

PRODUCT INFORMATION

Tablets

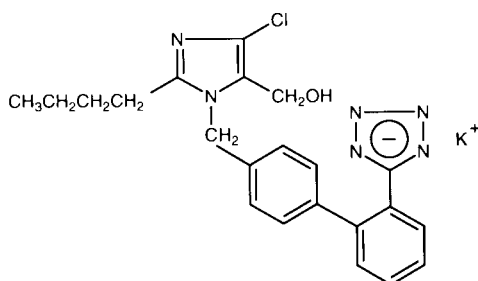
COZAAR®

(losartan potassium)

NAME OF THE MEDICINE

Losartan potassium, a non-peptide molecule, is chemically described as 2-butyl-4-chloro-1-[[2'-(1H-tetrazol-5-yl)[1,1'-biphenyl]-4-yl]methyl]-1H-imidazole-5-methanol monopotassium salt.

Its empirical formula is $C_{22}H_{22}ClKN_6O$, and its structural formula is:



The CAS No is 124750-99-8.

DESCRIPTION

COZAAR® (losartan potassium) is the first non-peptide orally active angiotensin II receptor (type AT_1) antagonist to be used for the treatment of hypertension. COZAAR also provides a reduction in the risk of stroke in hypertensive patients with left ventricular hypertrophy and renal protection for type 2 diabetic patients with proteinuria.

Losartan potassium is a white to off-white free-flowing crystalline powder with a molecular weight of 461.01. It is freely soluble in water, soluble in alcohols, and slightly soluble in common organic solvents, such as acetonitrile and methyl ethyl ketone.

Oxidation of the 5-hydroxymethyl group on the imidazole ring results in the active metabolite of losartan.

Composition

Each tablet of COZAAR contains the following inactive ingredients: microcrystalline cellulose, lactose monohydrate, starch - pregelatinised maize, magnesium stearate, hypollose, hypromellose, titanium dioxide and carnauba wax.

COZAAR 50 mg tablets contain 4.24 mg (0.108 mEq) of potassium.

Pharmacodynamic properties

Losartan is an oral angiotensin II receptor (type AT₁) antagonist. Angiotensin II binds to the AT₁ receptor found in many tissues (e.g. vascular smooth muscle, adrenal gland, kidneys and the heart) and elicits several important biological actions, including vasoconstriction and the release of aldosterone. Angiotensin II also stimulates smooth muscle cell proliferation. Based on binding and pharmacological bioassays, losartan binds selectively to the AT₁ receptor. There is also an AT₂ receptor found in many tissues. The functions of AT₂ receptors have not been established. In vitro and in vivo, both losartan and its pharmacologically active carboxylic acid metabolite (E-3174) block all physiologically relevant actions of angiotensin II, regardless of the source or route of synthesis. The active metabolite is 10 to 40 times more potent by weight than losartan and appears to be a reversible, non-competitive inhibitor of the AT₁ receptor.

During losartan administration, removal of angiotensin II negative feedback on renin secretion leads to increased plasma renin activity. Increases in plasma renin activity lead to increases in angiotensin II in plasma. Even with these increases, antihypertensive activity and suppression of plasma aldosterone concentration are maintained, indicating effective angiotensin II receptor blockade.

Losartan binds selectively to the AT₁ receptor and does not bind to or block other hormone receptors or ion channels important in cardiovascular regulation. Furthermore, losartan does not inhibit ACE (kininase II), the enzyme that degrades bradykinin. Consequently, effects not directly related to blocking the AT₁ receptor, such as the potentiation of bradykinin-mediated effects or the generation of oedema (losartan 1.7%, placebo 1.9%), are not associated with losartan.

Losartan has been shown to block responses to angiotensin I and angiotensin II without affecting responses to bradykinin, a finding which is consistent with the specific mechanism of action of losartan. In contrast, ACE inhibitors have been shown to block responses to angiotensin I and enhance responses to bradykinin without altering the response to angiotensin II, thus providing a pharmacodynamic distinction between losartan and ACE inhibitors.

In a study specifically designed to assess the incidence of cough in patients treated with COZAAR as compared to patients treated with ACE inhibitors the incidence of cough reported by patients receiving COZAAR or hydrochlorothiazide was similar and was significantly less than in patients treated with an ACE inhibitor. In addition, in an overall analysis of 16 double-blind clinical trials in 4131 patients, the incidence of spontaneously reported cough in patients treated with COZAAR was similar (3.1%) to that of patients treated with placebo (2.6%) or hydrochlorothiazide (4.1%), whereas the incidence with ACE inhibitors was 8.8%.

