the placebo group vs. 142 events in the rosuvastatin group) with a statistically significant ($p < 0.001$) relative risk reduction of 44% (see Figure 1). The risk reduction was consistent across multiple predefined population subsets based on assessments of age, sex, race, smoking status, family history of premature CHD, body mass index, LDL-C, HDL-C or hsCRP levels at the time of entry into the study.



The safety profile for subjects taking rosuvastatin 20 mg was generally similar to that of subjects taking placebo. There were 1.6% of rosuvastatin and 1.8% of placebo subjects who withdrew from the trial due to an adverse event, irrespective of treatment causality. The most common adverse reactions that led to treatment discontinuation were: myalgia (0.3% rosuvastatin, 0.2% placebo), abdominal pain (0.03% rosuvastatin, 0.02% placebo) and rash (0.03% rosuvastatin, 0.03% placebo). Adverse reactions reported in $\geq 2\%$ of patients and at a rate greater than or equal to placebo were myalgia (7.6% rosuvastatin, 6.6% placebo), constipation (3.3% rosuvastatin, 3.0% placebo) and nausea (2.4% rosuvastatin, placebo, 2.3%).

In JUPITER, there was a statistically significant increase in the frequency of diabetes mellitus reported by investigators; 2.8% of patients in the rosuvastatin group and 2.3% of patients in the placebo group (HR: 1.27, 95% CI: 1.05-1.53, $p=0.015$). The difference between treatment groups (rosuvastatin versus placebo) in mean HbA1c change from baseline was approximately 0.1%. A post hoc analysis of this study suggests that the risk of development of diabetes on rosuvastatin therapy is limited to patients already at high risk of developing diabetes. The cardiovascular and mortality benefits of rosuvastatin therapy exceeded the diabetes hazard in the trial population as a whole as well as in participants at increased risk of developing diabetes (see Sections 4.4 and 4.8).

5.2 Pharmacokinetic properties

Absorption: Maximum rosuvastatin plasma concentrations are achieved approximately 5 hours after oral administration. The absolute bioavailability is approximately 20%.

Distribution: Rosuvastatin is taken up extensively by the liver which is the primary site of cholesterol synthesis and LDL-C clearance. The volume of distribution of rosuvastatin is approximately 134 L. Approximately 90% of rosuvastatin is bound to plasma proteins, mainly to albumin.

Metabolism: Rosuvastatin undergoes limited metabolism (approximately 10%). *In vitro* metabolism studies using human hepatocytes indicate that rosuvastatin is a poor substrate for cytochrome P450-based metabolism. CYP2C9 was the principal isoenzyme involved, with 2C19, 3A4 and 2D6 involved to a lesser extent. The main metabolites identified are the N-desmethyl and lactone metabolites. The N-desmethyl metabolite is approximately 50% less active than rosuvastatin whereas the lactone form is considered clinically inactive. Rosuvastatin accounts for greater than 90% of the circulating HMG-CoA reductase inhibitor activity.

Excretion: Approximately 90% of the rosuvastatin dose is excreted unchanged in the faeces (consisting of absorbed and non-absorbed active substance) and the remaining part is excreted in urine. Approximately 5% is excreted unchanged in urine. The plasma elimination half-life is approximately 19 hours. The elimination half-life does not increase at higher doses. The geometric mean plasma clearance is approximately 50 litres/hour (coefficient of variation 21.7%). As with other HMG-CoA reductase inhibitors, the hepatic uptake of rosuvastatin involves the membrane transporter OATP-C. This transporter is important in the hepatic elimination of rosuvastatin.

Linearity: Systemic exposure of rosuvastatin increases in proportion to dose. There are no changes in pharmacokinetic parameters following multiple daily doses.

Special populations:

Age and sex: There was no clinically relevant effect of age or sex on the pharmacokinetics of rosuvastatin

Race: Pharmacokinetic studies show an approximate 2-fold elevation in median AUC and C_{max} in Asian subjects (Japanese, Chinese, Filipino, Vietnamese and Koreans) compared with Caucasians; Asian-Indians show an approximate 1.3-fold elevation in median AUC and C_{max} . A population pharmacokinetic analysis revealed no clinically relevant differences in pharmacokinetics between Caucasian and Black groups.

Renal insufficiency: In a study in subjects with varying degrees of renal impairment, mild to moderate renal disease had no influence on plasma concentration of rosuvastatin or the N-desmethyl metabolite. Subjects with severe impairment ($CrCl < 30$ ml/min) had a 3-fold increase in plasma concentration and a 9-fold increase in the N-desmethyl metabolite concentration compared to healthy volunteers. Steady-state plasma concentrations of rosuvastatin in subjects undergoing haemodialysis were approximately 50% greater compared to healthy volunteers.

Hepatic insufficiency: In a study with subjects with varying degrees of hepatic impairment there was no evidence of increased exposure to rosuvastatin in subjects with Child-Pugh scores of 7 or below. However, two subjects with Child-Pugh scores of 8 and 9 showed an increase in systemic exposure of at least 2-fold compared to subjects with lower Child-Pugh scores. There is no experience in subjects with Child-Pugh scores above 9.

Genetic polymorphisms: Disposition of HMG-CoA reductase inhibitors, including rosuvastatin, involves OATP1B1 and BCRP transporter proteins. In patients with SLCO1B1 (OATP1B1) and/or ABCG2 (BCRP) genetic polymorphisms there is a risk of increased rosuvastatin exposure. Individual polymorphisms of SLCO1B1 c.521CC and ABCG2 c.421AA are associated with a higher rosuvastatin exposure (AUC) compared to the SLCO1B1 c.521TT or ABCG2 c.421CC genotypes. This specific genotyping is not established in clinical practice, but for patients who are known to have these types of polymorphisms, a lower daily dose of Crestor is recommended.

5.3 Preclinical safety data

Preclinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity and carcinogenicity potential. Specific tests for effects on hERG have not been evaluated. Adverse reactions not observed in clinical studies, but seen in animals at exposure levels similar to clinical exposure levels were as follows: In repeated-dose toxicity studies histopathologic liver changes likely due to the pharmacologic action of rosuvastatin were observed in mouse, rat, and to a lesser extent with effects in the gall bladder in dogs, but not in monkeys. In addition, testicular toxicity was observed in monkeys and dogs at higher dosages. Reproductive toxicity was evident in rats, with reduced litter sizes, litter weight and pup survival observed at maternally toxic doses, where systemic exposures were several times above the therapeutic exposure level.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Lactose monohydrate

Microcrystalline cellulose

Calcium phosphate

Crospovidone

Magnesium stearate

Tablet coat

Lactose monohydrate

Hypromellose

Glycerol triacetate

Titanium dioxide (E171)

Ferric oxide, yellow (E172) (5 mg tablet)

Ferric oxide, red (E172) (10 mg, 20 mg, and 40 mg tablets)

6.2 Incompatibilities

Not applicable.

6.3 shelf life

3 years.

6.4 Special precautions for storage

Blisters: Do not store above 30°C. Store in the original package

6.5 Nature and content of container

Blisters of aluminium laminate/aluminium foil of 28 tablets.

6.6 Instructions for use and handling

No special requirements.

7 DRUG REGISTRATION NUMBER

Crestor 5 mg: 139 22 31615 00

Crestor 10 mg: 129 74 30798 00

Crestor 20 mg: 129 75 30799 00

Crestor 40 mg: 129 76 30800 00

8 MANUFACTURER

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9 LICENSE HOLDER

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