In non diabetic hypertensive patients with proteinuria, the administration of losartan potassium significantly reduces proteinuria, fractional excretion of albumin and IgG. Losartan maintains glomerular filtration rate and reduces filtration fraction. The mechanism of action of the uricosuric effect of losartan studied in normotensive subjects appears to be independent of angiotensin II blockade. Generally, in clinical trials, losartan caused a decrease in serum uric acid (usually 0.4mg/dL) which was persistent in chronic therapy.

Losartan has no effect on autonomic reflexes and no sustained effect on plasma noradrenaline.

Losartan potassium, administered in doses of up to 150mg once daily, did not cause clinically important changes in fasting triglycerides, total cholesterol in patients with hypertension. The same doses of losartan had no effect on fasting glucose levels.

In patients with left ventricular failure, 25-mg and 50-mg doses of losartan produced positive haemodynamic and neurohormonal effects characterised by an increase in cardiac index and decreases in pulmonary capillary wedge pressure, systemic vascular resistance, mean systemic arterial pressure and heart rate and a reduction in circulating levels of aldosterone and noradrenaline. The occurrence of hypotension was dose related in these heart failure patients.

The antihypertensive efficacy of COZAAR was demonstrated in randomised, double-blind, placebo controlled and comparator studies over a 12 week period and in an open-label extension study for over 12 months.

Once-daily administration of COZAAR to patients with mild to moderate essential hypertension produced statistically significant reductions in systolic and diastolic blood pressure; the antihypertensive effect was maintained in clinical studies for up to one year. Measurement of blood pressure at trough (24 hours postdose) relative to peak (5-6 hours postdose) demonstrated relatively smooth blood pressure reduction over 24 hours. The antihypertensive effect paralleled the natural diurnal rhythms. Blood pressure reduction at the end of the dosing interval was approximately 70-80% of the effect seen 5-6 hours postdose. Discontinuation of losartan in hypertensive patients did not result in an abrupt rebound of blood pressure. Despite the significant decrease in blood pressure, administration of COZAAR has no clinically significant effect on heart rate. The mechanism involved in the lack of reflex tachycardia is not clearly established.

The antihypertensive effect of COZAAR 50mg is similar to once-daily administration of enalapril 20mg. The antihypertensive effect of once-daily administration of COZAAR 50-100mg is comparable to once-daily administration of atenolol 50-100mg. The effect of administration of COZAAR 50-100mg once daily also is equivalent to felodipine extended-release 5-10mg in older hypertensives (> 65 years) after 12 weeks of therapy.

COZAAR is equally effective in males and females and in younger (<65 years) and older (>65 years) hypertensives. Plasma concentrations of losartan were about twice as high in female hypertensives as male hypertensives, but concentrations of the active metabolite were similar in males and females. Although COZAAR is antihypertensive in all races, as with other drugs that affect the renin-angiotensin system, black hypertensive patients have a smaller average response to losartan monotherapy than non black patients. Pharmacokinetic differences due to race have not been studied.

When given together with thiazide-type diuretics, the blood pressure lowering effects of COZAAR are approximately additive.

Data are currently not available to assess the long-term beneficial effect on morbidity and mortality in patients taking angiotensin II receptor antagonists.

Pharmacokinetic properties

Absorption

Following oral administration, losartan is well absorbed and undergoes first-pass metabolism, forming an active carboxylic acid metabolite and other inactive metabolites. The active carboxylic metabolite is responsible for most of the angiotensin II receptor antagonism.

The systemic bioavailability of losartan tablets is approximately 33%. Mean peak concentrations of losartan and its active metabolite are reached in 1 hour and in 3-4 hours, respectively. While maximum plasma concentrations of losartan and its active metabolite are approximately equal, the AUC of the metabolite is about 4 times as great as that of losartan. Food slows the absorption of losartan and leads to slightly decreased levels of losartan (AUC about 18% decreased) and the active metabolite (AUC about 13% decreased). However, in each case the changes were small and there was no clinically significant effect on the plasma concentration profile of losartan.

Distribution

Both losartan and its active metabolite are >99% bound to plasma proteins, primarily albumin. The volume of distribution of losartan is 34 litres. Studies in rats indicate that losartan crosses the blood-brain barrier poorly, if at all.

The volume of distribution of losartan is about 34 litres and of the active metabolite is about 12 litres.

Metabolism

Losartan undergoes substantial first-pass metabolism by cytochrome P450.

About 14% of an intravenously- or orally-administered dose of losartan is converted to its active metabolite. Following oral and intravenous administration of ¹⁴C-labelled losartan potassium, circulating plasma radioactivity primarily is attributed to losartan and its active metabolite. In vitro studies indicate that cytochrome P450 2C9 and 3A4 are involved in the biotransformation of losartan to its metabolites. Minimal conversion of losartan to its active metabolite was seen in about one percent of individuals studied.

In addition to the active metabolite, inactive metabolites are formed, including two major metabolites formed by hydroxylation of the butyl side chain and a minor metabolite, an N-2 tetrazole glucuronide.

Elimination

Plasma clearance of losartan and its active metabolite is about 600 mL/min and 50mL/min, respectively. Renal clearance of losartan and its active metabolite is about 74mL/min and 26mL/min, respectively. When losartan is administered orally, about 4% of the dose is excreted unchanged in the urine, and about 6% of the dose is excreted in the urine as active metabolite. The pharmacokinetics of losartan and its active metabolite are linear with oral losartan potassium doses up to 200 mg.

Following oral administration, plasma concentrations of losartan and its active metabolites decline polyexponentially with a terminal half-life of about 2 hours and 6-9 hours, respectively. During once-daily dosing with 100 mg, neither losartan nor its active metabolite accumulates significantly in plasma.

Both biliary and urinary excretion contribute to the elimination of losartan and its metabolites. Following an oral dose of ¹⁴C-labelled losartan in man, about 35% of radioactivity is recovered in the urine and 58% in the faeces.

Characteristics in Patients

Plasma concentrations of losartan are not altered in patients with creatinine clearance above 30 mL/min. In patients with lower creatinine clearance, AUC's are about 50% greater and they are doubled in haemodialysis patients.

Plasma concentrations of the active metabolite are not significantly altered in patients with renal impairment or in haemodialysis patients. No dosage adjustment is necessary for patients with renal impairment unless they are volume depleted.

Following oral administration in patients with mild to moderate alcoholic cirrhosis of the liver, plasma concentrations of losartan and its active metabolite were, respectively, 5-fold and 1.7-fold greater than those seen in young male volunteers.

Neither losartan nor the active metabolite can be removed by haemodialysis.

CLINICAL TRIALS

LIFE Study

The Losartan Intervention For Endpoint reduction in hypertension (LIFE) study was a large, multicenter, multinational, randomised, triple-blind, active-controlled study conducted in 9193 hypertensive patients aged 55 to 80 years (mean 67 years) with ECG-documented left ventricular hypertrophy. Of the patients enrolled at baseline, 1195 (13%) had diabetes; 1326 (14%), isolated systolic hypertension; 1468 (17%), coronary heart disease; and 728 (8%), cerebrovascular disease. The goal of the study was to demonstrate the cardiovascular protective effects of COZAAR versus atenolol, over and above the benefits of blood pressure control alone (blood pressure was measured at trough). To meet this objective, the study was designed to achieve equal blood pressure in both treatment groups. Patients were randomised to receive once daily COZAAR 50 mg or atenolol 50 mg. If goal blood pressure (<140/90 mmHg) was not reached, hydrochlorothiazide (12.5 mg) was added first and, if needed, the dose of COZAAR or atenolol was then increased to 100 mg once daily. If necessary, other antihypertensive treatments (e.g., increase in dose of hydrochlorothiazide therapy to 25 mg or addition of other diuretic therapy, calcium channel blockers, alpha-blockers, or centrally acting agents, but not ACE inhibitors, angiotensin II antagonists, or beta-blockers) were added to the treatment regimen to reach the goal blood pressure.

In both treatment groups, blood pressure was significantly lowered to similar levels and a similar proportion of patients achieved goal blood pressure. The mean length of follow up was 4.8 years.

The primary endpoint was the composite of cardiovascular morbidity and mortality as measured by a reduction in the combined incidence of cardiovascular death, stroke and myocardial infarction. In this trial 5% of the patients treated with Cozaar suffered stroke compared to 7% of patients treated with atenolol, a reduction of 25% in the relative risk of stroke compared to atenolol (see table 1). The effect of Cozaar on stroke appeared to be over and above its beneficial effects on blood pressure control alone. The rates of cardiovascular death and myocardial infarction were not significantly different between the treatment groups. Although the results showed that treatment with Cozaar resulted in a 13% risk reduction as compared with atenolol for patients reaching the primary composite endpoint this effect was largely driven by a reduction in the risk on stroke.

Outcome	TABLE 1 STROKE RESULTS					
	COZAAR (N=4605) n (%)	Rate*	Atenolol (N=4588) n (%)	Rate*	Risk Reduction**	p-value
Stroke	5%	10.8	7%	14.5	25%	0.001

*Per 1000 patient-years of follow up;

**Adjusted for baseline Framingham risk score and ECG measure of LVH

The difference in the incidence of stroke in patients treated with COZAAR and atenolol amounts to 1 additional stroke prevented for every 53 patients treated with COZAAR for 5 years. The reduction in the incidence of stroke does not replace the need to adequately titrate patients to adequate blood pressure control.

The effects of COZAAR versus atenolol on cardiovascular morbidity and mortality were examined in subgroups of patients with a baseline history of diabetes mellitus (n=1195) or isolated systolic hypertension (ISH) (n=1326). For the primary composite endpoint, the results seen in these subgroups were consistent with the benefit of therapy with COZAAR seen in the overall study population: in diabetic patients, a 24% risk reduction (p=0.03) was observed and in patients with isolated systolic hypertension, a 25% risk reduction (p=0.06) was observed. Consistent with the results seen in the overall population, a reduction in stroke was an important contributor to the benefit observed in patients with diabetes or ISH.

Outcome	TABLE 2 STROKE EVENTS WITHIN DEMOGRAPHIC SUBGROUPS					
	COZAAR n/N (%)	Rate*	Atenolol n/N (%)	Rate*	Risk Reduction**	p-value
Diabetes	51/586 (8.7%)	19.0	65/609 (10.7%)	24.5	21.2%	0.20
ISH	32/660 (4.8%)	10.6	56/666 (8.4%)	18.9	40.5%	0.020

*Per 1000 patient-years of follow up;

**Adjusted for baseline Framingham risk score and ECG measure of LVH

Race: Based on the LIFE study, the benefits of COZAAR on cardiovascular morbidity and mortality compared to atenolol do not apply to Black patients with hypertension and left ventricular hypertrophy although both treatment regimens effectively lowered blood pressure in Black patients. In the LIFE study, COZAAR decreased the risk of cardiovascular morbidity and mortality compared to atenolol in non-Black, hypertensive patients with left ventricular hypertrophy (n=8660) as measured by the primary endpoint of the combined incidence of cardiovascular death, stroke, and myocardial infarction (p=0.003). In this study, however, Black patients treated with atenolol were at lower risk of experiencing the primary composite endpoint compared with Black patients treated with COZAAR (p=0.03). In the subgroup of Black patients (n=533; 6% of the LIFE study patients), there were 29 primary endpoints among 263 patients on atenolol (11%, 25.9 per 1000 patient-years) and 46 primary endpoints among 270 patients (17%, 41.8 per 1000 patient-years) on COZAAR.

RENAAL Study

The Reduction of Endpoints in NIDDM with the Angiotensin II Receptor Antagonist Losartan (RENAAL) study was a large, multicenter, randomised, placebo-controlled, double-blind study conducted world-wide in 1513 type 2 diabetic patients with proteinuria¹ (751 treated with COZAAR), with or without hypertension. The goal of the study was to demonstrate the renal protective effects of COZAAR over and above the benefits of blood pressure control alone. To meet this objective the study was designed to achieve equal blood pressure control in both treatment groups. Patients with proteinuria and serum creatinine of 1.3-3.0 mg/dL² (115-265 µmol/L) were randomised to receive COZAAR 50 mg once daily titrated according to blood pressure response, or placebo, on a background of conventional antihypertensive therapy excluding ACE inhibitors and angiotensin II antagonists. Investigators were instructed to titrate study drug to 100 mg once daily as appropriate; 72% of patients were taking the 100 mg daily dose the majority of the time they were on study drug. Other antihypertensive agents (diuretics, calcium-channel blockers, alpha- or beta-blockers, and centrally acting agents) could be added as needed in both groups. Patients were followed for up to 4.6 years (mean of 3.4 years).

¹ Assessed by a urinary albumin to creatinine ratio in 2 of 3 morning voids of greater than or equal to 300mg/g

² Male patients over 60kg were only enrolled if serum creatinine was > 1.5 mg/dl (>133 µmol/L)

The primary endpoint of the study was the composite endpoint of doubling of serum creatinine, end-stage renal disease (need for dialysis or transplantation), or death. For patients reaching the primary composite endpoint the results showed that treatment with COZAAR as compared with placebo resulted in a reduction in the relative risk of 16.1% . For the following individual and combined components of the primary endpoint, the results also showed significant risk reduction in the group treated with COZAAR a reduction in the relative risk of 25.3% in doubling of serum creatinine; a reduction in the relative risk of 28.6% in end-stage renal disease; a reduction in the relative risk of 19.9% in end-stage renal disease or death; a reduction in the relative risk of 21.0% in doubling serum creatinine or end-stage renal disease (see Table 3).

Table 3 Incidence of Primary Endpoint Events

Primary Composite Endpoint	Incidence		Risk Reduction	95% C.I.	p-Value
	Losartan (n=751)	Placebo (n=762)			
Primary Composite Endpoint	43.5%	47.1%	16.1%	2.3% to 27.9%	0.022
Doubling of Serum Creatinine	21.6%	26.0%	25.3%	7.8% to 39.4%	0.006
ESRD	19.6%	25.5%	28.6%	11.5% to 42.4%	0.002
ESRD or death	255/751 (34.0%)	300/762 (39.4%)	19.9%	5.3% to 32.3%	0.009
Doubling of sCr or ESRD	226/751 (30.1%)	263/762 (34.5%)	21.0%	5.6%, 33.9%	0.010

There was no significant difference observed in the rate of death among patients treated with COZAAR (21%) compared to those on placebo (20.3%). There was no significant difference observed in the incidence of cardiovascular mortality and morbidity between patients treated with COZAAR and those who received placebo (p=0.253).

The secondary endpoints of the study were: change in proteinuria; the rate of progression of renal disease; and the composite of morbidity and mortality from cardiovascular causes (hospitalisation for heart failure, myocardial infarction, revascularisation, stroke, hospitalisation for unstable angina, or cardiovascular death). The results showed an average reduction of 34.3% in the level of proteinuria in the group treated with COZAAR (p<0.001). Treatment with COZAAR reduced the rate of decline in renal function during the chronic phase of the study by 13.9%, p=0.003 (median rate of decline of 18.5%, p=0.01) as measured by the reciprocal of the serum creatinine.

In this study, COZAAR was generally well tolerated as evidenced by a similar incidence of discontinuations due to side effects compared to placebo.

There was a significant reduction in the mean number of end stage renal disease [ESRD] days with COZAAR treatment over 3.5 years [33.6 less ESRD days with COZAAR treatment, (-56.3, -10.9, 95% Confidence Interval)]. It is estimated that one case of ESRD would be prevented for every 16 patients that are treated with COZAAR over a 3.5 year period.

INDICATIONS

Hypertension

COZAAR is indicated for the treatment of hypertension.

It may be used alone or in combination with other antihypertensive agents (eg. thiazide diuretics).

Renal Protection in Type 2 Diabetic Patients with Proteinuria

COZAAR is indicated to delay the progression of renal disease in hypertensive type 2 diabetics with proteinuria, defined as urinary albumin to creatinine ratio ≥ 300 mg/g.

CONTRAINDICATIONS

COZAAR is contraindicated in pregnant women and in patients who are hypersensitive to any component of this product.

COZAAR should not be administered with aliskiren in patients with diabetes (see INTERACTIONS WITH OTHER MEDICINES).

PRECAUTIONS

Fetal Toxicity

Use of drugs that act on the renin-angiotensin system during the second and third trimesters of pregnancy reduces fetal renal function and increases fetal and neonatal morbidity and death. Resulting oligohydramnios can be associated with fetal lung hypoplasia and skeletal deformations. Potential neonatal adverse effects include skull hypoplasia, anuria, hypotension, renal failure, and death. When pregnancy is detected, discontinue COZAAR as soon as possible. See Use in Pregnancy.

Hypersensitivity: Angioedema (see ADVERSE EFFECTS).

Intravascular Volume Depletion

In patients who are intravascularly volume-depleted (e.g., those treated with high-dose diuretics), symptomatic hypotension may occur. These conditions should be corrected prior to administration of COZAAR, or a lower starting dose should be used (see DOSAGE AND ADMINISTRATION).

Hepatic Impairment

Based on pharmacokinetic data which demonstrate significantly increased plasma concentrations of losartan in cirrhotic patients, a lower dose should be considered for patients with a history of hepatic impairment (see DOSAGE AND ADMINISTRATION and, and CLINICAL PHARMACOLOGY, *Pharmacokinetics*).

Impaired Renal Function

As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function including renal failure have been reported in susceptible individuals. In patients whose renal function may depend on the activity of the renin-aldosterone system (e.g., patients with severe congestive heart failure), treatment with angiotensin converting enzyme inhibitors has been associated with oliguria and/or progressive azotemia and

(rarely) with acute renal failure and/or death. Angiotensin II receptor antagonists would be expected to behave similarly.

Other drugs that affect the renin-angiotensin system may increase blood urea and serum creatinine in patients with bilateral renal artery stenosis or stenosis of the artery to a solitary kidney. Similar effects have been reported with COZAAR.

Use in Pregnancy (Category D)

Drugs that act directly on the renin-angiotensin system can cause injury, and death to the developing fetus when administered to pregnant women. Several dozen cases have been reported in the world literature in patients who were taking angiotensin converting enzyme inhibitors. When pregnancy is detected, discontinue COZAAR as soon as possible.

The use of drugs that act directly on the renin-angiotensin system during the second and third trimesters of pregnancy reduces fetal renal function and increases fetal and neonatal morbidity and death. Potential neonatal adverse effects include hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased foetal renal function; oligohydramnios in this setting has been associated with skeletal deformations, foetal limb contractures, craniofacial deformation, fetal lung hypoplasia and hypoplastic lung development. Prematurity, intrauterine growth retardation and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to exposure to the drug. When pregnancy is detected, discontinue COZAAR as soon as possible.

These adverse effects do not appear to have resulted from intrauterine drug exposure that has been limited to the first trimester. Mothers whose embryos and foetuses are exposed to an angiotensin II receptor antagonist only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should have the patient discontinue the use of COZAAR as soon as possible.

These adverse outcomes are usually associated with the use of these drugs in the second and third trimesters of pregnancy. Most epidemiologic studies examining fetal abnormalities after exposure to antihypertensive use in the first trimester have not distinguished drugs affecting the renin-angiotensin system from other antihypertensive agents. Appropriate management of maternal hypertension during pregnancy is important to optimize outcomes for both mother and fetus. Although there is no experience with the use of COZAAR in pregnant women, animal studies with losartan potassium have demonstrated foetal and neonatal injury and death, the mechanism of which is believed to be pharmacologically mediated through effects on the renin-angiotensin system. In humans, foetal renal perfusion, which is dependent upon the development of the renin-angiotensin system, begins in the second trimester; thus, risk to the foetus increases if COZAAR is administered during the second or third trimesters of pregnancy.

Neonates with a history of *in utero* exposure to COZAAR:

Infants with histories of in utero exposure to an angiotensin II receptor antagonist should be closely observed for hypotension, oliguria and hyperkalaemia.

If oliguria or hypotension occur, direct attention toward support of blood pressure and renal perfusion. Exchange transfusions or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function.

Use in Lactation

It is not known whether losartan is excreted in human milk, but studies in rats indicate that both losartan and its active carboxylic acid metabolite are excreted in milk. Many drugs are excreted in human milk and because of the potential for adverse effects on the

nursing infant, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Paediatric use

Safety and effectiveness in children have not been established.

Use in elderly

In clinical studies there was no age-related difference in the efficacy or safety profile of losartan.

Mutagenesis, Carcinogenesis and Impairment of Fertility

In animal studies, there was no evidence of carcinogenic activity when losartan potassium was administered orally to mice at doses up to 200 mg/kg/day for 92 weeks, or to rats at doses up to 270 mg/kg/day for 105 weeks. No evidence of genotoxic activity was observed in assays for DNA damage, gene mutations and chromosomal damage. Repeat-dose studies in animals did not show any evidence of toxic effect on the reproductive system, and no adverse effects on fertility were observed in male or female rats at oral doses of losartan potassium up to 150-200 mg/kg/day.

INTERACTIONS WITH OTHER MEDICINES

No drug interactions of clinical significance have been identified. Compounds which have been studied in clinical pharmacokinetic trials include digoxin, warfarin, cimetidine and phenobarbitone and ketoconazole. Rifampicin and fluconazole have been reported to reduce levels of active metabolite. Clinical studies have shown that concomitant use of losartan and hydrochlorothiazide may lead to potentiation of the antihypertensive effects.

As with other drugs that block angiotensin II or its effect, concomitant use of potassium-sparing diuretics (eg, spironolactone, triamterene, amiloride), potassium supplements or salt substitutes containing potassium may lead to increases in serum potassium.

As with other drugs which affect the excretion of sodium, lithium excretion may be reduced. Therefore, serum lithium levels should be monitored carefully if lithium salts are to be co-administered with angiotensin II receptor antagonists.

The antihypertensive effect of losartan may be attenuated by the non-steroidal anti-inflammatory drug indomethacin.

Non-steroidal anti-inflammatory drugs (NSAIDs) including selective cyclooxygenase-2 inhibitors (COX-2 inhibitors) may reduce the effect of diuretics and other antihypertensive drugs. Therefore, the antihypertensive effect of angiotensin II receptor antagonists or ACE inhibitors may be attenuated by NSAIDs including selective COX-2 inhibitors.

In some patients with compromised renal function (e.g., elderly patients or patients who are volume-depleted, including those on diuretic therapy) who are being treated with non-steroidal anti-inflammatory drugs, including selective cyclooxygenase-2 inhibitors, the co-administration of angiotensin II receptor antagonists or ACE inhibitors may result in a further deterioration of renal function including possible acute renal failure which is usually reversible. Therefore, the combination should be administered with caution in patients with compromised renal function.

These interactions should be considered in patients taking NSAIDs including selective COX-2 inhibitors concomitantly with diuretics and angiotensin II antagonists. Therefore, the combination should be administered with caution, especially in the elderly.

Combination use of ACE inhibitors or angiotensin receptor antagonists, anti-inflammatory drugs and thiazide diuretics

The use of an ACE inhibiting drug (ACE-inhibitor or angiotensin receptor antagonist), an anti-inflammatory drug (NSAID or COX-2 inhibitor) and a thiazide diuretic at the same time increases the risk of renal impairment. This includes use in fixed-combination products containing more than one class of drug. Combined use of these medications should be accompanied by increased monitoring of serum creatinine, particularly at the institution of the combination. The combination of drugs from these three classes should be used with caution particularly in elderly patients or those with pre-existing renal impairment.

Dual blockade of the renin-angiotensin-aldosterone system (RAAS) with angiotensin receptor blockers, ACE inhibitors, or aliskiren is associated with increased risks of hypotension, syncope, hyperkalemia, and changes in renal function (including acute renal failure) compared to monotherapy. Closely monitor blood pressure, renal function, and electrolytes in patients on COZAAR and other agents that affect the RAAS. Do not co-administer aliskiren with COZAAR in patients with diabetes. Avoid use of aliskiren with COZAAR in patients with renal impairment (GFR <60 ml/min).

ADVERSE EFFECTS

COZAAR has been evaluated for safety in more than 3300 patients treated for essential hypertension and 4058 patients overall. Over 1200 patients were treated for over 6 months and more than 800 for over one year. In general, treatment with COZAAR was well tolerated. The overall incidence of adverse experiences reported with COZAAR was comparable to placebo. For the most part, adverse experiences have been mild and transient in nature and have not required discontinuation of therapy. In controlled clinical trials, discontinuation of therapy due to clinical adverse experiences was required in only 2.3% and 3.7% of patients treated with COZAAR and placebo, respectively.

In controlled clinical trials for essential hypertension, dizziness was the only adverse experience reported as drug-related that occurred with an incidence greater than placebo in one percent or more of patients treated with COZAAR. In addition, dose-related orthostatic effects were seen in less than one percent of patients. Rarely, rash was reported, although the incidence in controlled clinical trials was less than placebo.

The following table of adverse events is based on four 6-12 week placebo controlled trials involving over 1000 patients on various doses (10-150 mg) of losartan and over 300 patients given placebo. All doses of losartan are grouped because none of the adverse events appeared to have a dose-related frequency. The table includes all adverse events, whether or not attributed to the treatment, occurring in at least 1% of patients treated with losartan and that were more frequent on losartan than placebo.

	Losartan (n=1075) Incidence	Placebo (n=334) Incidence
Digestive		
Diarrhoea	2.4	2.1
Dyspepsia	1.3	1.2
Musculoskeletal		
Cramp, muscle	1.1	0.3
Myalgia	1.0	0.9
Pain, back	1.8	1.2
Pain, leg	1.0	0.0
Nervous System/Psychiatric		
Dizziness	3.5	2.1
Insomnia	1.4	0.6
Respiratory		
Congestion, nasal	2.0	1.2
Cough	3.4	3.3
Infection, upper respiratory	7.9	6.9
Sinus disorder	1.5	1.2
Sinusitis	1.0	0.3

The following adverse events were also reported at a rate of 1% or greater in patients treated with losartan, but were as, or more frequent, in the placebo group: asthenia/fatigue, oedema/swelling, abdominal pain, chest pain, nausea, headache, pharyngitis.

Adverse events occurred at about the same rates in men and women, older and younger patients, and black and non-black patients.

A patient with known hypersensitivity to aspirin and penicillin, when treated with COZAAR, was withdrawn from study due to swelling of the lips and eyelids and facial rash, reported as angioedema, which returned to normal 5 days after therapy was discontinued.

Superficial peeling of palms and haemolysis was reported in one subject.

In addition to the adverse events above, potentially important events that occurred in at least two patients/subjects exposed to losartan or other adverse events that occurred in <1% of patients in clinical studies are listed below. It cannot be determined whether these events were causally related to losartan:

Body as a Whole: facial oedema, fever, orthostatic effects, syncope;

Cardiovascular: angina pectoris, second degree AV block, CVA, hypotension, myocardial infarction, arrhythmias including atrial fibrillation, palpitation, sinus bradycardia, tachycardia, ventricular tachycardia, ventricular fibrillation;

Digestive: anorexia, constipation, dental pain, dry mouth, flatulence, gastritis, vomiting;

Hematologic: anaemia;

Metabolic: gout;

Musculoskeletal: arm pain, hip pain, joint swelling, knee pain, musculoskeletal pain, shoulder pain, stiffness, arthralgia, arthritis, fibromyalgia, muscle weakness;

Nervous System/Psychiatric: anxiety, anxiety disorder, ataxia, confusion, depression, dream abnormality, hypesthesia, decreased libido, memory impairment, migraine, nervousness, paraesthesia, peripheral neuropathy, panic disorder, sleep disorder, somnolence, tremor, vertigo;

Respiratory: dyspnoea, bronchitis, pharyngeal discomfort, epistaxis, rhinitis, respiratory congestion;

Skin: alopecia, dermatitis, dry skin, ecchymosis, erythema, flushing, photosensitivity, pruritus, rash, sweating, urticaria;
Special Senses: blurred vision, burning/stinging in the eye, conjunctivitis, taste perversion, tinnitus, decrease in visual acuity;
Urogenital: impotence, nocturia, urinary frequency, urinary tract infection.

The following adverse reactions have been reported in post-marketing experience:

Hypersensitivity: Anaphylactic reactions, angioedema including swelling of the larynx and glottis causing airway obstruction and/or swelling of the face, lips, pharynx and/or tongue has been reported rarely in patients treated with losartan; some of these patients previously experienced angioedema with other drugs including ACE inhibitors. Vasculitis, including Henoch-Schoenlein purpura, has been reported rarely.

Gastrointestinal: Hepatitis (reported rarely), diarrhoea, liver function abnormalities, vomiting.

General disorders and administration site conditions: Malaise

Haematologic: anaemia, thrombocytopenia (reported rarely)

Musculoskeletal: myalgia, arthralgia.

Rare cases of rhabdomyolysis have been reported in patients receiving angiotensin II receptor blockers.

Nervous System/Psychiatric: migraine, dysgeusia.

Reproductive system and breast disorders: Erectile dysfunction/impotence.

Respiratory: Cough

Skin: urticaria, pruritus, erythroderma, photosensitivity.

Laboratory Test Findings

In controlled clinical trials, clinically important changes in standard laboratory parameters were rarely associated with administration of COZAAR.

Creatinine, Blood Urea Nitrogen: Minor increases in blood urea nitrogen (BUN) or serum creatinine were observed in less than 0.1 percent of patients with essential hypertension treated with COZAAR alone. No patient discontinued taking COZAAR alone due to increased BUN or serum creatinine. (See WARNINGS AND PRECAUTIONS, Impaired Renal Function.)

Haemoglobin and Haematocrit: Small decreases in haemoglobin and haematocrit (mean decreases of approximately 0.11 grams percent and 0.09 volume percent respectively) occurred frequently in patients treated with COZAAR alone, but were rarely of clinical importance. No patients were discontinued due to anaemia.

Liver Function Tests: Occasional elevations of liver enzymes and/or serum bilirubin have occurred. In patients with essential hypertension treated with COZAAR alone, one patient (<0.1%) was discontinued due to these laboratory adverse experiences.

DOSAGE AND ADMINISTRATION

The usual starting and maintenance dose is 50 mg once daily for most patients. The maximal antihypertensive effect is attained 3-6 weeks after initiation of therapy.

If the antihypertensive effect using 50 mg once daily is inadequate, 25 mg twice daily is recommended prior to increasing the dose.

For patients with intravascular volume-depletion (e.g., those treated with high-dose diuretics), a starting dose of 25 mg once daily should be considered (see PRECAUTIONS).

COZAAR can be administered once or twice daily. The total daily dose ranges from 25 mg to 100mg.

No initial dosage adjustment is necessary for elderly patients or for patients with renal impairment, including patients on dialysis. A lower dose should be considered for patients with a history of hepatic impairment (see PRECAUTIONS).

COZAAR may be administered with other antihypertensive agents.

COZAAR may be administered with or without food.

OVERDOSAGE

Limited data are available in regard to overdosage in humans. The most likely manifestation of overdosage would be hypotension and tachycardia; bradycardia could occur from parasympathetic (vagal) stimulation. If symptomatic hypotension should occur, supportive treatment should be instituted.

Neither losartan nor the active metabolite can be removed by haemodialysis.

For information on the management of overdose, contact the Poisons Information Centre on 13 11 26 (Australia).

PRESENTATION AND STORAGE CONDITIONS

COZAAR 50 mg tablet: White, oval scored tablet, marked "952", available in a blister pack containing 30 tablets.

Storage conditions

Store at temperatures below 30°C.

NAME AND ADDRESS OF SPONSOR

Merck Sharp and Dohme (Australia) Pty Limited
Level 1 Building A, 26 Talavera Road,
Macquarie Park, NSW 2113Australia

POISON SCHEDULE OF THE MEDICINE

Prescription Only Medicine (Schedule 4)

DATE OF FIRST INCLUSION IN THE ARTG

28 March 1996

DATE OF MOST RECENT AMENDMENT

Last approved by the Therapeutic Goods Administration: 27 March 2017

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